

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Raymond Kingsland, a prisoner at HMP Holme House, on 6 February 2025**

**A report by the Prisons and Probation Ombudsman**

Third Floor, 10 South Colonnade  
Canary Wharf, London E14 4PU

Email: [mail@ppo.gov.uk](mailto:mail@ppo.gov.uk)  
Web: [www.ppo.gov.uk](http://www.ppo.gov.uk)

T | 020 7633 4100

## **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 June 2023, Mr Raymond Kingsland was sentenced to four years imprisonment for sexual offences. He died of lung cancer on 6 February 2025, at HMP Holme House. He was 74 years old. We offer our condolences to Mr Kingsland's family and friends.
4. The Ombudsman's office wrote to Mr Kingsland's brother 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 Kingsland's clinical care at Holme House.
6. The clinical reviewer concluded that the clinical care Mr Kingsland received at Holme House was of a reasonable standard and at least equivalent to that which he could have expected to receive in the community. She made six recommendations not related to Mr Kingsland's death that the Head of Healthcare will wish to address.
7. The PPO investigator investigated the non-clinical issues relating to Mr Kingsland's care. She interviewed two members of staff from Holme House with the clinical reviewer on 9 April 2025.
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, Spectrum Community Health CIC. They found no factual inaccuracies.

**Adrian Usher**  
**Prisons and Probation Ombudsman**

**June 2025**

## **Inquest**

At the inquest, held on 27 March 2025, the coroner concluded that Mr Kingsland died from natural causes.

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