

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Kevin Golby, a prisoner at HMP Five Wells, on 10 December 2024

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



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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 Kevin Golby was found unresponsive in his cell on 10 December 2024, at HMP Five Wells. He was 49 years old. A post-mortem was unable to ascertain the cause of his death. We offer our condolences to his family and friends.
4. Mr Golby had a history of dissociative seizures. While he was at Five Wells, he had numerous seizure episodes and was due to be seen by a neurologist at the time of his death. The clinical reviewer concluded that the care Mr Golby received at Five Wells was equivalent to that which he could have expected to receive in the community, noting that he was seen on numerous occasions by healthcare staff at Five Wells.
5. However, the clinical reviewer identified that there were delays in Mr Golby seeing a GP, despite arriving at Five Wells with an outstanding appointment. In addition, after the hospital advised that a referral should be made to the neurology team, there was a delay of over two weeks before the prison made this referral. We do note that Mr Golby was seen on several occasions at hospital, including the day before he died where a scan identified no concerns.

Recommendations

- The Head of Healthcare should ensure that all prisoners who arrive with outstanding GP appointments are promptly identified and a plan is put in place for them.

The Investigation Process

6. HMPPS notified us of Mr Golby's death on 10 December 2024.
7. NHS England commissioned an independent clinical reviewer, to review Mr Golby's clinical care at HMP Five Wells. The clinical review is attached as Annex 1.
8. The PPO investigator investigated the non-clinical issues relating to Mr Golby's care. The investigator and the clinical reviewer interviewed four members of staff and one prisoner from Five Wells in May and June 2025. The investigator interviewed an additional prisoner in May 2025.
9. The Ombudsman's office wrote to Mr Golby's sister to explain the investigation and to ask if she had any matters she wanted us to consider. She did not have any questions but requested a copy of the report.
10. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is an additional annex to this report.
11. We also shared the initial report with Mr Golby's family. They did not make any comments.
12. This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.
13. At the inquest into Mr Golby's death concluded on 20 March 2026 and found that the probable cause of death could not be ascertained.

Previous deaths at HMP Five Wells

14. Mr Golby was the fourth prisoner to die at Five Wells since December 2021. All of the previous deaths were from natural causes. There are no similarities between the findings in our investigation into Mr Golby's death and the findings from our investigations into the previous deaths. To the end of August 2025, there were two further deaths, one of which was due to natural causes and one of which was due to the use of illicit drugs.

Key Events

15. On 20 July 2023, Mr Kevin Golby was remanded to HMP Bullingdon for assaulting an emergency worker and assault by beating. On 14 August, he received a sentence of 18 months in prison. On 1 March 2024, he was released on licence.
16. On 6 May, Mr Golby was recalled to prison for breaching his licence. On 30 May, he was again released on licence.
17. Mr Golby's medical history included liver cirrhosis, anxiety, PTSD and dissociative seizures. (Dissociative seizures are similar to epileptic seizures as they cause involuntary movements and behaviours. However, unlike epileptic seizures, these can occur without corresponding seizure activity in the brain. Some dissociative seizures take place for psychological reasons, such as stress or traumatic events.) He was not prescribed medication for his seizures. Mr Golby also had a significant history of alcohol use.

HMP Bullingdon

18. On 1 June 2024, Mr Golby was recalled to prison for breaching his licence and sent to Bullingdon. He was due for release on 19 December 2024.
19. While at Bullingdon, Mr Golby had a number of episodes which were diagnosed as dissociative seizures. Mr Golby told staff that these usually increased when he felt stressed.
20. On 24 August, a nurse saw Mr Golby after prison officers radioed a medical emergency code due to Mr Golby feeling dizzy. The nurse sent a message requesting a more urgent GP appointment because of the number of episodes he was having. Mr Golby's next appointment was brought forward to 3 September. (Mr Golby had already moved prison and therefore did not attend this appointment.)

HMP Five Wells

21. On 30 August, Mr Golby transferred to HMP Five Wells.
22. At his initial health screening, Mr Golby told the reception nurse that he had concerns about the seizures that he had experienced in Bullingdon. That evening, healthcare staff saw Mr Golby due to a fall. Mr Golby said he had anxiety and that this was triggered when he was in a new environment. Healthcare staff planned for the nursing team to review Mr Golby the following day.
23. On 31 August, Nurse A saw Mr Golby and completed a set of clinical observations which raised no concerns. Mr Golby advised the nurse that he was due to see the GP at Bullingdon on 3 September. No action was taken and Mr Golby did not have a new appointment booked.
24. On 19 September, Nurse B, an advanced nurse practitioner, saw Mr Golby and undertook a full physical examination which did not identify any concerns. Mr Golby said he was anxious as he did not know where he would go when he was released. Mr Golby said he did not want to start anxiety medication but Nurse B made a

referral to the mental health team. The mental health team sent Mr Golby stress and anxiety self-help booklets the same day.

25. Between 12 October and 25 November, officers radioed a medical emergency code for Mr Golby on 17 occasions. Healthcare staff attended each time. On some occasions, staff called an emergency code due to Mr Golby falling or collapsing, on others due to apparent seizures and on others due to him losing consciousness. Mr Golby attended hospital four times following these episodes.
26. On 16 October, Nurse C sent a message to the GP explaining that Mr Golby had had three fainting episodes over the last two weeks and that he had attended outside hospital. She asked for the GP's advice on the next steps. On 17 October, Dr A responded that he had added Mr Golby to the GP waiting list for review. (The waiting list at the time of Mr Golby's death was 12 weeks.)
27. On 19 October, Mr Golby went to hospital and was diagnosed with vertigo and given prochlorperazine (an antipsychotic medication that is also prescribed to help with vertigo).
28. On 20 October, Nurse D sent a message to the GPs noting that officers (who had accompanied Mr Golby to hospital) had said that the hospital were not happy that Mr Golby had not yet been seen by a GP at Five Wells. Dr B responded that Mr Golby was on the waiting list.
29. On 22 October, Nurse B saw Mr Golby for a review of what she described as his syncopal episodes. (Syncopal episodes are episodes of falling with an unknown cause.) She carried out a full examination and had no concerns. Nurse B planned for Mr Golby to be reviewed by the GP and added him to the waiting list. (As above, Mr Golby had already been added to the waiting list.)
30. On 28 October, Mr Golby went to hospital after three seizures in a short period of time and hitting his head. The discharge summary from the hospital advised that a community referral should be made to the neurology team.
31. On 3 November, Mr Golby was taken to hospital after collapsing in a communal area. Healthcare staff noted that the discharge summary advised that Mr Golby should be booked into the first hospital fit clinic (a neurology clinic that sees patients who have seizures or fits).
32. On 13 November, Dr C, GP, saw Mr Golby for his appointment. He referred Mr Golby to the neurology team. (Healthcare staff subsequently sent the referral on 18 November.)
33. Mr Golby was due to attend his neurology appointment on 9 December. On 21 November, Dr B asked for this to be moved due to there being a prisoner who required to be seen more urgently. (Mr Golby's appointment was rebooked for 30 December.)

Events of 9 and 10 December

34. The following account has been drawn from CCTV footage from 9 December, staff statements, interviews, body worn video camera (BWVC) footage and ambulance

service records. (CCTV footage from 10 December was not saved by the prison and therefore we have been unable to watch this.)

35. On 9 December, Mr Golby met his prison offender manager (POM) to discuss his release arrangements. (Mr Golby was due for release on 19 December and was anxious about where he was going to live.) Mr Golby told his POM that he had another seizure over the weekend but that he had not informed healthcare staff.
36. At around 5.16pm, Mr Golby was queuing for food when another prisoner punched him and Mr Golby fell to the floor. An officer arrived quickly and radioed a medical emergency code blue. (The control room operator telephoned for an ambulance.) While on the floor, Mr Golby had a number of seizures. Healthcare staff arrived six minutes later and carried out observations which showed that Mr Golby had an elevated heart rate.
37. At 5.24pm, paramedics arrived at Five Wells.
38. At around 5.29pm, body worn footage showed an officer asking for additional staff to assist them. Six minutes later, the officer asked for an update on the additional members of staff explaining that they needed to lock up the landing but did not have enough staff on scene. After another six minutes, the officer advised that half of the prisoners on the landing were unlocked and that the ambulance crew could not therefore be brought in. (Staff could be heard shouting in the background for prisoners to get into their cell.)
39. At 5.39pm, paramedics arrived on the landing.
40. At 6.19pm, paramedics took Mr Golby to Kettering General Hospital. Hospital staff conducted a CT scan which did not identify any concerns and the discharge summary noted that there were no follow up appointments.
41. At around 2.29am, Mr Golby returned to Five Wells.
42. At around 2.30am, Nurse D saw Mr Golby. A healthcare assistant conducted a set of clinical observations which were within the normal range. At interview, Nurse D told the investigator that Mr Golby was alert and that she had reviewed the discharge summary from the hospital which did not raise any concerns.
43. At around 3.00am, Prison Custody Officer (PCO) A started his roll check (a routine count of prisoners). (PCO A was the only officer on the landing that evening and told us that he started the roll check earlier than usual because there were a lot of prisoners on the wing who required additional welfare checks due to their risk of suicide and self-harm.)
44. While PCO A was conducting his roll check, the duty manager brought Mr Golby to the landing and locked him in his cell. PCO A told the investigator that Mr Golby seemed fine and was laughing and joking with the duty manager. He said that the duty manager told him that there were no issues with Mr Golby and locked him in his cell.
45. At around 8.15am, PCO B conducted a routine morning welfare check of all prisoners. She said that she did this with another officer and she could not recall whether it was herself or her colleague who looked into Mr Golby's cell. (PCO B

said that generally one officer would look through the list and tell the other officer who to unlock and who not to unlock. She also said that usually Mr Golby's cell was dark and it was hard to see in so she would generally go back to his cell and speak to him after completing all of her welfare checks.)

46. Mr A and Mr B, both prisoners, told the investigator that they looked through Mr Golby's observation panel that morning and noted it was pitch black inside and they could not see anything. (We do not know what time they each looked in the cell.) Mr A said that he mentioned to Officer B that she should check on Mr Golby.
47. At around 8.50am, PCO B unlocked Mr Golby's door and called a medical emergency code blue (used to indicate when someone is unresponsive or not breathing). Mr Golby was in a seated position on the floor, with his legs outstretched and his head bent forwards. A prisoner joined PCO B in the cell and she shouted for him to get another officer.
48. Less than a minute later, other officers joined and noted that Mr Golby was cold, stiff and that he was in rigor mortis. At 8.53am, Nurse E and Ms A, a pharmacy technician, arrived and started CPR.
49. At 9.10am, paramedics arrived and identified that rigor mortis and post-mortem staining were present (two conditions which are unequivocally associated with death). At 9.11am, paramedics pronounced life extinct.

Contact with Mr Golby's family

50. At 1.30pm on 10 December, Ms B, family liaison officer (FLO), Mr C, chaplain, and Mr D, an operational manager, left the prison. At 2.30pm, they arrived at Mr Golby's father's address and broke the news.

Post-mortem report

51. The report of the post-mortem examination concluded that the cause of Mr Golby's death was unascertained. The pathologist noted that it was well recognised that patients with a history of seizures had an increased risk of sudden death. She noted that although Mr Golby had a history of seizures, there was not a formal diagnosis of epilepsy and she therefore concluded that the medical cause of death should be considered as 'unascertained'.
52. The pathologist concluded that the lack of demonstrable recent injury to Mr Golby's brain and his history of seizures meant that the assault on 9 December did not contribute to Mr Golby's death.

Findings

Clinical findings

53. The clinical reviewer concluded that the clinical care Mr Golby received at Five Wells was of a good standard and equivalent to that which he could expect to receive in the community. She noted that Mr Golby had a long-standing complex medical history and was seen on numerous occasions by the healthcare team in relation to his seizure episodes.
54. However, Mr Golby arrived at Five Wells on 30 August with an outstanding GP appointment at his previous prison (which had been bought forward due to an increase in his seizure episodes). There is no evidence that this was taken into account when Mr Golby arrived at the prison and healthcare staff only added him to the GP waiting list on 16 October.
55. At the time of Mr Golby's arrival in Five Wells, there was a 12-week waiting list for the GP, although he was seen more quickly than this following referral, on 13 November. The clinical reviewer highlighted that Mr Golby was seen before this appointment by an advanced nurse practitioner on two occasions and at outside hospital where no concerns were raised.
56. We make the following recommendation:
- The Head of Healthcare should ensure that all prisoners who arrive with outstanding GP appointments are promptly identified and a plan is put in place for them**
57. The clinical reviewer also raised concerns that there was a delay of over two weeks before a referral was made to neurology when it was requested by hospital staff. The Head of Healthcare, told us that she is liaising with healthcare staff to improve how referrals to hospital are risk assessed and undertaken to avoid delays.
58. The clinical reviewer has made two other recommendations not relevant to the cause of death which the Head of Healthcare will want to address.

Director to note

Prison escorts to hospital

59. Mr Golby was due to attend a neurology appointment on 9 December. However, on 21 November, Dr B asked to postpone this due to another urgent appointment that was a higher priority. The Head of Healthcare told the investigator that, given the hospital had not acknowledged Mr Golby's referral as urgent, this would be considered as a routine referral from a GP perspective.
60. At Five Wells, there is currently capacity for prison staff to escort four planned hospital appointments per day. The Head of Healthcare has informed us that there are plans to increase to the number of escorts for planned appointments to seven per day.

Welfare check

61. On 26 November 2024, Five Wells issued a notice to staff noting that not all staff were conducting morning welfare checks as required. They detailed that welfare checks should be completed at 8.45am and that staff should receive a verbal response from each prison. At interview, PCO B told us that at the time of Mr Golby's death, staff usually conducted unlock and welfare checks at 8.15am.
62. PCO B said that Mr Golby's cell was often dark as he usually covered his night light and used to put something underneath his curtain which blocked out the light. She told us that usually she would do her unlock, look through his panel but as it was dark in the cell she would go back after unlock to speak to him.
63. It is unclear who conducted the welfare check on the morning of 10 December. PCO B thought it was herself and another PCO who conducted welfare checks (from around 8.15am) that morning, but no one was sure who checked Mr Golby's cell. (The prison did not retain the CCTV footage and we have not therefore been able to confirm this. The Director will wish to ensure that CCTV relevant to deaths in custody is properly preserved in future.)
64. PCO B told us she went back to Mr Golby's cell after unlock and this was when she found him unresponsive. While it was positive that PCO B did go back to Mr Golby's cell, it is essential that welfare checks are carried out effectively at the time and that staff are able to properly see into a prisoner's cell.
65. Following Mr Golby's death, Five Wells brought forward the morning welfare check to 7.00am. On 11 December, they issued a notice to staff reminding them of the requirement to get a positive response from every prisoner. They also advised that only curtains should be covering the cell window and that staff may need to use a night light (a light which can be switched on from outside) to see into the cell. (We consider that staff should also consider using a torch when appropriate.)
66. As part of this investigation, a prisoner told us that not all staff complete these 7.00am welfare checks. This demonstrates the need for robust quality assurance processes to ensure that measures have been embedded. We bring this to the Director's attention.

Ambulance access

67. When the paramedics arrived on 9 December, it took around 15 minutes before they were able to access the wing to see Mr Golby. It is clear from viewing body worn footage that a PCO made numerous attempts to ask for additional staff to lock up the landing. The footage shows that it took around 30 minutes for the landing to be locked up.
68. This did not appear to have an impact on Mr Golby's care but the Director will want to consider the events of the 9 December and ensure that staff can appropriately manage these situations and ensure there are no delays in paramedics accessing patients.

Adrian Usher
Prisons and Probation Ombudsman

November 2025

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