

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

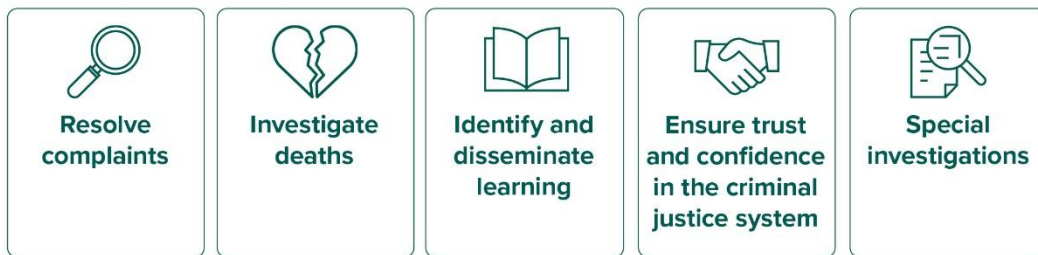
# **Independent investigation into the death of Mr John Richards, a prisoner at HMP Aylesbury, on 6 October 2023**

**A report by the Prisons and Probation Ombudsman**

## 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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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.

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.

Mr Richards was found collapsed in his cell on 6 October 2023 and was taken to hospital where he died shortly after. At post-mortem he was found to have a large plum lodged in his lower throat. The pathologist gave his cause of death as acute upper airway obstruction (choking). Mr Richards was 49 years old. I offer my condolences to his family and friends.

Mr Richards had been displaying signs of anxiety and paranoia for an extended time before his death. He believed that other prisoners falsely thought he was a sex offender and were planning to attack him. His anxiety appeared to increase markedly in the days leading up to his death.

Mr Richards consistently denied having thoughts of suicide or self-harm, so he was not subject to suicide and self-harm monitoring (known as ACCT). Mr Richards received considerable support from officers in his final days trying to reassure him that he was safe.

The clinical reviewer concluded that there was no pro-active intervention in response to Mr Richards' deteriorating mental health. The clinical care during the emergency response was also not adequate.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

**Adrian Usher**  
**Prisons and Probation Ombudsman**

**March 2025**

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## Summary

### Events

1. On 27 September 2022, Mr John Richards was remanded to HMP Elmley, charged with controlling and coercive behaviour to his partner. He was later sentenced to five and a half years in prison. While at Elmley, Mr Richards was briefly supported through prison suicide and self-harm procedures, known as ACCT, when he made superficial cuts to his neck as he feared other prisoners intended to harm him. On 28 July 2023, Mr Richards transferred to HMP Aylesbury.
2. From 4 September onwards, Mr Richards felt under threat from other prisoners who he thought mistakenly believed that he was a sex offender. Mr Richards acknowledged, at times, that he was probably suffering with paranoia, but he said that recognising that did not prevent him hearing voices of prisoners planning to attack him.
3. Mr Richards moved to different wings, but he continued to say that he felt under threat. Mr Richards denied having thoughts of suicide or self-harm and staff did not start ACCT procedures.
4. At 8.42am on 6 October, a prisoner looked into Mr Richards' cell and alerted staff that he appeared to be dead. Officers went into the cell and, after checking Mr Richards, they radioed a medical emergency code. More officers responded and started cardiopulmonary resuscitation (CPR). As the room was cramped, they gave CPR to Mr Richards while he was lying on his bed. Nurses arrived four minutes later, and they took over CPR.
5. Ambulance paramedics arrived at 8.57am. They moved Mr Richards from his cell to the landing and continued efforts to try to resuscitate him. At 9.32am, paramedics took Mr Richards to hospital. At 9.58am, a hospital doctor pronounced Mr Richards' life extinct.
6. At post-mortem, Mr Richards was found to have a large plum lodged in his windpipe, which had caused his death by choking.

### Findings

7. By 4 October, Mr Richards had become acutely mentally unwell but planned actions for medication and a psychiatric review had not occurred by the time of his death and there was no written care plan to include monitoring and escalation of the management of his care including advice to officers.
8. The nursing response on 6 October was inadequate: it is unclear whether nurses checked Mr Richards' airway, they did not deliver oxygen adequately and they delivered CPR with Mr Richards lying on his bed rather than a hard surface like the floor.

## Recommendations

- The Head of Healthcare should introduce a robust audit process to ensure that when prisoners are acutely mentally unwell, clear care plans are constructed including processes for effective monitoring of prisoners and advice to officers on escalating concerns.
- The Governor and Head of Healthcare should identify the learning from the investigation into the emergency response and implement an appropriate training plan.

## The Investigation Process

9. HMPPS notified us of Mr John Richards' death on 9 October 2023. The investigator issued notices to staff and prisoners at HMP Aylesbury informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
10. The investigator visited HMP Aylesbury on 24 October. He obtained copies of relevant extracts from Mr Richards' prison and medical records.
11. The investigator interviewed 11 members of staff and one prisoner at Aylesbury on 4, 5, 21 and 22 December. He interviewed one further member of staff by video link and one further prisoner by telephone.
12. NHS England commissioned a clinical reviewer to review Mr Richards' clinical care at the prison. The investigator and clinical reviewer jointly interviewed clinical staff.
13. We informed HM Coroner for Buckinghamshire of the investigation. He gave us the results of the post-mortem examination. We have sent him a copy of this report.
14. We contacted Mr Richards' sister to explain the investigation and to ask if she had any matters she wanted us to consider. She raised the following issues:
  - Why was her brother in self-isolation?
  - Were her brother's mental health needs recognised by staff and was he prescribed and given medication?
  - Her brother tried to telephone her at 2.30am on 2 October but she was told that prisoners' phones were switched off at that time.
  - At what time was her brother checked on the morning of 6 October and how was his mood at that time?
  - What were the circumstances surrounding another prisoner raising the alarm later on that morning?
  - Did the nurse responders check her brother's airway?
15. These questions are addressed in our report and the clinical review. Mr Richards' sister asked further questions which we have answered in separate correspondence.
16. We shared our initial report with HM Prison and Probation Service (HMPPS). HMPPS clarified that challenge, support and intervention plans (CSIPs) are only for prisoners posing a risk to others and are not used to support potentially vulnerable prisoners. In light of this information, we have removed our previous references to use of a CSIP to support Mr Richards. HMPPS also provided evidence that Mr Richards was discussed at a Safety Intervention Meeting (SIM) on 26 September. We have included information on discussion of Mr Richards at the SIM that day and have adjusted our findings to take account of this new information.

17. We also shared our initial report with Mr Richards' sister. She wrote that reading the report raised further questions for her which she understood she would be able to raise at her brother's inquest. We also answered one of her questions in separate correspondence.

## Background Information

### HMP Aylesbury

18. HMP Aylesbury holds category C prisoners. All cells are designed for single occupancy. Central and Northwest London NHS Foundation Trust provides physical and mental healthcare services. Nurses are on duty from 7.30am to 6.30pm in the week and from 8.30am to 5.30pm at weekends.

### HM Inspectorate of Prisons (HMIP)

19. The most recent full inspection of HMP Aylesbury was in November and December 2022. Inspectors noted that Aylesbury was then in a period of transition moving from a longstanding function of holding long-term and high-risk young adult prisoners into a new role as a category C training prison. Inspectors noted that they had been consistently critical of Aylesbury over many years and this inspection was no different. Inspectors found that there was poor provision of purposeful activity, that prisoners were not treated well enough, and their needs were not being met.
20. Inspectors noted that a contributory factor to Aylesbury's difficulties was a problem in recruiting staff. The prison was short of around 50 officers, and staffing shortages in healthcare were of such concern that the prison tried to resist accepting prisoners over the age of 40. Prisoners time in the open air was limited to 30 minutes a day and unemployed prisoners spent up to 23 hours a day locked up. Inspectors noted that, at the time of the inspection, two prisoners were self-isolating because they felt under threat. However, their regime was too restrictive, and they only left their cells to collect food and medication.
21. Inspectors noted that in their survey, 53% of prisoners said they had felt unsafe at some point in their time at Aylesbury and 27% felt unsafe at the time of the inspection. Inspectors found that the SIM should have reviewed the care of the most vulnerable and challenging prisoners but work usually carried out by the safety team ahead of the meeting was not being done which undermined the effectiveness of the meetings.
22. Inspectors found that during the previous 12 months, there had been 215 self-harm incidents. Rates of self-harm were slightly higher than at comparable prisons, but the safety strategy did not focus on the factors that caused self-harm.
23. Inspectors found that the re-categorisation of the prison, along with the change in healthcare provider and staff shortages had affected some healthcare services. They noted that Central and Northwest London NHS Foundation Trust had delivered mental health services since October 2022, but the team's constitution reflected the needs of a young offender population and the change in contract had created vacancies which resulted in a fragile staffing position.
24. HMIP identified 15 key concerns, five of which were to be treated as priorities.
25. In August 2023, HMIP returned to Aylesbury to carry out a review of progress following the full inspection. HMIP noted that the Aylesbury's achievements in the

nine months since the inspection were commendable and provided a good foundation for future progress. In particular, inspectors found that the mental health team had recruited six of 13 posts, and that priority was being given to prisoners with the greatest need, although the lack of cover during periods of leave was still creating delays in psychiatric assessments. Inspectors found that leaders had implemented a new daily regime that had improved time out of cell considerably.

## Independent Monitoring Board

26. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to March 2023, the IMB reported that staffing shortages throughout the year had impacted negatively on the prison regime. The IMB noted that prisoners often reported feeling unsafe, particularly in their early days in the prison. They found that the change of population from young offenders to category C adults had resulted in a decline in violence, but not self-harm. The IMB reported that it had seen a more systematic approach to safety from the middle of the year with more in-depth analysis of incidents of violence. The IMB noted that key working had been reintroduced in January 2023. However, many prisoners did not know who their key worker was for several weeks and only saw the benefits of the scheme after regular meetings with their key worker.
27. The IMB noted that the healthcare provider from October 2022 had won the contract on the basis that they would be treating a population of 18 to 21 year olds and had had to make a significant transformation with the change in population to older prisoners with complex needs. The IMB found that the transition did not go smoothly and that for three months health services were patchy and sometimes chaotic.

## Previous deaths at HMP Aylesbury

28. Mr Richards was the fifth prisoner to die at Aylesbury since May 2020, but the first man over 25. Of the previous deaths, one was a self-inflicted death of an 18 year old man, one was from natural causes and the other two were most likely due to misuse of illicit substances. There were no similarities between Mr Richards' death and the previous deaths. Up to the end of December 2024, there had been no further deaths at Aylesbury since that of Mr Richards.

## Assessment, Care in Custody and Teamwork

29. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.

30. As part of the process, a care plan (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the care plan have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures at the time Mr Richards was in Aylesbury was set out in Prison Service Instruction (PSI) 64/2011.

## Key worker scheme

31. The key worker scheme is a key part of HMPPS's response to self-inflicted deaths, self-harm, and violence in prisons. It is intended to improve safety by engaging with people, building better relationships between staff and prisoners, and helping people settle into life in prison. Details of how the scheme should work are set out in HMPPS's Manage the Custodial Sentence Policy Framework. This says:
- All prisoners in the male closed estate must be allocated a key worker whose responsibility is to engage, motivate and support them through the custodial period.
  - Key workers must have completed the required training.
  - Governors in the male closed estate must ensure that time is made available for an average of 45 minutes per prisoner per week for delivery of the key worker role, which includes individual time with each prisoner.
32. Within this allocated time, key workers can vary individual sessions to provide a responsive service, reflecting individual need and stage in the sentence. A key worker session can consist of a structured interview or a range of activities such as attending an ACCT review, meeting family during a visit or engaging in conversation during an activity to build relationships.
33. In 2023/24, due to exceptional staffing and capacity pressures in parts of the estate, some prisons are delivering adapted versions of the key work scheme while they work towards full implementation. Any adaptations, and steps being taken to increase delivery, should be set out in the prison's overarching Regime Progression Plan which is agreed locally by Prison Group Directors and Executive Directors and updated in line with resource availability.

## Key Events

34. On 27 September 2022, Mr John Richards was remanded to prison and taken to HMP Elmley charged with controlling and coercive behaviour and actual bodily harm. The alleged victim was his long-term partner.
35. On the morning of 24 November, staff found that Mr Richards had made superficial cuts to his neck the previous night. He said that he believed other prisoners had wanted to harm him, although he no longer believed that was the case and he thought instead that he was suffering from paranoia. Staff started prison suicide and self-harm support procedures (known as ACCT) which continued until 5 December.
36. On 20 December, a GP prescribed Mr Richards an antidepressant, mirtazapine. On 24 December, Mr Richards was admitted to Elmley's healthcare unit following concerns from officers that he was suffering paranoia as he was hearing voices that people wished to harm him.
37. Mr Richards remained in the healthcare unit until 9 January 2023 when a psychiatrist assessed that he was fit to move to a standard prison wing. After two days on the wing, he returned to the healthcare unit at his own request.
38. On 13 January, a doctor prescribed Mr Richards olanzapine (an antipsychotic). During January, records show that Mr Richards remained in his cell due to a fear of other prisoners, that he used his cell bell excessively and that he made an excessive number of calls to the Samaritans' telephone line.
39. Staff spoke to Mr Richards about moving back to a standard prison wing. He refused to move to a standard wing but agreed to move to the segregation unit on 28 January. On 2 February, Mr Richards moved to a standard wing and records suggest that he then grew more settled.
40. On 16 March, Mr Richards was convicted of controlling and coercive behaviour and actual bodily harm. On 13 June, he was sentenced to five and a half years in prison.

### **HMP Aylesbury, 28 July 2023 onwards**

41. On 28 July, Mr Richards transferred to HMP Aylesbury. He arrived late in the working day so received a curtailed reception assessment for his first night. An officer noted that Mr Richards raised no concerns.
42. On 29 July, a nurse saw Mr Richards for a reception health screen. She noted that Mr Richards was prescribed mirtazapine and olanzapine. However, he said he did not want to be re-prescribed these medicines as he did not believe they helped him. She noted that Mr Richards engaged appropriately, he appeared calm and settled and he said that he had no thoughts of suicide or self-harm. She referred Mr Richards to a GP to review his request to discontinue his medication. Mr Richards spent his first three days at Aylesbury in the first night centre before moving to D wing on 31 July.

43. On 1 August, a mental health nurse assessed Mr Richards and noted that he was managing his mental health and well-being satisfactorily so did not need further support at that time.
44. On 4 August, a prison GP saw Mr Richards further to the nurse's earlier referral. Mr Richards said that he had been stressed, paranoid and in a low mood at Elmley but he was better now. He said that he had not taken his prescribed medicines for the past three weeks and he no longer wanted them. The GP noted that Mr Richards had no thoughts of suicide or self-harm and was experiencing no auditory or visual hallucinations. He told Mr Richards to tell officers if he had any hallucinations or future thoughts of suicide or self-harm. He sent a message to the mental health team to say that he was going to formally stop Mr Richards' mirtazapine and olanzapine prescriptions and asked them whether they had any concerns about that (they raised no concerns). He booked Mr Richards for a review in four weeks.
45. On 14 August, a mental health nurse saw Mr Richards for a welfare check. He noted that Mr Richards was stable in mood and mental state. He told Mr Richards to tell staff if his mental state deteriorated. The next day, the mental health team discussed Mr Richards and agreed that he would be discharged from their caseload.
46. On 18 August, Mr Richards moved to B wing. On 4 September, Mr Richards told officers that he felt under threat. An officer noted that there had been no incidents to suggest any threat, but staff agreed to his request to move to F wing that afternoon.
47. On 12 September, Mr Richards told an officer that he had heard prisoners on the landing above saying that they would assault him on the exercise yard that morning. He could not identify the prisoners involved, but he asked to move wings. An officer sent a referral to the mental health team. Mr Richards did not go to exercise that day.
48. On 22 September, the prison GP saw Mr Richards for a follow-up appointment. He noted that Mr Richards looked well and reported no concerns. On the same day, his workshop instructor made an entry in Mr Richards' record to say that in his six weeks in the workshop he had been a pleasure to work with due to his very hard work and diligent attitude.
49. On the evening of 24 September, Mr Richards rang his cell bell and asked to speak to a Listener (Listeners are prisoners trained by the Samaritans to provide the same support to prisoners as the Samaritans provide to the general public). Mr Richards spoke to the Listener for 15 minutes and he then told an officer that he had heard other prisoners calling out his name saying they were planning to attack him. The officer sent a referral to the mental health team, submitted a security report and emailed the supervising officer who would be on duty the following morning.
50. Mr Richards repeated his fears of assault on 25 September, and he did not go to work that day.

51. On 26 September, Mr Richards was discussed at the weekly SIM - a multidisciplinary meeting to discuss prisoners with potential risks and to consider what further support might be needed for them. With Mr Richards, the SIM noted that he was paranoid and had not gone to work the previous day. The SIM also noted that he had been referred to the mental health team. The action point for him was that a safety officer would go to see him.
52. Following the discussion at the SIM, an officer from the safer custody team saw Mr Richards that afternoon. The officer noted that Mr Richards was much better. He acknowledged that no prisoners had directly threatened him, instead some prisoners had spoken to him to reassure him that no one was planning to assault him. He also spoke about the support he was receiving from officers on the wing. (Mr Richards went to work that day.)
53. On 28 September, a mental health nurse saw Mr Richards following the referral to the mental health team two days before. Mr Richards said that he had thought that other prisoners were talking about him, but after speaking to the other prisoners, he realised he had made a mistake. He said that he was eating, drinking and sleeping well and had no thoughts of suicide or self-harm. Mr Richards said that he did not need support from the mental health team. The nurse advised him to contact the team if there was any deterioration in his mental health. He noted that Mr Richards was to be discussed at the multi-disciplinary meeting on 29 September, but there is no record that he was discussed that day.
54. On 1 October, Mr Richards again told staff that other prisoners were talking about him, and he felt under threat. Staff told Mr Richards that they would arrange a wing move for him and in the meantime, he would remain locked in his cell.
55. On 2 October, Mr Richards moved from F wing to A wing. An officer told the investigator that she greeted Mr Richards on his arrival and showed him to his cell. He then spoke to her several times that day about his fear of being attacked by other prisoners. He said that there was another prisoner elsewhere in the prison estate who had the same name as him and had been convicted of sexual offences. He said that he believed other prisoners were confusing him with that prisoner. She told the investigator that she tried to reassure Mr Richards that he was safe, but nothing she said seemed to help. She said that she asked two of the wing's trusted prisoners to speak to him in the hope that that would help.
56. Prisoner A told the investigator that he worked as a wing representative, as well as a Listener. He said that Mr Richards had spoken to a few prisoners when he initially arrived on A wing, but he very soon began to talk about being in fear of other prisoners. He said that he tried to reassure Mr Richards that he was not at risk, but nothing he said was of any help. He said that he had spoken to Mr Richards on a previous occasion, that time in his role of Listener, when he tried to get him to focus on his family.
57. Prisoner B was a prison Listener and he spoke to Mr Richards on 2 October in that role. He declined to speak to the investigator.
58. A Supervising Officer (SO) told the investigator that he went to see Mr Richards on 3 October after an officer told him that he was shouting at other prisoners. He

said that he could hear Mr Richards shouting as he approached the cell, although he could not distinguish any words. He said that Mr Richards told him that other prisoners had been outside his cell threatening him as they believed he was a sex offender. He said that after checking with another prisoner he returned to Mr Richards to tell him that other prisoners were not talking about him. He said that Mr Richards calmed down as they spoke, and he gave no indications that he was at risk of suicide or self-harm. He told Mr Richards to tell staff if prisoners made inappropriate comments about him.

59. Also on 3 October, an officer noted that he attempted to have a key worker meeting with Mr Richards, but he was not happy for the officer to open his door as he felt under threat. (This was the only attempted key work session recorded for Mr Richards at Aylesbury.)

#### 4 October

60. On the morning of 4 October, an SO spoke to Mr Richards to ask him why he was not coming out of his cell. She said that Mr Richards was clearly agitated and believed he was at risk from prisoners and staff. She tried to reassure him but, as they were speaking, he said that he could hear people outside his cell threatening him. She said that he acknowledged that he did not know whether this was real but said that he could hear the threats. She told him that she would start a self-isolation plan (prisoners on self-isolation plans are kept locked in their cells and their meals and medication are delivered to them. They take exercise and showers at a time when other prisoners are locked in their cells). Mr Richards confirmed that he was being supported by the mental health team and she told him that she would contact the safer custody team.
61. An officer from the safer custody team went to see Mr Richards in response to the SO's referral. He said that he knocked on Mr Richards' door and said who he was. Mr Richards allowed him into his cell, and he quickly looked out to check if there were other prisoners around. Mr Richards asked him to sit on a chair directly in front of the door to prevent other prisoners from entering. Mr Richards repeated his belief that he was under threat as prisoners thought he was a sex offender. The officer said that Mr Richards was very agitated and tried to look through the gaps in the door to see if there were other prisoners around. After speaking to Mr Richards for around 15 minutes, he told Mr Richards that he would make some checks about the allegations and speak to him again when he was next on duty on 6 October. He said that he asked Mr Richards if he had any thoughts of suicide or self-harm and he said that he had no such thoughts. He said that when he later Googled the name, it confirmed that there was another prisoner of the same name in prison for sexual offences.
62. Officers had again referred Mr Richards to the mental health team (it is not documented when) and, as a result, a mental health nurse saw him in the early afternoon of 4 October. The nurse noted that Mr Richards said that other prisoners were accusing him of serious sexual offences. He told the investigator that although Mr Richards denied having thoughts of suicide or self-harm, he presented as acutely unwell, and he referred him for a review by the psychiatrist. He said that a psychiatrist worked at Aylesbury on Mondays. However, another psychiatrist was due to visit on the coming Friday, 6 October, and he would have

expected him to have reviewed Mr Richards that day. He said that after seeing Mr Richards, he briefed an SO. He told her that Mr Richards did not have any plans for suicide, but he asked that staff monitor him due to his level of stress.

63. Mr Richards had also told the nurse that he had not slept for two days. He told the investigator that he planned to ask a GP to prescribe him sleeping tablets, but there was no GP in the prison at that time.
64. The clinical reviewer asked the nurse if he considered arranging for Mr Richards to transfer to HMP Bullingdon, a prison around 15 miles from Aylesbury which has a healthcare in-patient unit for prisoners with mental health issues. He said that any such transfer would have to be approved by the multi-disciplinary team and in Mr Richards' case, he had not yet been assessed by a psychiatrist nor started on medication.
65. The SO told the investigator that she could not recall being briefed by the nurse but said that the options for wing staff in that situation were primarily to either start an isolation plan or arrange a wing move. In the late afternoon, Mr Richards moved to C wing as his cell telephone on A wing was not working. Mr Richards spoke to a Listener that night and he later told the night patrol officer that he believed that other prisoners would come into his cell in the night. The officer told him that that would not happen.

## 5 October

66. Officer A told the investigator that she had had no previous contact with Mr Richards, but he was mentioned at the wing briefing on the morning of 5 October, including that he was possibly paranoid. She said that she responded to him pressing his cell bell that morning (she was unsure what time) and she spent around 30 to 45 minutes with him. He said that he felt unsafe and was keeping his kettle boiled in case he needed to protect himself. She tried to reassure Mr Richards and suggested that he should come out of his cell and mix with other prisoners, but he refused as he thought that would be too dangerous. He also asked her if she had ever seen anyone 'disappear from prison and go without a trace'. She told the investigator that she asked the Safer Custody team to see Mr Richards and she stayed with him until Officer B arrived.
67. Officer B said that Mr Richards was pacing around his cell when she arrived. He again spoke about being labelled a sex offender, but he acknowledged that it was probably paranoia rather than reality. He also said that his cell telephone was not working, and he wanted to contact his sister. She told an SO. who said that he would escort Mr Richards to use the landing telephone. The SO also said he would move Mr Richards to a cell with a working telephone. The officer said that she also referred Mr Richards to the mental health team.
68. The SO said that he escorted Mr Richards to the landing telephone but the call went through to voicemail and he asked Mr Richards to return to his cell.
69. Mr Richards' telephone records confirm that the call to his sister lasted four seconds. He also telephoned his solicitors and that call lasted 48 seconds. The length of the call to the solicitors would suggest that Mr Richards put down the telephone before his call was answered, however the investigator was not able to

listen to the call as calls to prisoners' legal representatives are not recorded due to legal protection.

70. Mr Richards had made several other calls to his solicitors while at Aylesbury. He had also made several attempted calls to his sister, but some were before her telephone number had been approved and he also tried to telephone her in the early hours of 2 October when the telephone lines had been closed for the night (the night-time closure of the telephone system dated from when Aylesbury held young offenders and this restriction has now been removed). The only partially successful personal call that Mr Richards made at Aylesbury was a call to a friend on 28 July. The friend did not pick up the call, but Mr Richards left a 61 second voice mail message.
71. An SO told the investigator that he met Mr Richards when he first arrived at Aylesbury when he presented without any concerns. He said that he then heard that Mr Richards had grown fearful of other prisoners. He said that he spoke to Mr Richards on 5 October about his cell telephone. He told Mr Richards that he could move to a cell on B wing that had a working telephone, but Mr Richards said he would not move. He told him that he was not happy leaving him in a cell without a telephone and he later noted in the wing observation book that there would be vacant cell on C wing the next day with a working telephone and Mr Richards would move to that cell. (It is unclear if he told Mr Richards this.) He said that he did not consider that Mr Richards was a risk to himself.
72. A Listener told the investigator that just before evening lock-up on 5 October another prisoner told him that Mr Richards was paranoid and believed that other prisoners thought that he was a sex offender. He said that he planned to introduce himself to Mr Richards the following morning to explain his role, to assure him that no-one was talking about him and that he would be safe on C wing.

## Events of 6 October

73. The investigator watched CCTV and body worn video camera (BWVC) footage and listened to the staff radio communications. He studied staff response statements and records and interviewed key staff. The account below is based on all these sources of information.
74. Officer C was making a routine check of all prisoners at 7.26am on the morning of 6 October when she found Mr Richards standing at his cell door. He said 'Miss, Miss', and she told him that she would speak to him later. She said that there was nothing different about Mr Richards' demeanour compared to how he had been previously, and she had no immediate concerns about him. She said that she intended to go back to speak to him when she had a chance, but another prisoner asked her to do something, and she then became involved in standard morning duties such as unlocking prisoners for exercise, showers, and medication.
75. At 8:42am, the Listener went to Mr Richards' cell to introduce himself and to offer him support. When he looked into the cell, he saw Mr Richards lying on his bed curled on his side. It seemed clear to him that Mr Richards was dead, and he called to Officer D, who was standing nearby.

76. Officer D looked into the cell and saw Mr Richards curled on his bed. She called to him but got no response. She then called to another officer and unlocked Mr Richards' door and went into the cell. She again called Mr Richards' name and shook his shoulder and again gained no response. She then radioed a medical emergency code blue (to indicate a prisoner is unconscious or having breathing difficulties). Control room staff immediately requested an ambulance.
77. An SO reached the cell within ten seconds and was followed by an officer. The SO told staff to move Mr Richards into the recovery position. Mr Richards had no pulse and was not breathing so staff moved him onto his back and an officer started CPR. Two officers also took turns in giving CPR. (Ideally, CPR should be given with the patient lying on a hard surface, but staff gave CPR with Mr Richards lying on his bed as the room layout meant that there was insufficient space on the cell floor.)
78. A nurse and a nursing auxiliary (NA) arrived at 8.46am, followed a few seconds later by another nurse. The first nurse noted that she checked Mr Richards' airway and found no obstruction and the NA then took over giving CPR.
79. CCTV shows that officers had locked prisoners back in their cells by around 8.47am, but staff continued giving CPR to Mr Richards on his bed.
80. Paramedics arrived at 8.57am and almost immediately brought Mr Richards out of his cell. After placing him on the landing floor, they continued efforts to resuscitate him. At 9.32am, the paramedics took Mr Richards to the ambulance to take him to hospital. At 9.58am, hospital staff pronounced his life extinct.

### **Contact with Mr Richards' family**

81. Mr Richards had named his sister as next-of-kin and had provided her telephone number but the only reference to her address was that she lived in Folkestone in Kent. Aylesbury contacted Elmley, in Kent, and asked for their assistance in making contact. A Custodial Manager (CM) made a number of telephone calls to Mr Richards' sister but found each time that her telephone was turned off. At around 4.00pm, the police were able to provide Elmley with the address and the CM and a colleague drove to Mr Richards' sister's home where he broke the news of Mr Richards' death at around 5.45pm and offered their condolences. Mr Richards' sister informed other family members of the death, including Mr Richards' ex-partner.
82. Aylesbury contributed to the cost of Mr Richards' funeral in line with national instructions.

### **Support for prisoners and staff**

83. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoner support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners to identify prisoners most affected by the death.

84. After Mr Richards was taken to hospital, one of Aylesbury's functional heads debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
85. Following Mr Richards' death, the prison posted notices informing other prisoners of his death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Richards' death.

### **Post-mortem report**

86. Toxicological investigation found that Mr Richards had no alcohol or other illicit substances in his blood.
87. At post-mortem, a large plum (4.5 centimetres in diameter) was found lodged in Mr Richards' laryngopharynx (the lower part of the throat that serves as a passageway for air, food and water). The pathologist noted that on examination, the plum had some light teeth marks with slight piercing of the skin but was otherwise intact. The pathologist explained that choking occurs when breathing is impeded by a constricted or obstructed windpipe. He noted that in adults, choking often involved food blocking the airway and that various risk factors included alcohol, sedatives, oral appliances, and medical conditions that caused difficulty in swallowing or impaired coughing reflex. The pathologist noted that the only potential risk factor with Mr Richards was that his teeth were in poor condition with some teeth missing. The pathologist gave Mr Richards' cause of death as acute upper airway obstruction (choking).

## Findings

### Management of Mr Richards' risk of suicide and self-harm

88. Prison Service Instruction (PSI) 64/2011, *Safer Custody*, which was in place at the time of Mr Richards' death (now replaced by the Prison Safety Framework) listed risk factors and potential triggers for suicide and self-harm. It said all staff should be alert to the increased risk of suicide or self-harm posed by prisoners with these risk factors and should act appropriately to address any concerns. Any prisoner identified as at risk of suicide and self-harm must be managed under Assessment, Care in Custody and Teamwork (ACCT) procedures. PSI 64/2011 also stated that any information that became available which might affect a prisoner's risk of harm to self must be recorded and shared, to inform proper decision making.
89. Mr Richards died from choking after he partially swallowed a whole plum that became lodged in his windpipe. We cannot say for certain whether it was Mr Richards' intention to harm himself or even take his life this way, however it is clear that he was extremely disturbed. He acknowledged that it was possible that he was paranoid, and that the threatening voices he was hearing were not real, but he said that the voices nevertheless continued and were real to him.
90. Despite Mr Richards' clear mental health difficulties, it does not follow that he was necessarily at risk of suicide or deliberate self-harm. None of the staff interviewed by the investigator believed Mr Richards to be at risk of suicide or self-harm and he denied any such thoughts when asked. Nor did Mr Richards harm himself at Aylesbury before 5 October or have any history of suicidal thoughts. He had only a limited history of self-harm. In the circumstances, we consider that it was appropriate that staff did not assess that Mr Richards was a risk to himself or open an ACCT.

### Mr Richards' feelings of being under threat

91. During the last six weeks of his life, Mr Richards reported feeling under threat from other prisoners. There is no evidence that this was actually the case but, nevertheless, the threat felt real for Mr Richards. Staff tried to reassure him, encourage him to come out of his cell, facilitated wing moves and asked Listeners to speak to him.
92. The Safer Prisons Hub Manager told the investigator that SIM meetings were held weekly to discuss set categories of prisoners, including prisoners on ACCT, prisoners posing a risk to others and being supported through challenge, support and intervention plans (CSIP) and prisoners in segregation. In addition, any member of staff can refer a prisoner to the SIM if they have concerns about them. She said that following Mr Richards' death, staff on C wing said that they had recognised his concerns, including that he did not have a working telephone in his cell, and they believed that they could manage his concerns.
93. Mr Richards' concerns about being at risk from other prisoners had been ongoing for a month by the time of his death and echoed similar concerns to when he was at Elmley. We note that Mr Richards was discussed at the SIM on 26 September

and an officer went to speak to him that same afternoon. Mr Richards told the officer that he felt better following reassurance from other prisoners that no one was planning to assault him. Mr Richards made similar comments to a mental health nurse on 28 September, when he also said that he did not need support from the mental health team. However, on 1 October Mr Richards again began to report his belief that other prisoners were talking about him and that he was under threat. While we acknowledge the discussion at the SIM on 26 September, the Governor will wish to assure himself that discussion of individuals at SIMs is sufficiently robust in discussing necessary support measures and follow up.

## Key worker scheme

94. Mr Richards was at Aylesbury for 10 weeks and had just one attempted key worker meeting in that time (he declined a meeting when offered). The Safer Prisons Hub Manager told the investigator that in the period that Mr Richards was in Aylesbury (August to October 2023), staff delivered a total of just 242 key work sessions. She said that that level was reflective of what was happening at the prison at the time including staff on sick leave, on annual leave and staff working on restricted duties. She said that in the period August to October 2024, Aylesbury had delivered a total of 509 key work sessions.
95. The Safer Prisons Hub Manager said that to improve performance, Aylesbury is due to start an initiative where prisoners will be locked in their cells on Friday afternoons to allow staff time to deliver a key work session to each prisoner with a particular focus on prisoners assessed as being at risk. In view of the action taken by Aylesbury to address key work, we make no recommendation.

## Clinical care

96. The clinical reviewer found that the care Mr Richards received at Aylesbury was not equivalent to that which he would have received in the wider community.

## Mental healthcare

97. The clinical reviewer concluded that it was clear by 4 October that Mr Richards was acutely unwell. Planned actions for medication and a psychiatric review had not occurred by the time of his death two days later. Staff had also not considered transferring Mr Richards to an inpatient unit. She found that there was no written care plan including monitoring and escalation to management of concerns. The clinical reviewer also concluded that prison officers were not given clear direction on management of Mr Richards' behaviour, how best to support his distress or how to escalate concerns beyond making a further referral to the mental health team. She also noted that, despite his rapidly deteriorating presentation, the mental health team did not revisit him on 5 October. We recommend that:

**The Head of Healthcare should introduce a robust audit process to ensure that when prisoners are acutely mentally unwell, clear care plans are constructed including processes for effective monitoring of prisoners and advice to officers on escalating concerns.**

## Emergency response

98. The clinical reviewer was also critical of the emergency response. She found that the BWVC footage did not confirm that nurses checked Mr Richards' airway when they first arrived and that they continued to give CPR with Mr Richards lying on his bed. The clinical reviewer also found that the nurses did not set up and correctly use the oxygen mask, so they did not deliver effective breaths. Nor did the nurses hold Mr Richards' airway open when delivering oxygen which meant that ventilation was ineffective. We recommend that:

**The Head of Healthcare should identify the learning from this investigation into the emergency response and implement an appropriate training plan.**

99. We note that staff failed to identify that Mr Richards had a plum in his throat while they were treating him, however we also note that it was only at post-mortem examination that the obstruction was identified.

## Governor to note

### Next of kin details

100. Mr Richards had named his sister as his next of kin and had given her telephone number. His records contain one reference to her living in Folkestone in Kent, but her address was incomplete. Fortunately, local police were able to provide the address quite quickly so there was not an excessive delay in Mr Richards' sister being informed of the news.
101. The Safer Prisons Hub Manager told the investigator that HMPPS South Central Region had raised the need for prisoners' next of kin details to be kept up to date and Aylesbury now has a member of staff whose role includes ensuring that prisoners' records are up to date and next of kin details are also checked during key work sessions. We make no recommendation, but the Governor will wish to assure himself that the process for identifying and checking next of kin details is sufficiently robust.

## Inquest

102. An inquest into Mr Richards' death held on 16 February 2026 concluded that his cause of his death was acute upper airway obstruction (choking) when he inadvertently inhaled a plum which lodged in his trachea causing him to choke and leading to cardiac arrest.

**Prisons &  
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