Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Steven Rylands, a prisoner at HMP Frankland, on 9 June 2024

A report by the Prisons and Probation Ombudsman

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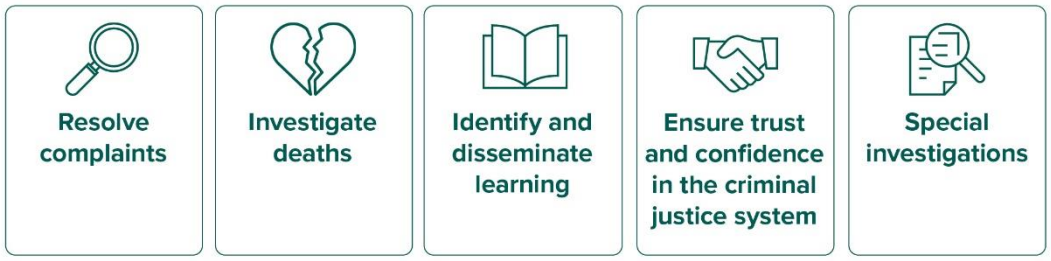
OUR VISION

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 March 1987, Mr Steven Rylands was sentenced to life imprisonment for kidnapping and other offences. He died of a combination of sepsis (a life-threatening overreaction of the body to an infection) resulting from leg ulcers and ketoacidosis (severe lack of insulin) which was caused by a complication of diabetes. He died on 9 June 2024 at HMP Frankland. He was 64 years old. We offer our condolences to Mr Rylands' family and friends.

4. The Ombudsman's office wrote to Mr Rylands' 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 Rylands' clinical care at Frankland.

6. The clinical reviewer concluded that the clinical care Mr Rylands received at Frankland was of a high standard and equivalent to that which he could have expected to receive in the community. She found that Mr Rylands received excellent individualised end of life care planning. The clinical reviewer made no recommendations.

7. The PPO investigator investigated the non-clinical issues relating to Mr Rylands' care. We did not find any non-clinical issues of concern. We make no recommendations.

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

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

Inquest

The inquest hearing was held on 7 February 2025. The Coroner concluded that Mr Rylands died of natural causes.

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