Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jason Kennedy, a prisoner at HMP High Down, on 9 November 2022

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.

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.

Mr Jason Kennedy died on 9 November 2022, at HMP High Down. He was 52 years old. Mr Kennedy died after sudden cardiorespiratory failure under the influence of several drugs, including methadone, pregabalin and morphine/heroin – not all of which were prescribed to him. I offer my condolences to Mr Kennedy's family and friends.

The clinical reviewer concluded that Mr Kennedy's clinical care was partly equivalent to that which he could have received in the community. There was no collaborative healthcare and substance misuse care plan covering the daily clinical observations linked to his methadone dose; missed medical appointments were not followed up; and some healthcare staff did not fully understand a key clinical assessment tool.

While I acknowledge that High Down has recently taken steps to improve the supervision of medicine dispensing, more needs to be done. I consider that the policy and processes need to be further strengthened, to help prevent the diversion of medication. Poor medicine supervision and a significant increase in prescribed medication are issues that HM Chief Inspector of Prisons and the Independent Monitoring Board, respectively, have also recently highlighted.

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

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

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Summary

Events

1. Mr Jason Kennedy was convicted of supplying drugs and sentenced to four years imprisonment on 24 June 2022. He moved to HMP High Down on 18 August.

2. Mr Kennedy had several lung conditions, including chronic obstructive pulmonary disease (COPD), emphysema, bronchiectasis (damaged airways), pulmonary embolism and respiratory failure. He had equipment to aid his breathing at night, but rarely used it. Mr Kennedy also had a history of substance misuse, with a high level of dependency. He used heroin and benzodiazepines daily.

3. In prison, Mr Kennedy was placed on methadone maintenance. He was informed of the risks of taking illicit substances and attended substance misuse support sessions. To mitigate the risk of respiratory depression from the combination of his lung conditions and use of methadone, clinical observations were taken before he received his daily dose, and it was withheld if his oxygen saturation levels were below 93%. At the end of September, Mr Kennedy agreed to start reducing his dosage of methadone, with a view to taking a safer alternative.

4. At around 8.05am on 9 November, just after cells were unlocked, a prisoner found Mr Kennedy unresponsive. Operational and healthcare staff attended quickly, but resuscitation was not attempted as rigor mortis had set in. Later that day, a prisoner told staff that Mr Kennedy had been taking medication that had not been prescribed to him and the post-mortem examination confirmed this.

Findings

5. The clinical reviewer concluded that Mr Kennedy's clinical care at High Down was only partly equivalent to that which he could have expected to receive in the community, due to weaknesses in managing his long-term respiratory conditions.

6. Mr Kennedy received good support from the substance misuse service. Prison, healthcare and substance misuse staff were unaware that he was using illicit medication.

7. There was no care plan to support the joint responsibility of substance misuse and healthcare staff to take daily clinical observations before dispensing methadone. The clinical checks were not always recorded.

8. Mr Kennedy's failure to attend medical appointments was not followed up.

9. Use of the National Early Warning Score 2 (NEWS2) clinical assessment tool was inconsistent, and some staff were uncertain about the correct scale to use for patients with underlying respiratory conditions.

10. High Down's drug strategy has insufficient focus on the diversion of medication and the dispensing of medicine is not consistently supervised by operational staff. Officers responsible for such supervision might benefit from guidance on how to detect irregularities.

Recommendations

- The Head of Healthcare and the Forward Trust Service Manager should ensure that there is a care plan in place for patients who require clinical observations immediately before receiving their medication; the results of observations are documented; and adjustments to medication doses are in line with the prescribers' instructions.

- The Head of Healthcare should ensure that healthcare staff follow up prisoners' non-attendance at medical appointments and document the reasons.

- The Head of Healthcare should ensure that healthcare staff consistently use the National Early Warning Score 2 (NEWS2) to assess patients and are trained to use the appropriate scale for those with respiratory failure.

- The Governor should ensure that the diversion and trading of prescribed medication is fully addressed in the prison's local drug strategy; medication dispensing is supervised at all times, in line with the local policy; and guidance is issued on effective supervision.

The Investigation Process

11. HMPPS notified us of Mr Kennedy's death on 9 November 2022.

12. The initial investigator issued notices to staff and prisoners at HMP High Down informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

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

14. NHS England commissioned a clinical reviewer to review Mr Kennedy's clinical care at the prison.

15. The latter stages of the investigation were completed by another investigator. She obtained further information about the prison's substance misuse strategy, diversion of medication and related processes. She also spoke to the Head of Security about the trafficking and conveyancing of illicit substances.

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

17. The Ombudsman's family liaison officer contacted Mr Kennedy's sister to explain the investigation and to ask if she had any matters she wanted us to consider. She did not reply.

18. The initial report was shared with HMPPS. They found no factual inaccuracies.

Background Information

HMP High Down

19. HMP High Down is in Surrey. It has an operational capacity of 1,180 and was re-categorised from a local to a training and resettlement prison in April 2022. Central and Northwest London NHS Foundation Trust provides physical and mental healthcare services. Substance misuse services are provided by Forward Trust.

HM Inspectorate of Prisons

20. The most recent inspection of HMP High Down was in August 2023. A priority concern was the critical threat to safety and stability, due to the widespread availability and use of illicit substances. Significantly more prisoners than at similar prisons said that it was easy to get drugs (45% compared to 31%) and the proportion of positive drug tests was among the highest in England and Wales.

21. Inspectors found that primary care services were well-led and equivalent to those in the community. Weekly multidisciplinary meetings were held to monitor patients with complex needs. However, key risks included poor medicine supervision and high non-attendance rates for medical appointments.

Independent Monitoring Board

22. 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 December 2022, the IMB reported that there had been an increase in complaints by prisoners, particularly relating to medication and access to care. However, the waiting times for GP appointments had reduced considerably.

23. The Board was very concerned about the availability of illicit drugs and prisoners said that it was relatively easy to obtain them. Up to a third of men were receiving clinical or social support to manage or reduce their drug dependence. They also noted that there had been a huge and inexplicable increase in prescriptions from 13,955 in 2021, to 22,279 in 2022.

Previous deaths at HMP High Down

24. Mr Kennedy was the seventh prisoner at High Down to die since November 2019. Four of the previous deaths were from natural causes and two were self-inflicted. There have been four further deaths, three from natural causes and one apparently drug related. There are no significant similarities between our findings in this investigation and those in the previous deaths.

Key Events

25. Mr Jason Kennedy was convicted of supplying a class A controlled drug. On 24 June 2022, he was sentenced to four years imprisonment and sent to HMP Wandsworth.

26. At his initial health screen, it was noted that Mr Kennedy had been diagnosed with several lung conditions, including COPD, emphysema, bronchiectasis, pulmonary embolism and respiratory failure and was under the care of a respiratory consultant. Mr Kennedy also had a history of substance misuse. He said that he had smoked heroin for ten years and took benzodiazepines daily. He was placed on a methadone maintenance regime and referred to the substance misuse service.

27. During clinical assessments over the next few days, healthcare staff recorded that Mr Kennedy was at risk of respiratory depression (slow, shallow breathing leading to a build-up of carbon dioxide in the body) due to end-stage COPD and that a referral for a lung transplant had been declined, as Mr Kennedy continued to smoke tobacco.

28. While in prison, Mr Kennedy had a nebuliser and a bilevel positive airway pressure (BPAP) machine, to assist his breathing at night, but he did not always use them.

29. On 28 July, an electrocardiogram (ECG) showed an irregular pulse rate. An appointment with the GP was arranged for the following day to explore this, but Mr Kennedy did not attend.

Transfer to HMP High Down

30. On 18 August, Mr Kennedy transferred to HMP High Down. A nurse conducted an initial health screen and recorded his medical conditions. (A second-stage health assessment was completed on 21 August by another nurse.) He was considered stable at that time.

31. On 19 August, a Forward Trust substance misuse practitioner gave Mr Kennedy advice on harm minimisation and explained the risks of using illicit substances. Mr Kennedy said that he was content with his dose of methadone and had not used illicit drugs in prison.

32. On 22 August, Forward Trust's substance misuse GP reviewed Mr Kennedy and re-prescribed his existing dose of methadone. He noted that Mr Kennedy's blood oxygen saturation level should be checked daily before he received his methadone, and the dose should be withheld if the level fell below 93%. The substance misuse team was expected to take clinical observations each morning.

33. A substance misuse practitioner assessed Mr Kennedy on 30 August and concluded that he had a high level of dependency. She repeated the advice he had previously been given about the risk of overdose and created a substance misuse care plan. Mr Kennedy had support sessions with the Forward Trust team approximately every ten days. He engaged well and asked to participate in group work and join Narcotics Anonymous.

34. On 26 September, Mr Kennedy attended the long-term conditions clinic for review of his COPD. As his blood pressure and pulse rate were raised, a paramedic employed at the prison was also asked to check him. A GP examination on the same day indicated a wheeze in his lungs and he was treated with antibiotics.

35. Over the next few days, Mr Kennedy's oxygen saturation levels fluctuated and were sometimes low. On 28 September, the prison paramedic consulted a respiratory nurse at a local hospital, who thought this might be due to Mr Kennedy not using his BPAP machine, which he had been advised to use every night.

36. Safer alternatives to methadone had been discussed with Mr Kennedy several times. At an appointment with the substance misuse GP in the afternoon, he agreed to start reducing his methadone, with a view to replacing it with buprenorphine.

37. The nurse who took Mr Kennedy's clinical observations on 3 October, asked if he used illicit substances and he said no. On the same day, Mr Kennedy told a healthcare assistant that he had not used the BPAP machine since June 2022, as it made his face sore and prevented him from sleeping. A new mask was supplied on 24 October.

38. On 27 October, Mr Kennedy missed an appointment for his annual GP respiratory review. The reason for his non-attendance was not recorded and the appointment was not rearranged.

39. On 8 November, Mr Kennedy collected medication from healthcare staff at 3.42pm. He went to his cell just after 5.00pm and several prisoners visited him until around 8.15pm, when his cell was locked.

Events on the morning of 9 November

40. An Operational Support Grade (OSG) checked and counted prisoners at around 4.30am. He recorded that they all appeared to be physically well.

41. At around 8.05am, an officer unlocked Mr Kennedy's cell. As there was no response when he greeted him, he assumed that Mr Kennedy was asleep and decided not to disturb him. After opening two further cells, the officer and his colleague heard a prisoner shouting to them that Mr Kennedy was not breathing and seemed to be dead. The officers went into the cell, and it was clear that Mr Kennedy had been dead for some time. One officer radioed a code blue medical emergency at 8.07am and an ambulance was requested.

42. The prison paramedic was on the houseblock and immediately went to the cell. He checked Mr Kennedy and found that he had no pulse and that he was cold, with signs of rigor mortis so staff did not attempt CPR. He confirmed Mr Kennedy's death at 8.09am. The ambulance crew arrived at 9.00am and formally documented the death.

43. Later that day, a prisoner informed prison staff that Mr Kennedy had been using medication that had not been prescribed to him and had smoked psychoactive substances in the evenings.

Contact with Mr Kennedy's family

44. The prison's family liaison officer broke the news of Mr Kennedy's death to members of his family at his sister's home and gave information about the immediate processes to be followed. She maintained close contact and provided support over the following weeks.

45. In line with national policy, the prison contributed to the cost of Mr Kennedy's funeral.

Support for prisoners and staff

46. The deputy governor debriefed the staff involved in the emergency response to discuss any issues arising and offer support. The staff care team also spoke to them individually. Some of the staff and prisoners were offered further support through the mental health team.

47. Staff conducted welfare checks on the prisoners in Mr Kennedy's unit and reviewed all those assessed as being at risk of suicide or self-harm, in case they had been adversely affected by his death. The prison posted notices informing other staff and prisoners of Mr Kennedy's death and signposting to avenues of support.

Post-mortem report

48. The post-mortem examination found that Mr Kennedy had a sudden adult cardiac death caused by acute cardiorespiratory failure, under the influence of several drugs including methadone, pregabalin and morphine/heroin, not all of which were prescribed to him. Underlying chronic obstructive pulmonary disease, emphysema and bronchiectasis contributed to, but did not cause his death.

Findings

Clinical findings

49. The clinical reviewer considered that the substance misuse service had provided good support to Mr Kennedy and the risk of respiratory depression while using methadone, as well as safer options had been discussed with him. However, she concluded that the clinical care he received at High Down was only partly equivalent to that which he could have expected to receive in the community, as his respiratory conditions were not appropriately managed.

50. Full details of the clinical reviewer's findings are in the clinical review report. We summarise the issues directly related to the conditions that caused or contributed to Mr Kennedy's death. The Heads of Healthcare at Wandsworth and High Down will also need to consider the clinical reviewer's additional recommendations.

Management of Mr Kennedy's long-term medical conditions

51. The clinical reviewer noted that some of the weaknesses in Mr Kennedy's care, such as the delay in recognising the need for a long-term condition review and the absence of a formal COPD plan, had been addressed by the healthcare providers after his death. However, there were remaining concerns.

52. As Mr Kennedy was at high risk of respiratory depression, clinical observations had to be taken before each methadone dose was dispensed. The clinical reviewer found there was no collaborative care plan in place to manage this and ensure a common understanding between the healthcare and substance misuse staff involved in this process. Mr Kennedy checked his oxygen levels in his cell and the results were not always recorded. None were documented before the last dose on the day of his death. We recommend:

    The Head of Healthcare and the Forward Trust Service Manager should ensure that there is a care plan in place for patients who require clinical observations immediately before receiving their medication; the results of observations are documented; and adjustments to medication doses are in line with the prescribers' instructions.

53. Mr Kennedy failed to attend key medical appointments, including an annual respiratory review with the GP, listed for 27 October, two weeks before his death. There was no evidence that healthcare staff followed up the reasons for non-attendance, or rearranged appointments. We recommend:

    The Head of Healthcare should ensure that healthcare staff follow up prisoners' non-attendance at medical appointments and document the reasons.

54. NEWS2 is a tool to detect clinical deterioration in acutely unwell adults. The clinical reviewer noted that although staff generally escalated abnormal clinical results, the use of NEWS2 was inconsistent and staff were uncertain of which scale to use for patients with underlying respiratory conditions. We recommend:

The Head of Healthcare should ensure that healthcare staff consistently use the National Early Warning Score 2 (NEWS2) to assess patients and are trained to use the appropriate scale for those with respiratory failure.

Diversion and trafficking of medication

55. Mr Kennedy appeared to engage well with the substance misuse service. None of the healthcare or operational staff with whom he had contact were aware that he was possibly misusing illicit substances or medication and he denied it when the question was explicitly asked. If healthcare staff had known, he would have been discussed at the complex case meeting and his prescribed medication would have been reviewed.

56. The investigation found that High Down has an up to date and detailed *Drug Strategy Policy.* However, there is only a single reference to the potential for abuse of medication - "*Ensure safe and secure dispensing of pharmacy and prescription medication, including the use of medicine safes where necessary.*" The policy is due to be reviewed and reissued in April 2024.

57. Information about the operational handling of medication diversion and substance misuse issues was limited as it falls within the remit of the Head of Drug Strategy, currently a vacant post. However, the Head of Security told the investigator about the current initiatives for reducing the trafficking of illicit substances and outlined some of the drug strategy elements. Diversion intelligence reports are sent to the head of residence, healthcare provider and Forward Trust, for action. The monthly drug strategy and security meetings have been merged and will become active when the newly appointed drug strategy lead takes up post.

58. The Head of Security said that concerns about medication supervision had been raised by healthcare and operational staff, which had led to implementation of a policy that all medication queues must be supervised. (A notice was circulated to staff on 20 February 2023, explicitly stating that this had been introduced to identify diversion and trading, and to reduce the fear of bullying and coercion.) As it is not a dedicated task within the prison officer role, there are sometimes resource issues and failures to assign staff are reported at the Governor's daily briefing.

59. The Head of Healthcare informed the clinical reviewer that the lack of supervision of medication dispensing was added to the healthcare provider's risk register in November 2022 and removed in March 2023. There had since been concerns about a decline in supervision. In response to this, the Head of Healthcare, together with operational and substance misuse managers had jointly agreed to reinforce the supervision policy and healthcare staff had been told not to issue medication without an officer present.

60. Mr Kennedy had not been prescribed pregabalin, which was detected in his system and contributed to his death, so he must have obtained it illicitly. Given the concerns highlighted by the inspectorate, the vast increase in prescribed medication noted by the IMB and the findings of this investigation, we consider that there should be more visibility and focus on medication diversion and trading in the prison's drug strategy policy, which is due to be reviewed and reissued in April 2024. In addition to the deterrent effect of having an officer located at medication

queues, those conducting this task might benefit from procedural guidance on how to effectively identify attempts to divert medication. We recommend:

The Governor should ensure that the diversion and trading of prescribed medication is fully addressed in the prison's local drug strategy; medication dispensing is supervised at all times, in line with the local policy; and guidance is issued on effective supervision.

Governor to note

61. High Down's local guidance on night duty tasks says that OSGs should ensure that each prisoner is alive and well during roll counts. Additionally, Governor's Notice 72/2022, states that wellbeing and verbal response checks should take place twice a day, at approximately 8.00am and 2.00pm.

62. The prison officer who checked Mr Kennedy on the morning of his death failed to seek a response from him. This did not affect the outcome as he was found moments later and had been dead for some time, but it was distressing for other prisoners to find him. This shortcoming and the need to get a response from prisoners during welfare checks was listed as a key lesson to consider at the debrief after Mr Kennedy's death, so we make no further comment.

Inquest

63. At an inquest held on 5 February 2025, the Coroner concluded that Mr Kennedy's death was misadventure - the combination of methadone, morphine and pregabalin combined with his underlying health issues of chronic obstructive pulmonary disease, emphysema and bronchiectasis caused acute cardio-respiratory failure leading to sudden adult cardiac death.

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