

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr George Richards, on 4 January 2026, following his release from HMP Lincoln

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



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Summary

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. Since 6 September 2021, the PPO has investigated post-release deaths that occur within 14 days of the person's release from prison.
3. 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.
4. Mr George Richards died from septic shock caused by group A streptococcus (a contagious bacteria that causes various infections) on 4 January 2026, following his release from HMP Lincoln on 30 December 2025. He was 24 years old. We offer our condolences to those who knew him.
5. The clinical reviewer found that the clinical care Mr Richards received during his time at Lincoln, including arrangements at the point of his release, was of an appropriate standard and was equivalent to that which he could have expected to receive in the community. The clinical reviewer found that Mr Richards had minimal engagement with healthcare services during his period in prison, and that where healthcare staff had seen him, they made timely and detailed records which clearly outlined continuity of care.
6. We did not identify any significant learning relating to the pre-release planning or post-release supervision of Mr Richards. We make no recommendations.

The Investigation Process

7. HMPPS notified us of Mr Richards' death on 5 January 2026.
8. The PPO investigator obtained copies of relevant extracts from Mr Richards' prison and probation records.
9. NHS England commissioned an independent clinical reviewer, to review Mr Richards' clinical care at HMP Lincoln. The clinical review is attached as Annex 1.
10. The PPO investigator investigated the non-clinical issues relating to Mr Richards' care. The investigator and the clinical reviewer jointly interviewed two members of healthcare staff at Lincoln. The investigator further interviewed a former prisoner who had shared a cell with Mr Richards at Lincoln.
11. We informed HM Coroner for Leicester of the investigation, and they told us Mr Richards was not known to them. Leicestershire hospitals bereavement services told us that Mr Richards' case was referred to the Coroner, but the hospital cause of death had been accepted. We have sent the Coroner a copy of this report.
12. The Ombudsman's office contacted Mr Richards' mother to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Richards' mother asked about the healthcare Mr Richards had received at Lincoln and whether any symptoms of his illness had been missed. She asked for a copy of our report. We have answered these questions in our report.
13. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.
14. We also shared the initial report with Mr Richards' mother. She did not make any comments.

Background Information

HMP Lincoln

15. HMP Lincoln is a category B prison which holds convicted and remanded male prisoners. When Mr Richards was at Lincoln, Nottinghamshire Healthcare NHS Trust provided healthcare services. From 21 January 2026, Northamptonshire Healthcare NHS Foundation Trust provide healthcare services.

Probation Service

16. The Probation Service works with all individuals subject to custodial and community sentences. During a person's imprisonment, they oversee their sentence plan to assist in rehabilitation, prepare reports to advise the Parole Board and have links with local partnerships to which they refer people for resettlement services, where appropriate. Post-release, the Probation Service supervises people throughout their licence period and post-sentence supervision.

Deaths following release from prison

17. Between September 2021 and the end of March 2026, the PPO started investigations into approximately 300 deaths of people who died within 14 days of release from prison. The PPO has published two learning lessons bulletins about post-release deaths, most recently in July 2024. Our investigations highlight the acute vulnerability of prison leavers, especially during the first few days post-release, and indicate that prison leavers often have multiple risk factors such as mental health and substance use issues and homelessness which further increase their vulnerability and risk of death following release from prison.

Previous deaths following release from HMP Lincoln

18. Mr Richards was the sixth man to die within 14 days of release from Lincoln since January 2023, and the first to die from natural causes. To the end of April 2026, there have not been any further deaths within 14 days of release from Lincoln.
19. We identified no similarities between our investigation findings about the previous deaths and those about Mr Richard's death.

Key Events

Background

20. On 21 November 2025, Mr George Richards was convicted of burglary and was sentenced to 14 weeks in prison. He was sent to HMP Lincoln. This was his first time in prison.
21. A nurse saw Mr Richards upon his arrival at Lincoln. He reported that he was fit and well and did not identify any concerns about his physical health. On 23 November, a nurse saw Mr Richards for a secondary health screen. He reported an enlarged heart and hereditary multiple exostoses (a genetic disorder causing multiple benign bone growths) but reported no current physical health concerns.
22. On 2 December, Mr Richards' community offender manager (COM) attended a multi-agency professionals' meeting to discuss how best to support Mr Richards upon his release from prison. During this meeting it was confirmed that Mr Richards had appropriate accommodation to be released to, and this was the same property he had been living in prior to coming to prison. Mr Richards' COM also discussed the licence conditions she would be adding to Mr Richards' licence on his release from prison.
23. On 7 December, a nurse saw Mr Richards who said that he had pain all over his body. The nurse referred Mr Richards to the GP.
24. On 9 December, Dr A, a GP working at Lincoln, saw Mr Richards. She recorded that Mr Richards had hereditary exostoses affecting numerous joints. Mr Richards reported that the pain was worse during cold weather and said that he was on a waiting list to undergo surgery on his left leg. The doctor prescribed anti-inflammatory medication and paracetamol. (Mr Richards did not collect this medication.)
25. Between 9-30 December there were no recorded contacts between Mr Richards and the healthcare team at Lincoln. Mr Richards' cellmate told us that he appeared healthy during his time in prison and that he did not say at any point that he felt unwell.
26. On 26 December, a member of prison staff issued Mr Richards with a copy of his licence, which he signed. Mr Richards' COM added conditions to his licence which included a requirement for Mr Richards to attend appointments with a medical practitioner as required.

Post-release management/release from HMP Lincoln

27. On 30 December, Mr Richards was released from Lincoln. Nurse A saw Mr Richards ahead of his release. Mr Richards confirmed that he was not in receipt of any prescribed medication and said that he would attend hospital in Nottingham where he was awaiting surgery on his leg. During interview, Nurse A told us that Mr Richards did not appear as unfit or unwell, nor did he raise any concerns about his health.

28. At 12.00pm, Mr Richards failed to attend an induction appointment with his COM at his local probation office. Mr Richards' COM liaised with staff from Mr Richards' accommodation providers who advised that he had not returned to his address.
29. At 4.15pm, probation staff decided to recall Mr Richards to prison. Mr Richards' COM submitted the recall paperwork to the public protection casework section (PPCS).
30. On 31 December, Mr Richards' COM received an email from staff at his accommodation to advise that he had returned to his property at 7.55pm the previous day.
31. On 2 January 2026, staff from Mr Richards' accommodation sent an email to his COM stating that Mr Richards was still at the property and had stayed at home all day on 1 January as he felt unwell. Mr Richards' COM advised that she was on leave when this email was sent, and she did not return to work until 5 January.

Circumstances of Mr Richards' death

32. Mr Richards' mother told us that, on 3 January 2026, a staff member at Mr Richards' accommodation saw that he was unwell and called an ambulance for him. Mr Richards was initially taken to Queen's Medical Centre hospital in Nottingham and, on 4 January, he was transferred to Glenfield hospital, Leicestershire. He died on the same day.

Cause of death

33. A post-mortem examination was not carried out as the Coroner accepted the cause of death provided by a hospital doctor. The doctor gave the cause of death as septic shock caused by group A streptococcus, with influenza A contributing to but not causing the death.

Findings

34. Mr Richards died as a result of natural causes relating to septic shock. The clinical reviewer found that there was no indication that Mr Richards was unwell during his time at Lincoln or at the time of his release. She found that the clinical care he received in prison was equivalent to that he could have expected to receive in the community. We are satisfied that there is nothing further that prison, probation or healthcare staff could have done to prevent Mr Richards' death.

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