Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Phillip Chell, a prisoner at HMP Oakwood, on 28 June 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. Mr Phillip Chell died of pulmonary haemorrhage (bleeding into the lung) on 28 June 2023, at HMP Oakwood. He was 43 years old. We offer our condolences to Mr Chell's family and friends.

4. The PPO family liaison officer wrote to Mr Chell's parents to explain the investigation and to ask if they had any matters they wanted us to consider. They were concerned that Mr Chell was not prescribed painkillers for an existing elbow injury and was not seen by a doctor when he first started to cough up blood. These issues have been addressed in the clinical review.

5. NHS England commissioned an independent clinical reviewer to review Mr Chell's clinical care at HMP Oakwood. The clinical reviewer concluded that the clinical care Mr Chell received at Oakwood was of a good standard and equivalent to that which he could have expected to receive in the community. She made one recommendation not connected to Mr Chell's death, which the Head of Healthcare will wish to address.

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

7. We shared our initial report with HMPPS. They found no factual inaccuracies.

8. We sent Mr Chell's parents a copy of the initial report. They raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

Adrian Usher **December 2023**
Prisons and Probation Ombudsman

Inquest

The inquest, held on 12 June 2025, concluded that Mr Chell died from natural causes.

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