

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Sean Kelly, a prisoner at HMP Dovegate, on 12 October 2020

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

## Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

## Our Values

We are:

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



© Crown copyright 2022

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit [nationalarchives.gov.uk/doc/open-government-licence/version/3](https://nationalarchives.gov.uk/doc/open-government-licence/version/3)

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

## 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. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr Sean Kelly died of liver cancer, which had spread, on 12 October 2020 at HMP Dovegate. He was 69 years old. We offer our condolences to those who knew him.
4. The clinical reviewer found that the clinical care that Mr Kelly received at Dovegate was good and equivalent to that which he could have expected to receive in the community. However, she made three recommendations which were not related to Mr Kelly's death but which the Head of Healthcare will need to address.
5. We identified one non-clinical issue of concern about the need for Dovegate to provide evidence as requested during the course of our investigations.

## Recommendations

- The Director should ensure that prison documentation is stored securely and provided promptly when requested during a PPO investigation.

## The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Kelly's clinical care at HMP Dovegate.
7. The PPO has investigated non-clinical issues, including Mr Kelly's location, the security arrangements for his hospital escorts and whether compassionate release was considered.
8. As Mr Kelly had not identified a next of kin, our family liaison officer was unable to contact anyone about our investigation.
9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

### Previous deaths at HMP Dovegate

10. Mr Kelly's death was the eighth death at Dovegate since October 2018. Of those deaths, two were self-inflicted, two were drug-related and four (including Mr Kelly's) were from natural causes. Since Mr Kelly died, there have been two more deaths at Dovegate, both from natural causes.

## Key Events

11. In February 1999, Mr Sean Kelly was sentenced to life in prison for sexual offences. In 2014, he was released on temporary licence but was recalled to prison in December 2019 for breaching the terms of his licence.
12. Mr Kelly had several significant health conditions, including asthma, COPD (a lung condition), Type 2 diabetes, severe left ventricular heart failure and rheumatoid arthritis. Mr Kelly had in place an implantable cardioverter-defibrillator (ICD, a battery-powered device placed in the chest to monitor the heart rhythm and detect irregular heartbeats. An ICD can deliver electric shocks to fix an abnormal heart rhythm). He also misused alcohol.
13. Mr Kelly was recalled to prison and admitted to Royal Stoke Hospital after his ICD triggered administering three shocks for rapid ventricular tachycardia (a fast, irregular heartbeat) because of excessive alcohol intake and poor medication compliance.
14. On 9 December, Mr Kelly was discharged from hospital and went to HMP Dovegate. He arrived at 11.04pm so his initial health screen took place the next day. Mr Kelly was initially located in the prison's inpatient unit as he had arrived from hospital. A nurse recorded that Mr Kelly was taking prescribed medication, which he held and administered himself, misused alcohol and appeared unsteady on his feet.
15. On 20 March, Mr Kelly had a cough and said that he felt unwell. He tested negative for COVID-19. He was kept in isolation until 6 April.
16. On 15 May, Mr Kelly was advised to shield (measures to minimise exposure to COVID-19 through isolation) because he was considered clinically vulnerable. He declined to do so.
17. On 16 June, nurses noted that Mr Kelly had lost two stones in weight, he felt unwell, dizzy and lethargic and looked pale. A prison GP saw him the next day, identified an abdominal mass and suspected cancer. The GP referred Mr Kelly to hospital. Prison healthcare staff continued to monitor Mr Kelly's weight loss and treated him for pain management.
18. On 13 July, a prison GP prescribed morphine and moved him to Dovegate's inpatient unit for closer monitoring. That day, a hospital consultant arranged a CT scan (a computerised X-ray) for 17 July.
19. On 16 July, an order was put in place not to resuscitate Mr Kelly if his heart or breathing stopped.
20. On 17 July, Mr Kelly went to hospital for his CT scan which identified a 20cm liver tumour. Mr Kelly's cancer had also spread to his lungs. A hospital consultant discussed the findings with Mr Kelly who declined invasive hospital treatment and said that he wanted palliative care at Dovegate.
21. On 29 July, Mr Kelly went to hospital for a liver biopsy.

22. On 30 July, the hospital consultant wrote to the prison GPs, informing them of the cancer diagnosis and his discussion with Mr Kelly. The consultant noted that prison GPs may want to discuss disabling Mr Kelly's ICD. A prison GP sought advice from the hospital cardiology department about this. On 4 August, a hospital consultant advised that the application of a magnet to the chest over the ICD would prevent shock therapy from the device. The consultant referred Mr Kelly to the community nursing team.
23. On 31 July, a Macmillan nurse specialist assessed Mr Kelly by telephone and a follow up multidisciplinary team meeting was held.
24. On 13 August, Dovegate started an application for early release on compassionate grounds. This was approved in principle on 21 September in the event that he needed to go to a hospice. However, Mr Kelly wanted to remain at Dovegate.
25. On 26 September, the application was withdrawn because it was considered that Mr Kelly would not benefit from early release as he was not in contact with friends and family and wanted to remain in prison.
26. Mr Kelly died on 12 October at Dovegate.

### **Post-mortem report**

27. A post-mortem examination was not conducted. A hospital doctor confirmed Mr Kelly's death and the Coroner accepted the cause of death as metastatic hepatocellular carcinoma (liver cancer which had spread).

## **Findings**

### **Clinical findings**

28. The clinical reviewer concluded that the care that Mr Kelly received was of a good standard and equivalent to that which he could have expected to receive in the community. Although not relevant to the cause of his death, the clinical reviewer made several recommendations about appropriate pressure-relieving equipment, access to dressings and record keeping, which the Head of Healthcare will need to address.

### **Non-clinical Findings**

#### *Restraints and failure to provide evidence*

29. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and considers a prisoner's health and mobility.
30. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when they have a serious

medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment and reviewed as circumstances change. The judgment found that using handcuffs or other restraints on terminally or seriously ill prisoners was inhumane, unless justified by security considerations.

31. Mr Kelly travelled to hospital twice in July but we have not been able to determine if he was restrained or whether risk assessments were conducted as Dovegate did not provide us with the relevant prison escort records and risk assessments. Mr Kelly was a Category B prisoner. He was 69 years old, he had poor mobility and he had lost a significant amount of weight.
32. PSI 58/2010 makes it clear that the PPO should have unfettered access to relevant documents during investigations and that prisons must provide the information that the Ombudsman requests as part of her investigation.
33. The guidance for prisons on the handling, retention and disposal of records is set out in PSI 35/2014. It says that the handling of records should be overseen by a Local Information Manager who should ensure that "records are clearly labelled and organised and can be retrieved quickly when required". This was not the case and despite chasing for documentation a number of times, the prison did not provide the PPO with the relevant escort risk assessments or prisoner escort records, and did not provide an explanation for this. We would expect the prison to ensure that evidence is preserved following a death in custody to ensure appropriate scrutiny and accountability. In the absence of evidence, we are unable to comment on the use of restraints when Mr Kelly went to hospital. We make the following recommendation:

**The Director should ensure that prison documentation is stored securely and provided promptly when requested during a PPO investigation.**

**Caroline Mills**  
**Assistant Ombudsman**

**December 2021**

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations