Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Robert Kalton, a prisoner at HMP Dovegate, on 2 February 2025

A report by the Prisons and Probation Ombudsman

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

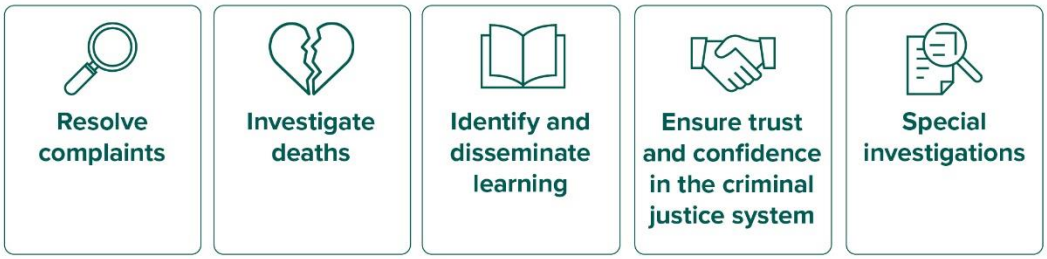
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 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

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 2017, Mr Robert Kalton was sentenced to nine years in prison for sex offences. In 2019, he was sentenced to four years in prison for further sex offences. In January 2023, he was released but was recalled to prison in February 2024 following sentencing for further sex offences. He died of frailty of old age on 2 February 2025, in hospital, while a prisoner at HMP Dovegate. He also had hypertension (high blood pressure) and cerebrovascular disease (a condition that affects blood flow to your brain) which did not cause but contributed to his death. He was 89 years old. We offer our condolences to those who knew him.

4. NHS England commissioned an independent clinical reviewer to review Mr Kalton's clinical care at HMP Dovegate.

5. The clinical reviewer concluded that the clinical care Mr Kalton received at Dovegate was of a good standard and equivalent to that which he could have expected to receive in the community. She found evidence of high-quality nursing and social care that met Mr Kalton's needs. The clinical reviewer noted that the healthcare team regularly reviewed him and appropriately prescribed anticipatory medication to manage his symptoms. She commended healthcare staff for delivering compassionate and person-centred end-of-life care. The clinical reviewer made no recommendations.

6. The PPO investigator investigated the non-clinical issues relating to Mr Kalton's care. We did not find any non-clinical issues of concern. We make no recommendations.

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

8. At the inquest, held on 25 September 2025, the Coroner concluded that Mr Kalton died of natural causes.

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

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 I 020 7633 4100