Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Sean Harknett, a prisoner at HMP Rye Hill, on 20 October 2023

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 29 April 2020, Mr Sean Harknett was sentenced to 17 years imprisonment for sexual offences. On 20 October 2023, Mr Harknett died of respiratory failure caused by motor neurone disease (progressive weakening of the nervous system), at HMP Rye Hill. He was 58 years old. We offer our condolences to Mr Harknett's family and friends.

4. The PPO family liaison officer wrote to Mr Harknett's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond to our letter.

5. NHS England commissioned an independent clinical reviewer to review Mr Harknett's clinical care at Rye Hill.

6. The clinical reviewer concluded that the clinical care Mr Harknett received at Rye Hill was of a high standard and equivalent to that which he could have expected to receive in the community. She found that Mr Harknett's medical records contained evidence of compassionate care by competent and confident staff. She made recommendations not related to Mr Harknett's death that the Head of Healthcare will wish to address.

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

8. We shared our initial report with HMPPS. They found no factual inaccuracies.

Adrian Usher **May 2024**
Prisons and Probation Ombudsman

Inquest

At the inquest, held on 8 October 2025, the Coroner concluded that Mr Harknett died from natural causes.

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