

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Richard Pinder, a prisoner at HMP Leeds, on 28 December 2025

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100

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



© Crown copyright, 2026

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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 30 June 2025, Mr Richard Pinder was remanded to prison for alleged offences of grievous bodily harm and assault and was taken to HMP Leeds. Mr Pinder was 41 years old when he died on 28 December in hospital. We offer our condolences to Mr Pinder's family and friends.
4. Mr Pinder died of severe respiratory failure (lung failure) which was caused by exacerbation of interstitial lung disease (inflammation and scarring of the lungs) which, in turn, was caused by pneumonia and pneumocystis carini (lung infections). The following conditions contributed but did not cause Mr Pinder's death: decompensated liver disease (when the liver does not function properly and the body is unable to compensate), autoimmune cirrhosis (scarring of the liver caused by autoimmune disease) with progression to portal hypertension (raised pressure in the portal vein to the liver), hypertrophic cardiomyopathy (thickening of the heart muscle), chronic hypersensitivity pneumonitis (lung disease caused by inhalation of allergens), diabetes mellitus (high blood sugar levels), and paroxysmal atrial fibrillation (fast heart rate).
5. The Coroner for West Yorkshire held an inquest on 19 January 2026. The inquest concluded that Mr Pinder died of natural causes.
6. The Ombudsman's office wrote to Mr Pinder's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They asked us several questions which have been addressed in separate correspondence.
7. NHS England commissioned an independent clinical reviewer, to review Mr Pinder's clinical care at HMP Leeds.
8. The clinical reviewer concluded that the clinical care Mr Pinder received at Leeds was not equivalent to that which he could have expected to receive in the community. She concluded that healthcare staff did not appropriately identify which medications Mr Pinder had been prescribed in the community and, as result, he was inappropriately medicated for several months. The clinical reviewer made the following recommendation which we endorse and recast:

The Head of Healthcare should ensure that all previously prescribed medicines are continued after arrival at HMP Leeds unless there is a clinical rationale not to continue.

9. The clinical reviewer also found that healthcare staff inappropriately discharged Mr Pinder from the Learning Disability caseload. We make the following recommendation:

The Head of Healthcare should ensure that all decisions to discharge someone from a mental health/learning disabilities caseload are based on a complete picture of the individual's needs for support and monitoring.

10. The clinical reviewer also made other recommendations, not related to Mr Pinder's death, which the Head of Healthcare will wish to address.
11. The PPO investigator investigated the non-clinical issues relating to Mr Pinder's care.
12. We did not find any non-clinical issues to warrant making a recommendation, but we bring the below to the attention of the Governor.

Governor to note

Family liaison

Mr Pinder was taken to hospital on 9 December, but staff only notified the family on 22 December. Staff told us that they notified the family once Mr Pinder's condition became life threatening, in line with policy. Prison staff told us that Mr Pinder could have requested to speak to his family after seven days, but there is no evidence that he did so. Considering Mr Pinder's vulnerability and that this was his first time in prison, we find that staff should have been more proactive and offered this to him. We bring this to the attention of the Governor.

13. We shared the initial report with HM Prison and Probation Service (HMPPS) and Practice Plus Group. They did not find any factual inaccuracies and their action plan is an additional annex to this report. Practice Plus Group provided some additional information for the clinical review which has been added.
14. We also shared the initial report with Mr Pinder's next of kin. They did not make any comments.

Adrian Usher
Prisons and Probation Ombudsman

September 2026

**Prisons &
Probation**

Ombudsman

Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100