Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Robert Dearden, a prisoner at HMP Rye Hill, on 25 April 2025

A report by the Prisons and Probation Ombudsman

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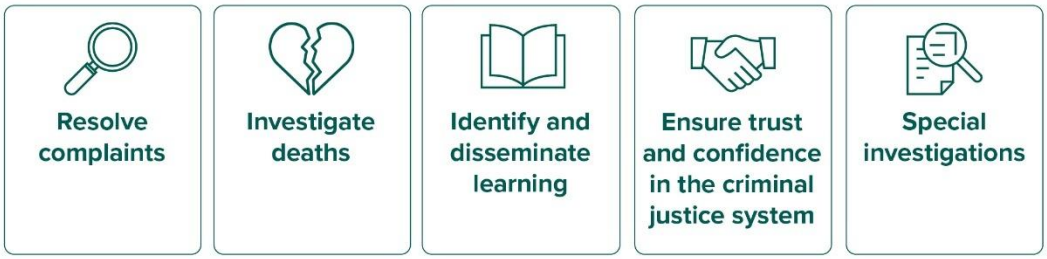
OUR VISION

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 November 2019, Mr Robert Dearden was sentenced to 14 years in prison for sexual offences. He died in hospital of decompensated alcoholic liver disease on 25 April 2025, while a prisoner at HMP Rye Hill. He was 73 years old. We offer our condolences to Mr Dearden's family and friends.

4. The Ombudsman's office wrote to Mr Dearden's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They had no questions but asked for a copy of our report.

5. NHS England commissioned an independent clinical reviewer, to review Mr Dearden's clinical care at HMP Rye Hill.

6. The PPO investigator and the clinical reviewer jointly interviewed the Deputy Head of Healthcare by video conference on 20 June 2025.

7. The clinical reviewer concluded that the clinical care Mr Dearden received at Rye Hill was of a good standard and least equivalent to what he could have expected to receive in the community. She found that Mr Dearden's medical records contained evidence of excellent individualised end of life care planning. The clinical reviewer made recommendations not related to Mr Dearden's death that the Head of Healthcare will wish to address.

8. Mr Olowu investigated the non-clinical issues relating to Mr Dearden's care. We did not find any non-clinical issues of concern. We make no recommendations.

Good practice

9. We found documented evidence that prison officers held regular key work sessions with Mr Dearden during which they consistently discussed his health.

10. The initial report was shared with the HM Prison and Probation Service (HMPPS) and healthcare. HMPPS and Practice Plus Group did not find any factual inaccuracies.

11. At the inquest held on 19 December 2025, the coroner concluded that Mr Robert Dearden died of natural causes.

Adrian Usher
Prisons and Probation Ombudsman **October 2025**

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