

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Kenneth Kesans, a prisoner at HMP Usk, on 21 December 2024**

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

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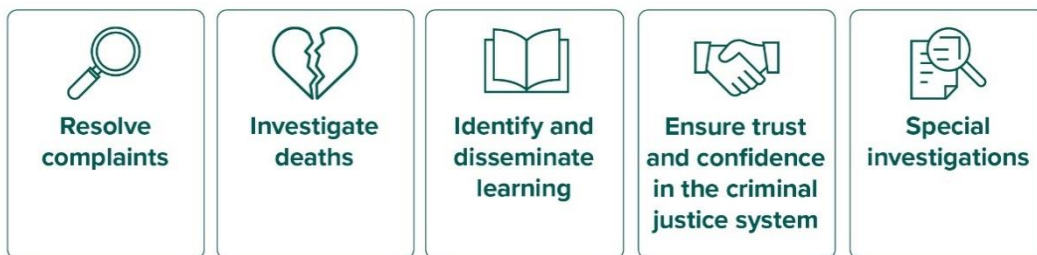
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## **OUR VISION**

**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 January 2022, Mr Kenneth Kesans was sentenced to 12 years in prison for sexual offences. He died of pneumonia, on 21 December 2024, in hospital, while a prisoner at HMP Usk. This was caused by an Influenza A infection (a viral infection commonly known as flu) and idiopathic pulmonary fibrosis (a condition where the lungs become scarred, making it difficult to breathe). He was 47 years old. We offer our condolences to Mr Kesans' family and friends.
4. The Ombudsman's office wrote to Mr Kesans' next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They wanted to know what contributed to Mr Kesans' death. This has been addressed in both this report and the clinical review.
5. The PPO investigator investigated the non-clinical issues relating to Mr Kesans' care. We did not find any non-clinical issues of concern.
6. Healthcare Inspectorate Wales commissioned an independent clinical reviewer, to review Mr Kesans' clinical care at Usk.
7. The clinical reviewer concluded that Mr Kesans received appropriate care and had access to a range of health services, including excellent mental health support. He noted that a GP promptly reviewed Mr Kesans' condition when healthcare staff raised concerns. However, the clinical reviewer found that healthcare staff should have asked a GP to speak with Mr Kesans about a chest X-ray after he declined it in November 2023. He noted that the GP could have explained the importance of the X-ray for monitoring his condition and the potential risks of not having it. The reviewer also noted that healthcare staff did not offer Mr Kesans a flu vaccination in 2024. We make the following recommendations regarding the clinical care Mr Kesans received:
  - **The Head of Healthcare should ensure that any declined follow-up medical appointments are reviewed and appropriately escalated to the GP.**
  - **The Head of Healthcare should ensure that all vaccinations, including the flu vaccine, are offered and administered in a timely manner, on an annual basis.**
8. The clinical reviewer also made one other recommendation not related to Mr Kesans' death which the Head of Healthcare will wish to address.

9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies. Their action plan is annexed to this report.
10. Mr Kesans' family received a copy of the draft report. They did not make any comments.

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

**September 2025**

### **Inquest**

11. The inquest into Mr Kesans' death concluded on 8 April 2026 and returned a verdict of natural causes. The jury concluded that Mr Kesans died from respiratory failure which was caused by Influenza A infection and idiopathic pulmonary fibrosis.



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