Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr David Kelly, a prisoner at HMP Whatton, on 9 June 2025

## A report by the Prisons and Probation Ombudsman

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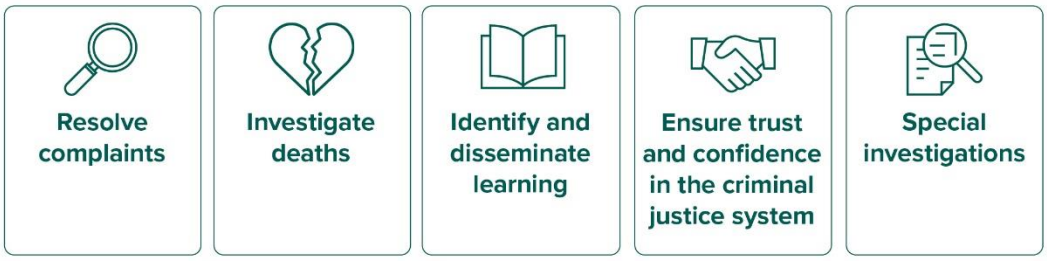
## OUR VISION

**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. In July 1987, Mr David Kelly was sentenced to life imprisonment for attempted murder. He died in hospital of oesophageal cancer on 9 June 2025, while a prisoner at HMP Whatton. He was 62 years old. We offer our condolences to Mr Kelly's family and friends.

4. The Ombudsman's office wrote to Mr Kelly'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.

5. NHS England commissioned an independent clinical reviewer to review Mr Kelly's clinical care at HMP Whatton.

6. The clinical reviewer concluded that the clinical care Mr Kelly received at Whatton was of a very high standard and at least equivalent to that which he could have expected to receive in the community. The clinical reviewer made one recommendation about making timely hospital referrals but was satisfied that the delay in this case did not affect the outcome for Mr Kelly.

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

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

9. The initial report was shared with HM Prison and Probation Services (HMPPS) and Practice Plus Group, the healthcare provider. They did not find any factual inaccuracies.

10. Mr Kelly's next of kin received a copy of the draft report. They did not make any comments.

11. At the inquest, held on 28 August 2025, the Coroner concluded that Mr Kelly died from natural causes.

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

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