Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Sean Revere, a prisoner at HMP/YOI Moorland on 26 August 2024

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

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 16 January 2024, Mr Sean Revere was sentenced to 13 years imprisonment for sexual offences.

4. Mr Revere died of bilateral pneumonia (an infection in both lungs) and pleural effusions (a build-up of excess fluid around the lung) on 26 August 2024, while a prisoner at HMP/YOI Moorland. He was 86 years old. We offer our condolences to Mr Revere's family and friends.

5. The Ombudsman's office wrote to Mr Revere's next of kin to explain the investigation and to ask if they had any matters, they wanted us to consider. They had no questions but asked for a copy of our report.

6. NHS England commissioned an independent clinical reviewer to review Mr Revere's clinical care at HMP/YOI Moorland.

7. The clinical reviewer concluded that the clinical care Mr Revere received at Moorland was of a reasonable standard and partially equivalent to what he could have expected to receive in the community. She noted that Mr Revere was appropriately referred to healthcare professionals for mobility issues and to the hospital. She concluded that escalation of NEWS2 scoring (a national tool to monitor clinical deterioration), care planning, falls risk and post risk management was not equivalent. The clinical reviewer made recommendations not related to Mr Revere's death that the Head of Healthcare will wish to address.

8. The PPO investigator investigated the non-clinical issues relating to Mr Revere's care.

9. We did not find any non-clinical issues of concern. We make no recommendations.

10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

11. Mr Revere's family received a copy of the initial report. They had no questions.

12. At the inquest held on 17 April 2025, the coroner concluded that Mr Sean Humphrey Revere died of natural causes.

Adrian Usher **February 2025**
Prisons and Probation Ombudsman

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