Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Robert Astley, a prisoner at HMP Norwich, on 27 December 2023

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. In 1983, Mr Robert Astley was sentenced to life imprisonment with a tariff (minimum time he would spend in prison) of 20 years for murder. He died in hospital of sepsis caused by a leg ulcer on 27 December 2023, while a prisoner at HMP Norwich. He also had diabetes and chronic kidney disease which did not cause but contributed to his death. He was 64 years old. We offer our condolences to Mr Astley's family and friends.

4. NHS England commissioned an independent clinical reviewer to review Mr Astley's clinical care at HMP Norwich.

5. The clinical reviewer concluded that the clinical care Mr Astley received at HMP Norwich was of a satisfactory standard and equivalent to that which he could have expected to receive in the community. The clinical reviewer recognised several areas of good practice. She also made four recommendations, which did not impact on her assessment of equivalence, that the Head of Healthcare will wish to address.

6. The Ombudsman's office wrote to Mr Astley's sister to explain the investigation and to ask if she had any matters she wanted us to consider. She had concerns relating to Mr Astley's healthcare at Norwich and asked for a copy of our report. Her concerns have been addressed by the clinical reviewer.

7. The PPO investigator investigated the non-clinical issues relating to Mr Astley's 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.

9. Mr Astley's family received a copy of the draft report. They did not make any comments.

Good practice

10. The compassion demonstrated by the family liaison officer when Mr Astley's condition deteriorated and following his death was commendable. The family liaison officer demonstrated efforts that went above and beyond what could be expected in the support she offered to Mr Astley's sister.

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

At the inquest, held on 4 March 2025, the Coroner concluded that Mr Astley died from natural causes.

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