Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Robert Rixon, a prisoner at HMP Parc, on 17 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

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 November 2022, Mr Robert Rixon was sentenced to 25 years imprisonment for several sexual offences. He died of pneumonia (infection to the lungs) which was caused by chronic obstructive pulmonary disease (COPD – a group of lung conditions which cause breathing difficulties) on 17 June 2024 in hospital. He was 77 years old. We offer our condolences to Mr Rixon's family and friends.

4. The Ombudsman's office wrote to Mr Rixon'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.

5. Healthcare Inspectorate Wales commissioned an independent clinical reviewer to review Mr Rixon's clinical care at HMP Parc.

6. The clinical reviewer concluded that the clinical care Mr Rixon received at HMP Parc was of a high standard and equivalent to that which he could have expected to receive in the community. He found that Mr Rixon's medical records contained evidence of excellent individualised end of life care planning. The clinical reviewer made recommendations not related to Mr Rixon's death that the Head of Healthcare will wish to address.

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

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

Inquest

The inquest hearing was held on 13 February 2025. The Coroner concluded that Mr Rixon died of natural causes.

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