Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Richard Keeling, a prisoner at HMP Stafford, on 17 May 2024

A report by the Prisons and Probation Ombudsman

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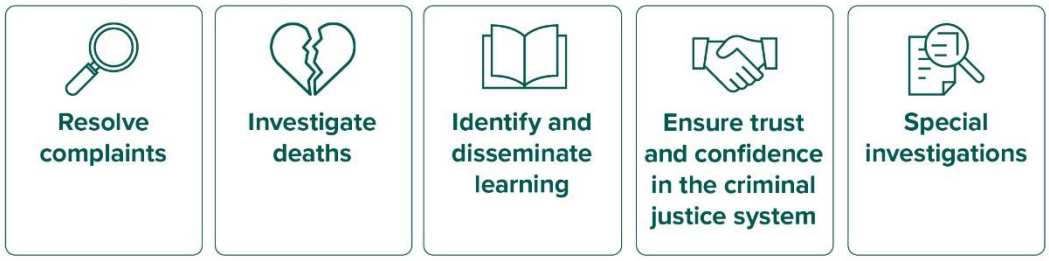
OUR VISION

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

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. On 14 February 2022, Mr Richard Keeling was convicted of sexual offences and sentenced to 13 years in prison.

4. On 17 May 2024, Mr Keeling died of progression of chronic myelomonocytic leukaemia while a prisoner at HMP Stafford. He was 73 years old. We offer our condolences to Mr Keeling's family and friends.

5. The Ombudsman's office contacted Mr Keeling'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.

6. NHS England commissioned an independent clinical reviewer to review Mr Keeling's clinical care at Stafford.

7. The clinical reviewer concluded that the care Mr Keeling received at Stafford was of a good standard and at least equivalent to what he could have expected to receive in the community. Mr Keeling had medical conditions that the healthcare team generally managed well. The clinical reviewer made recommendations not related to his death which the Head of Healthcare will wish to address.

8. The PPO investigator investigated the non-clinical issues relating to Mr Keeling's care. We did not find any non-clinical issues of concern related to his death. We make no recommendations.

Governor to note

9. When Mr Keeling died, during the night, the allocated family liaison officer was not on duty. The night manager did not deploy an alternative family liaison officer to break the news of Mr Keeling's death to his family. The family were contacted on 17 May by the night manager. A senior manager reminded the night manager that he should have deployed a family liaison officer promptly. We are satisfied that the prison has addressed the omission but bring it to the Governor's attention for monitoring.

10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies, and this report has been amended accordingly.

Adrian Usher **December 2024**
Prisons and Probation Ombudsman

At the inquest held on 18 February 2025 the coroner concluded Mr Keeling died of natural causes.

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