Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr James Kiteley, a prisoner at HMP Sudbury, on 5 June 2021

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

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.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr James Kiteley died on 5 June 2021, having been found unresponsive in his room in HMP Sudbury. Post-mortem examinations concluded that he died from an overdose of propranolol (a beta-blocker) and cocaine use. Mr Kiteley was 46 years old. I offer my condolences to Mr Kiteley's family and friends.

The investigation did not find any evidence to suggest that staff should have suspected the Mr Kiteley was misusing drugs before he died. However, I share the clinical reviewer's concerns about the risk assessment for Mr Kiteley to hold his own medication and the lack of a mental health care plan.

I am also concerned that Mr Kiteley appears to have been able to access illicit drugs while a prisoner at Sudbury, although I note the proactive steps that the prison is taking to tackle and reduce their supply.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Sue McAllister CB
Prisons and Probation Ombudsman **February 2022**

Contents

Summary

Events

1. In February 2017, Mr James Kiteley was sentenced to six years and eight months in prison. He had a history of anxiety and depression, and alcohol misuse.

2. In April 2021, Mr Kiteley transferred to HMP Sudbury, an open prison. He was anxious about being in open conditions. He was prescribed medication for anxiety and was told about substance misuse services at the prison. A nurse assessed that it was safe for Mr Kiteley to have his medication with him in his room.

3. After initially refusing to engage with substance misuse services, Mr Kiteley eventually worked with them and with the mental health team. He said he was having some difficulty adjusting to open conditions but was preparing for release from prison. He continued to express anxiety at times but could also be positive about the future.

4. On the night of 4 June, Mr Kiteley's room-mate said they watched a film and then went to sleep. His room-mate awoke at approximately 4.00am and said he heard Mr Kiteley snoring. When a prison officer made a roll check on the morning of 5 June, Mr Kiteley was unresponsive. The officer called an emergency medical code, prompting the control room to call for an ambulance. Officers attempted to resuscitate Mr Kiteley, despite signs of rigor mortis. They continued until ambulance paramedics arrived and confirmed that Mr Kiteley had died.

5. Post-mortem tests showed that Mr Kiteley died as a result of an overdose of propranolol (which he was prescribed) and cocaine use.

Findings

Substance misuse

6. Mr Kiteley had a background of substance misuse. He worked with substance misuse services at Sudbury and told his offender supervisor that he was determined not to misuse drugs again. We are satisfied that there were no signs or intelligence that Mr Kiteley was misusing drugs before he died.

7. We are concerned that Mr Kiteley could access drugs within the prison with apparent ease, although we note the proactive steps the prison is taking to try to address this problem.

Mr Kiteley's clinical care

8. The clinical reviewer concluded that, overall, the healthcare provided to Mr Kiteley was equivalent to that which he could have expected in the community.

9. However, she had concerns that the risk assessment for him to hold his own medication was not adequate, and that he did not have a mental health care plan.

Emergency response

10. Mr Kiteley showed signs of rigor mortis when he was found in his cell on the morning on of 5 June. Despite this and nurses advising them to stop, officers continued to attempt resuscitation, which was inappropriate.

Recommendations

- The Head of Healthcare and the manager of the integrated mental health team should ensure that prisoners with mental health issues have appropriate reviews and care plans which are recorded and implemented.
- The Head of Healthcare should ensure that the prisoner's history and risk factors for suicide and self-harm are taken into account in medication in-possession risk assessments.
- The Governor should ensure that staff are aware of the signs of rigor mortis, and fully understand the circumstances in which they should not start, or continue, resuscitation, in line with Resuscitation Council Guidelines.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Sudbury informing them of the investigation and asking anyone with relevant information to contact him. No-one responded.

12. The investigator obtained copies of relevant extracts from Mr Kiteley's prison and medical records.

13. The investigator interviewed four members of staff and a prisoner at Sudbury. NHS England commissioned an independent clinical reviewer to review Mr Kiteley's clinical care at the prison. All the interviews were conducted by telephone because of the COVID-19 restrictions in place.

14. We informed HM Coroner for Derby and Derbyshire of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

15. One of the Ombudsman's family liaison officers contacted Mr Kiteley's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She asked for any information about how her son died.

Background Information

HMP Sudbury

16. HMP Sudbury is an open prison that houses over 580 adult men. Sudbury caters for prisoners in the latter stages of their sentence and specialises in rehabilitation and resettlement in preparation for release into the community. A number of prisoners are released each day on licence to help with their resettlement.

17. Care UK provides primary and mental health services. South Staffordshire and Shropshire Healthcare NHS Foundation Trust provides drug and substance misuse services.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Sudbury was a short scrutiny visit in June 2020. Inspectors reported that the COVID-19 pandemic had been difficult for prisoners in open conditions who were preparing for release. There were some reports of negative relationships between prisoners and staff but there was no evidence of deterioration in security or order. Support from healthcare providers and partnership working was good, and face-to-face support for prisoners with mental health and substance misuse problems, including drug recovery work, continued and access was good.

19. The most recent full inspection of Sudbury was in April 2017. Inspectors found that the prison was proactive in its approach to controlling drugs, with enhanced CCTV monitoring and a good flow of intelligence to the security department. The prison had also built good relationships with the local police, which had led to prosecutions. Inspectors considered that there was an effective strategic approach to substance misuse treatment and the range of interventions was generally good.

Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 31 May 2021, the IMB reported that through the difficulties of COVID-19 restrictions the prison provided good access to outside space for prisoners. Levels of self-harm were low, and wings within the prison had acted as “bubbles” to maintain social contacts. The Board noted that the open nature of the site made the availability of illicit items, including drugs, a problem and quantities had been detected through the year. Support for prisoners with drug and alcohol dependence was good.

Previous deaths at HMP Sudbury

21. Mr Kiteley was the third Sudbury prisoner to die since April 2019. Both of the previous deaths were due to natural causes (including one due to COVID-19).

Key Events

February 2017 – April 2021

22. In February 2017, Mr James Kiteley was convicted of wounding with intent to cause grievous bodily harm and sentenced to six years and eight months imprisonment. Mr Kiteley had problems with alcohol and suffered from anxiety and depression.

23. In December 2018, Mr Kiteley failed a drug test. He said that his cellmate used psychoactive substances (PS) and that he had been feeling down at the time so when offered drugs he took them for a short period. In 2020, Mr Kiteley began working with Forward Trust, a charity which works with prisoners with problems with drugs or alcohol. He said he was looking forward to moving to open conditions (Category D) and wanted to ensure that he was doing all that was necessary to ensure his progress.

HMP Sudbury: 13 April 2021 onwards

24. On 13 April 2021, Mr Kiteley transferred to HMP Sudbury. He told staff that he was a little anxious and said he would keep a low profile. He was given written information on substance misuse, including the services available and how to access them. Healthcare staff noted that he had no physical health issues. He was prescribed propranolol (a beta-blocker) for anxiety, and a nurse assessed that he could hold the medication in his own possession.

25. On 16 April, Mr Kiteley said that he did not wish to engage with substance misuse services (SMS). At a secondary health screen on 17 April, Mr Kiteley said that he had no issues but asked to see someone from the mental health team.

26. On 20 April, Mr Kiteley told his offender supervisor that he had been surprised to have to share a room and facilities, but that he was settling in and wanted to progress. He was considering working with substance misuse services. He said he had no physical health needs, but that he suffered from anxiety and paranoia and he asked to see the mental health team. She suggested that he seek support from the safer custody team if he needed it. She sent an email to the SMS team asking them to make an appointment for Mr Kiteley.

27. On 21 April, a nurse saw Mr Kiteley for a mental health case management risk assessment. He said that he was paranoid and anxious, worrying constantly if people were talking about him. He told her that he had taken an overdose in his twenties and that he had fleeting thoughts of suicide. He had previously been prescribed sertraline (an antidepressant) but did not feel it worked for him, so he had stopped taking it. She recorded that she considered Mr Kiteley to be at risk of deliberate self-harm and she referred him to the mental health team.

28. On 27 April, Mr Kiteley saw a substance misuse worker. He said that his current emotional health was not good, but he did not want to be referred to the mental health team. She gave Mr Kiteley some material to complete so that at their next session they could work on a care plan. She gave him advice, including how his tolerance to drugs might have changed after a period of abstaining from drug use.

29. On 30 April, a nurse carried out a mental health review. Mr Kiteley said that he had been prescribed sertraline in the past but not recently. He said he was having trouble adjusting to the new regime in Sudbury and was feeling paranoid. She did not record the outcome of the review.

30. On 4 May, the substance misuse worker saw Mr Kiteley and reviewed the paperwork he had completed. He was worried about living in a hostel on release where people might be abusing drugs or alcohol. She discussed alcohol blocker medication and provided more material to help him prepare for managing substance misuse issues after release.

31. On 5 May, Mr Kiteley had a meeting with his offender supervisor. He said he was still feeling a bit awkward sharing a room but understood that there was a waiting list for single rooms. He had been in contact with the mental health team and had an appointment pending. He had also been engaging with the SMS team and he was positive about the interaction. He said that he had agreed to the suggestion of alcohol blocker medication.

32. On 18 May, Mr Kiteley went to a meeting with his offender supervisor and the substance misuse worker to assess his progress. Mr Kiteley said he was not clear how his release plan would work and was unhappy about having to live in a Probation Service Approved Premises (formerly known as probation hostels). They discussed his previous alcohol use and things he could do while he was in Sudbury to improve his chances of employment. Mr Kiteley said that he was determined not to return to drinking. He said he was working with the mental health team to address his anxiety and knew how to seek support if he wanted it. A nurse saw Mr Kiteley again on 20 May. She noted that he was quite negative, particularly about settling into the new routine.

33. On 26 May, Mr Kiteley attended a sentence plan review meeting with his offender supervisor and his offender manager (probation officer). His main target was to complete further work around alcohol, and he updated them on what he had done so far. His offender supervisor noted that he appeared motivated and was pleased to have avoided temptation. He said he was still struggling with anxiety and was thinking about taking medication again after a year off it. He was waiting for an appointment with the psychiatrist. They discussed the process for applying for release on temporary licence (ROTL).

34. An intelligence report on 1 June indicated that Mr Kiteley did not like being on the wing where he lived (West 3) because there was drug use there. That day he saw the substance misuse worker and his offender supervisor. He said that he worked harder than others, which irritated him. They suggested he complete a Sudbury training project in how to develop relationships.

35. Mr Kiteley worked in the prison gardens and reports indicated that he was doing well. On 2 June, he asked his mother if she could lend him some money as he needed a watch.

Events of Friday 4 and Saturday 5 June 2021

36. Mr Kiteley's room-mate said that they watched a film together late on 4 June. This finished at about 1.30am on 5 June, and his room-mate went to sleep. He said he

woke up at approximately 4.00am and noticed that the television was switched off. He heard Mr Kiteley snoring.

37. At approximately 10.55am, an officer was making a roll check, and when he checked their room, he said he thought both Mr Kiteley and his room-mate were asleep. He completed the roll check, but on his return to the office it occurred to him that it was unusual for them both to be asleep at that time, so he decided to check them. By now it was approximately 11.05am.

38. The officer went into the room and spoke to the two prisoners. The room-mate woke up, but Mr Kiteley did not respond. The officer spoke directly to Mr Kiteley, still with no response. Now concerned, he used his radio to warn the control room of a potential code blue emergency (meaning a prisoner is not, or is having difficulty, breathing). He then pulled the cover off Mr Kiteley and found that he was not breathing. He used his radio to call the emergency code blue, and he was joined by a colleague straightaway. The code blue call prompted the control room to call for an ambulance, while the two officers began cardiopulmonary resuscitation (CPR).

39. They were joined by colleagues including healthcare staff. A nurse applied a defibrillator, but it could not detect a rhythm. She tried to insert an airway but could not as Mr Kiteley was showing clear signs of rigor mortis. She advised the officers that they should stop CPR, but they wanted to continue. The did so until ambulance staff arrived and took over. At 11.36am, the paramedics pronounced that Mr Kiteley had died.

Intelligence after Mr Kiteley's death

40. When prison staff searched Mr Kiteley's room, they found a quantity of pregabalin tablets (a prescribed medication used to treat conditions including anxiety, but which is also misused in prisons because it can produce feelings of euphoria and enhance the effects of other drugs), together with steroids, needles, and four mobile telephones. In a further search, they later found several USB chargers and cables, and more tablets. Mr Kiteley's room-mate said that they did not belong to him. He was subsequently returned to closed conditions.

41. After Mr Kiteley's death, there were intelligence reports about his interactions with other prisoners, including that he had shared telephone accounts and banking details, and about his use of pregabalin and other substances. There were no such intelligence reports before Mr Kiteley died.

Contact with Mr Kiteley's family

42. A supervising officer (SO) spoke to Mr Kiteley's mother to break the news of her son's death. In line with Prison Service guidance, Sudbury offered a contribution to the costs of Mr Kiteley's funeral.

Support for prisoners and staff

43. After Mr Kiteley's death, the Deputy Governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

44. The prison posted notices informing other prisoners of Mr Kiteley's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Kiteley's death.

Post-mortem report

45. The post-mortem report concluded that Mr Kiteley died of the effects of cocaine and propranolol. Toxicology tests also found pregabalin in his system, although this drug was at a therapeutic level. (Mr Kiteley was not prescribed pregabalin.)

46. The pathologist reported that although acute cocaine toxicity is rare, cocaine may still cause death, even where the levels detected are low, as in Mr Kiteley's case. The levels of propranolol found in post-mortem tests indicated that Mr Kiteley took an excessive amount of this drug before he died.

Findings

47. Mr Kiteley was only at Sudbury for a short time. Other prisoners described him as quiet and largely keeping to himself. Although he suffered from anxiety while settling at Sudbury, his offender supervisor said that he was positive about his future. He was open about his thoughts and feelings and willing to ask for help if he needed it.

Substance misuse

48. Mr Kiteley had a background of substance misuse. He was offered substance misuse services on arrival at Sudbury. After initially refusing, he did engage and was seen promptly and, thereafter, regularly.

49. Post-mortem tests showed the presence of cocaine, propranolol and pregabalin in Mr Kiteley's system. Intelligence reports after his death suggested that he had taken drugs previously at Sudbury.

50. During the COVID-19 pandemic, random drug testing was suspended, and drug tests were only undertaken in Sudbury when there was reason to suspect a prisoner was using drugs. Sudbury's Head of Security said in interview that there was no intelligence prior to Mr Kiteley's death to suggest that he had been taking drugs. There were no reports of him ever being under the influence of anything. The offender supervisor, who worked closely with Mr Kiteley, said in interview that she had no reason to suspect he had used drugs. He engaged with substance misuse services and talked positively about the future. We are satisfied that staff could not have known that Mr Kiteley was using drugs before he died.

51. Although Sudbury has a comprehensive drug strategy, we are very concerned that Mr Kiteley appears to have had no difficulty in obtaining and using both illicit drugs, such as cocaine, and prescription drugs, such as pregabalin.

52. Drug taking and trading is a serious problem across much of the prison estate. Individual prisons are, for the most part, doing their best to tackle the problem by developing their own local drug strategies. In April 2019, the Prison Service introduced a national drug strategy. This says that:

> "Every prison is different and will benefit from tools to assess their specific security needs. We have worked with prisons to carry out Vulnerability Assessments in prisons to build a picture of the security risks and enable establishments to better target their resources to tackle them. This resource will continue to be offered across the estate."

53. Sudbury has a strategy to address both the supply of, and demand for, drugs. It includes numerous actions intended to reduce the supply of drugs into the prison and movement of drugs around the prison. There are also measures to educate and support those known to use drugs and disciplinary measures to deter drug use, as well as partnership working with local police to secure prosecution for those involved.

54. Given the proactive steps the prison has taken in addressing the issue of drug misuse at Sudbury, we make no recommendation.

Mr Kiteley's clinical care

55. The clinical reviewer concluded that, overall, the healthcare provided to Mr Kiteley was equivalent to that which he could have expected to receive in the community.

56. The clinical reviewer noted that Mr Kiteley was referred to mental health services promptly and reviewed in line with guidance. However, the clinical reviewer was concerned that there was no evidence of a mental health care plan. The Head of Healthcare explained that a care plan would normally be generated by a full mental health assessment, and Mr Kiteley had not had such an assessment before he died.

57. The clinical reviewer reflected that national clinical guidelines require a care plan for prisoners with identified mental health needs. We agree with the clinical reviewer's concerns and make the following recommendation:

    The Head of Healthcare and the manager of the integrated mental health team should ensure that prisoners with mental health issues have appropriate reviews and care plans which are recorded and implemented.

58. The clinical reviewer was also concerned about the nurse's assessment of the risk of Mr Kiteley looking after his own medication. She was concerned that the nurse did not properly take into consideration Mr Kiteley's history of self-harm, particularly his previous overdose, and therefore inaccurately recorded his risk was zero.

59. We share the clinical reviewer's concern that the nurse assessing whether Mr Kiteley should have medication in his possession did not properly reflect all of his history and risk factors in her assessment. Mr Kiteley's death was partially caused by an overdose of his prescribed medication.

60. We make the following recommendation:

    The Head of Healthcare should ensure that the prisoner's history and risk factors for suicide and self-harm are taken into account in medication in-possession risk assessments.

Emergency response

61. When the officer found Mr Kiteley on the morning of 5 June, he described him as 'blue'. When a nurse assessed Mr Kiteley shortly afterwards, she found evidence of rigor mortis and advised the officers to stop resuscitation attempts. Prison officers wanted to continue as they believed that they had to.

62. The Quality Standards for Clinical Practice and Training in Cardiopulmonary Resuscitation, published by the Resuscitation Council, were updated in 2020. The Resuscitation Council guidance says, "There will be some people for whom attempting CPR is clearly inappropriate; for example, …. there will be cases where healthcare professionals discover patients with features of irreversible death, for example, rigor mortis".

63. We appreciate that staff wanted to do their best for Mr Kiteley. However, trying to resuscitate someone who is clearly dead is distressing for staff and undignified for

the deceased. When the nurse advised that staff should stop CPR, they should have accepted her advice.

64. We make the following recommendation:

The Governor should ensure that staff are aware of the circumstances in which resuscitation is inappropriate.

Inquest

65. The inquest, held on 10 July 2024, concluded that Mr Kiteley's death was drug related.

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