

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Anthony Philips, a prisoner at HMP Risley, on 3 October 2025

A report by the Prisons and Probation Ombudsman

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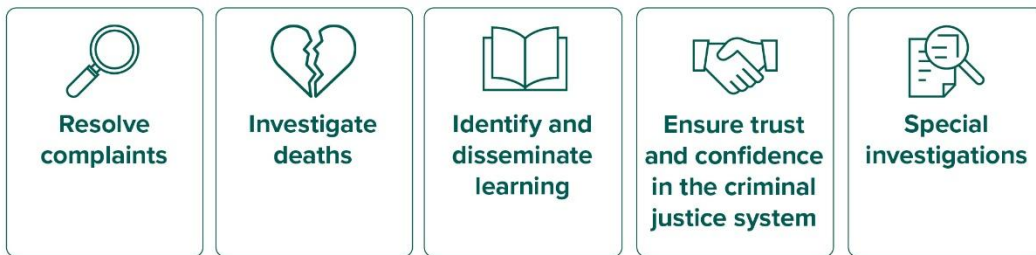
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OUR VISION

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 July 2025, Mr Anthony Philips was sentenced to twelve weeks imprisonment for harassment and breaching his Sexual Harm Prevention Order and taken to HMP Durham. He died of congestive heart failure on 3 October, at HMP Risley, having transferred there in August. This was caused by ischaemic heart disease due to coronary artery atheroma (a build-up of fatty plaque inside the arteries that supply blood to the heart) and left ventricular hypertrophy (thickening of the heart muscle wall). He was 62 years old. We offer our condolences to Mr Philips' family and friends.
4. The Ombudsman's office wrote to Mr Philips' 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 Philips' clinical care at Risley. The clinical reviewer's report is attached as Annex 1.
6. The clinical reviewer concluded that the clinical care Mr Philips received at Risley was of a good standard and equivalent to that which he could have expected to receive in the community. She found that Mr Philips' healthcare needs were appropriately managed with referrals undertaken when necessary. The clinical reviewer made no recommendations.
7. The PPO investigator investigated the non-clinical issues relating to Mr Philips' care.
8. We did not find any non-clinical issues of sufficient concern to make a recommendation, but we bring the issues below to the attention of the Governor and Head of Healthcare.
9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Governor to note

Roll checks

10. To complete roll checks, HMPPS' policy requires staff to obtain a clear view of the prisoner's face, wake them if necessary and confirm signs of life. On 3 October, an operational support grade (OSG) recorded no concerns during the morning roll check at 6.30am. When an officer unlocked Mr Philips' cell at 8.00am, they found him showing clear signs of rigor mortis (stiffening of the body that typically develops between two and four hours after death). No CCTV footage was available to corroborate the timing or completion of the morning roll checks.
11. We have not been able to interview the OSG who completed the check as she has been on sick leave since Mr Philips' death. However, we have not identified issues with inadequate roll checks in our recent investigations following deaths at Risley. We therefore bring this potential issue to the Governor's attention who will want to assure herself that roll checks are taking place in line with policy.

Head of Healthcare to note

Availability of defibrillators

12. At the time of Mr Philips' death, there were no defibrillators stored on the residential units. Although healthcare staff obtained a defibrillator in a timely manner, the absence of this equipment on the unit could delay critical intervention in a medical emergency. We bring this to the Head of Healthcare's attention.

Inquest

13. At the inquest held on 1 June 2026, the Coroner concluded that Mr Philips died from natural causes.

Adrian Usher
Prisons and Probation Ombudsman

May 2026

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