Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Edmunds, a prisoner at HMP Long Lartin, on 22 January 2025

A report by the Prisons and Probation Ombudsman

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 December 2017, Mr Paul Edmunds was sentenced to 30 years imprisonment for firearms offences. He died in hospital of bowel cancer on 22 January 2025, while a prisoner at HMP Long Lartin. He was 73 years old. We offer our condolences to Mr Edmunds' family and friends.

4. The Ombudsman's office wrote to Mr Edmunds' son to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond to our letter.

5. NHS England commissioned an independent clinical reviewer to review Mr Edmunds' clinical care at HMP Long Lartin.

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

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

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

9. We shared our initial report with HMPPS and the prison's healthcare provider, Practice Plus Group. HMPPS found no factual inaccuracies. Practice Plus Group pointed out some factual inaccuracies in the clinical review. This has been amended and has been reattached as an annex.

10. The inquest, held on 22 May 2025, concluded that Mr Edmunds died from natural causes.

Adrian Usher **July 2025**
Prisons and Probation Ombudsman

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