Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Kelk, a prisoner at HMP Wakefield, on 30 December 2023

A report by the Prisons and Probation Ombudsman

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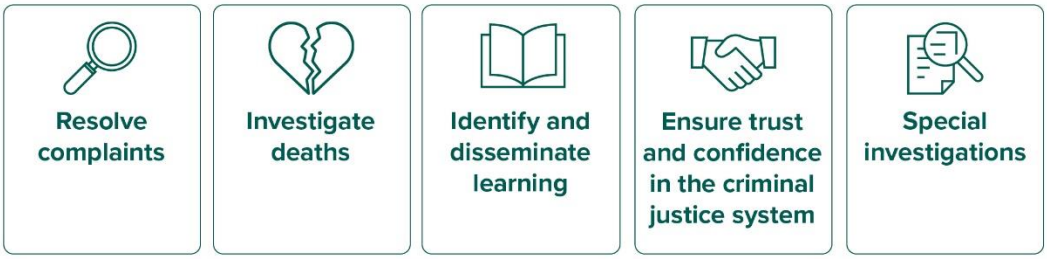
OUR VISION

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

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. 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. Mr John Kelk died in hospital of liver failure, caused by liver cirrhosis, on 30 December 2023, while a prisoner at HMP Wakefield. He was 69 years old. We offer our condolences to Mr Kelk's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Kelk received at HMP Wakefield was of a good standard and equivalent to that which he could have expected to receive in the community. They concluded that Mr Kelk's diabetes was appropriately managed, and referrals were made appropriately. Additionally, they found that Mr Kelk's end-of-life care was thorough, timely and caring.

5. However, the healthcare team missed that the hospital discharge letter on 7 May 2023 stated that Mr Kelk needed further investigations. This was not identified until 12 July when a consultant physician at HMP Wakefield reviewed Mr Kelk's discharge letter. The clinical reviewer made a recommendation to address this.

6. We found that the officer in charge on 28 August 2023 decided that Mr Kelk should not attend A&E, contrary to the advice of an out-of-hours doctor. While it is not possible to know whether this would have changed the outcome for Mr Kelk, we are concerned that clinical advice was not followed.

7. We also found that there was a delay in starting Mr Kelk's early release on compassionate grounds application.

Recommendations

- The Head of Healthcare should ensure that healthcare staff read discharge letters fully and complete any required actions promptly.

- The Governor should ensure that when a clinician advises that a prisoner should be sent to hospital:

    - the policy of referring such decisions to the duty governor is rigorously enforced and;

    - where the advice is not followed, the reasons should be clearly documented by the duty governor.

The Investigation Process

8. HMPPS notified us of Mr Kelk's death on 30 December 2023.

9. NHS England commissioned an independent clinical reviewer to review Mr Kelk's clinical care at HMP Wakefield.

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

11. The Ombudsman's office contacted Mr Kelk's next of kin, his daughter, to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.

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

Previous deaths at HMP Wakefield

13. Mr Kelk was the twenty-fourth prisoner to die at HMP Wakefield since 30 December 2020. Of the previous deaths, nineteen were from natural causes and four were self-inflicted. We have previously made recommendations about the need for Wakefield to make applications for early release on compassionate grounds as soon as a prisoner becomes eligible.

14. Wakefield told us that since October 2022, a tracking system has been in place to ensure that GPs complete an initial referral and that each section of the application is completed promptly. They said that this is monitored at monthly multidisciplinary team meetings. They also told us that the process for progressing timely applications had been agreed and shared with staff in April 2023. They said that it included defined areas of responsibility and deadlines.

Key Events

15. On 5 May 2022, Mr Kelk was remanded into custody at HMP Doncaster. The following day, he received an extended determinate sentence of 31 years for sexual offences. On 14 June, Mr Kelk was transferred to HMP Wakefield.

16. Mr Kelk had type 1 diabetes and had multiple hypoglycaemic attacks (caused by low blood sugar) between June 2022 and August 2023. On each occasion, healthcare staff monitored his blood glucose levels until they increased.

17. On 2 March 2023, Mr Kelk was referred to a specialist for his diabetes and was waiting for an appointment.

18. On 5 May, a GP operating at Wakefield saw Mr Kelk because he had abdominal pain and was vomiting. An ambulance was called, and Mr Kelk was admitted to hospital.

19. On 7 May, Mr Kelk was discharged to Wakefield with antibiotics and laxatives. The discharge letter stated that there were no outstanding actions post-discharge.

20. On 23 May, Mr Kelk attended a video appointment with the diabetes specialist.

21. On 7 July, a prison GP saw Mr Kelk. His medical records noted that Mr Kelk struggled to manage his own hypoglycaemic attacks as he often refused carbohydrates due to his loss of appetite. The GP encouraged Mr Kelk to manage his own blood sugar levels and only report high or low measures to nursing staff.

22. On 12 July, a GP operating at Wakefield reviewed Mr Kelk's recent medical admission and the results of his ultrasound scan. He noted that further investigation of Mr Kelk's intraduct hepatic dilatation (widening of the bile ducts inside the liver) was needed. The hospital had not arranged this when he was discharged.

23. On 14 July, a prison GP completed a two-week wait referral for Mr Kelk and for a magnetic resonance imaging (MRI) scan as he had ongoing abdominal pain and loss of appetite.

24. On 15 August, Mr Kelk attended a hospital appointment. A consultant arranged for him to have a computerised tomography (CT) scan, blood tests and a liver screen.

25. On 28 August, a nurse saw Mr Kelk at 11.15am after he reported abdominal pain. At 1.32pm, another nurse spoke by telephone to an out-of-hours doctor, who advised her to contact an ambulance and for Mr Kelk to go to hospital as he had had abdominal pain and had been vomiting since the previous day. The nurse contacted a Custodial Manager (CM), the officer in charge that day (known as Oscar 1). She said that the CM refused to send Mr Kelk to hospital due to the security risk of an unplanned escort.

26. On 29 August, a nurse saw Mr Kelk, as he still had abdominal pain and was vomiting. An ambulance was called, and Mr Kelk was sent to the emergency department for assessment. Healthcare staff liaised with the hospital daily by telephone while Mr Kelk was in hospital.

27. On 31 August, hospital staff told Mr Kelk that the CT scan results showed that he had decompensated liver disease.

28. On 8 September, an officer was appointed as Mr Kelk's family liaison officer and she informed his daughter that he was in hospital.

29. On 26 September, hospital staff told a prison nurse that Mr Kelk had been diagnosed with end-stage liver failure and advanced care planning was arranged.

30. On 28 September, hospital staff told the prison nurse that Mr Kelk's prognosis was a few months and a do not attempt cardiopulmonary resuscitation (DNACPR) order had been put in place. They advised that since his admission, Mr Kelk had been treated for sepsis, had a stricture stent inserted, and had been diagnosed with advanced liver cirrhosis and end-stage liver disease.

31. On 29 September, Mr Kelk was discharged to the healthcare unit at Wakefield for end-of-life care.

32. On 6 October, a prison GP saw Mr Kelk and discussed his prognosis with him. Mr Kelk was aware that he was very unwell but reported that he was not in any pain.

33. On 13 October, a prison GP discussed the potential of early release on compassionate grounds with Mr Kelk. A plan was put in place to start the paperwork the following week.

34. On 17 October, a prison GP completed the GP section of the application for Mr Kelk's early release on compassionate grounds. The progress of the application was then monitored by Wakefield's tracking system.

35. On 20 November, healthcare staff informed a GP operating at Wakefield of Mr Kelk's sudden deterioration. His electrocardiogram (ECG) results identified an abnormal heart rhythm. An ambulance was called, and Mr Kelk attended the emergency department.

36. On 29 November, Mr Kelk was discharged from hospital and returned to Wakefield.

37. On 28 December, Mr Kelk received a visit from his daughter and granddaughter. A nurse saw Mr Kelk and noticed a deterioration in his condition.

38. On 30 December, Mr Kelk died. Healthcare staff were with him during the last hours of his life. They reported that he remained comfortable and free from pain.

Post-mortem report

39. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Kelk's cause of death as liver failure caused by liver cirrhosis.

Inquest

40. At an inquest held on 19 January 2024, the Coroner concluded that Mr Kelk died from natural causes.

Clinical Findings

Clinical care

41. The clinical reviewer concluded that the clinical care Mr Kelk received at HMP Wakefield was of a good standard and equivalent to that which he could have expected to receive in the community. The clinical reviewer stated that this was evidenced by the appropriate ongoing management of Mr Kelk's diabetes and appropriate referrals for specialist input and care planning. They also found that the healthcare team provided Mr Kelk with thorough, timely and caring end-of-life care.

Hospital discharge letters

42. The clinical reviewer noted that when Mr Kelk was discharged from hospital on 7 May 2023, the front page of the hospital discharge letter stated that there were no actions for the GP at Wakefield or for the hospital post-discharge. This resulted in the healthcare team taking no action. However, they missed the subsequent detail in the letter which advised that Mr Kelk needed "further investigation of intrahepatic dilatation". The hospital had not arranged this when Mr Kelk was discharged, and the healthcare team did not follow it up with the hospital until a consultant physician operating at Wakefield reviewed Mr Kelk on 12 July and identified the outstanding action. The clinical reviewer was unable to state whether this two-month delay affected the outcome for Mr Kelk. We make the following recommendation:

    The Head of Healthcare should ensure that healthcare staff read discharge letters fully and complete any required actions promptly.

Non-Clinical Findings

Lack of compliance with clinical advice

43. HMP Wakefield does not have a doctor on site 24-hours a day. A nurse therefore appropriately contacted an out-of-hours doctor for advice on 28 August 2023 as Mr Kelk had abdominal pain and had been vomiting since the previous day. The doctor advised her to contact an ambulance and for Mr Kelk to attend hospital. There is an expectation that prison staff should adhere to the advice of a clinician and the prisoner's level of risk should be assessed using an escort risk assessment.

44. The nurse contacted a Custodial Manager (CM), Oscar 1 that day, and told him that Mr Kelk needed hospital admission. However, she said that he decided that Mr Kelk could not attend hospital. It is noted in Mr Kelk's medical records that the CM told her that if he was well enough to wait in A&E, he was well enough to stay and be monitored in the prison.

45. The medical records note that the nurse explained to the CM that she had assessed Mr Kelk and he needed to attend A&E to be triaged by hospital staff. However, the medical records state that he remained adamant that Mr Kelk could not go to hospital.

46. The CM told us that he had no recollection of this incident, and that an out-of-hours doctor does not understand the security risk of an unplanned escort. He also told us that it is standard procedure to seek advice from the duty governor who would make a final decision.

47. We contacted the Head of Business Assurance, who was the duty governor on 28 August, and she told us that she did not recall any staff members bringing this incident to her attention. She confirmed that she should have had the final decision, but if she decided to go against the doctor's advice, she would have documented this in the prison records. There is no record of this decision in the prison records.

48. Mr Kelk continued to experience abdominal pain and vomiting, and he attended A&E the following day. During this hospital admission, Mr Kelk was diagnosed with end-stage liver disease.

49. It is concerning that there are no records to explain why the CM and/or the Head of Business Assurance did not send Mr Kelk to hospital on 28 August. In the absence of further evidence, we cannot determine exactly why clear clinical advice from the out-of-office doctor and the nurse was not followed. We make the following recommendation:

    The Governor should ensure that when a clinician advises that a prisoner should be sent to hospital:

    - **the policy of referring such decisions to the duty governor is rigorously enforced and;**

      where the advice is not followed, the reasons should be clearly documented by the duty governor.

Governor to note

Early compassionate release

50. There was a three-week delay in starting Mr Kelk's application for early release on compassionate grounds after he received a prognosis of a few months on 28 September. It is important that early release applications are completed promptly when individuals have only a short prognosis. However, we recognise that once it was started on 17 October 2023, it was appropriately managed using Wakefield's tracking system. Unfortunately, Mr Kelk died before it was fully progressed.

Debriefs

51. Wakefield told us that they did not conduct a staff debrief as it was an expected death in custody. However, PSI 02/2018 is clear that a hot debrief should be held immediately after all deaths in custody.

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

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