Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Duncan Abrams, a prisoner at HMP Hewell, on 4 September 2025

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

1. The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into

deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

2. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. In July 2025, Mr Duncan Abrams was remanded to prison and taken to HMP Hewell for allegedly breaching his Sexual Harm Prevention Order. He died of adenocarcinoma of the rectum with metastases to liver and lungs (cancer that started in the rectum and spread to the liver and lungs) on 4 September, in a hospice. He was 66 years old. We offer our condolences to Mr Abrams' family and friends.

4. The Ombudsman's office wrote to Mr Abrams' next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond.

5. NHS England commissioned an independent clinical reviewer to review Mr Abrams clinical care at HMP Hewell.

6. The clinical reviewer concluded that the clinical care Mr Abrams received at Hewell was of a good standard and equivalent to that which he could have expected to receive in the community. The clinical reviewer made a recommendation not related to Mr Abrams' death that the Head of Healthcare will wish to address.

7. The PPO investigator investigated the non-clinical issues relating to Mr Abrams care.

8. We did not find any non-clinical issues of concern. We make no recommendations.

9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Adrian Usher **March 2026**
Prisons and Probation Ombudsman

Inquest

The inquest hearing was held on 29 April 2026. The Coroner concluded that Mr Abrams died of natural causes.

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