

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Donald Eaton, a prisoner at HMP Holme House, on 25 December 2024

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



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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 October 2023, Mr Donald Eaton was sentenced to 12 years in prison for sex offences. He died from liver cancer on 25 December 2024 at HMP Holme House. He was 73 years old. We offer our condolences to Mr Eaton's family and friends.
4. The Ombudsman's office wrote to Mr Eaton's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond to our letter.
5. NHS England commissioned an independent clinical reviewer to review Mr Eaton's clinical care at HMP Holme House.
6. The clinical reviewer concluded that the clinical care Mr Eaton received at HMP Holme House was of a good standard and equivalent to that which he could have expected to receive in the community. She found that Mr Eaton was supported by a consistent core team on the inpatient unit, and she identified good practice in the end-of-life care he received. The clinical reviewer did not make any recommendations.
7. The PPO investigator investigated the non-clinical issues relating to Mr Eaton's care.
8. We did not identify any non-clinical learning. We make no recommendations.
9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.
10. At an inquest held on 28 August 2025, the Coroner concluded that Mr Eaton died of natural causes.

Adrian Usher
Prisons and Probation Ombudsman

May 2025

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