Prisons &
Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Kevin Jennings a prisoner at HMP Coldingley on 1 June 2019

A report by the Prisons and Probation Ombudsman

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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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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. Our office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr Kevin Jennings died of coronary heart disease on 1 June 2019, while a prisoner at HMP Coldingley. He was 63 years old. We offer our condolences to Mr Jennings' family and friends.
4. The clinical reviewer concluded that the clinical care that Mr Jennings received was of a good standard and equivalent to that which he could have expected to receive in the community. He has made no recommendations about clinical issues.
5. We make no recommendations.

The Investigation Process

1. NHS England commissioned a clinical reviewer to review Mr Jennings' clinical care at the prison.

2. The PPO investigator has investigated non-clinical issues, including Mr Jennings' location, the security arrangements for his hospital escorts, liaison with his family, and whether compassionate release was considered.

1. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Previous deaths at HMP Coldingley

2. There have been no deaths from natural causes and three non-natural deaths at HMP Coldingley since June 2017. Since Mr Jennings died, there has been one more death from non-natural causes. There are no similarities between our findings in the investigation of Mr Jennings' death and the other deaths.

Key Events

3. In 2014, before entering prison, Mr Jennings was diagnosed with ischaemic heart disease, and in November 2014 he had a heart attack and underwent coronary artery bypass surgery.

4. On 23 March 2016, Mr Jennings was sent to prison for drug offences. On 6 October 2016, Mr Jennings was transferred to HMP Coldingley and it was noted at his transfer reception health screening that he had ischaemic heart disease.

5. 0n 4 January 2017, Mr Jennings attended an appointment at the cardiology department at hospital. He was admitted and diagnosed with left ventricular failure (a type of heart failure), and prescribed medication.

6. On 8 November 2017, Mr Jennings was reviewed by the cardiology department and found to have ischaemic dilated cardiomyopathy (where the muscle of his heart has been damaged and fails to work efficiently) and on 28 November, he was fitted with a pacemaker.

7. Mr Jennings' health gradually deteriorated and on 16 April at 2.25am, he pressed his cell bell for assistance as he was having anxiety, generally finding it hard to breathe, and not getting any sleep. An officer responded immediately and helped to calm Mr Jennings. Mr Jennings said that he would seek assistance from healthcare staff the following morning.

8. Healthcare staff were not on site between 6.30pm and 7.30am. The officer contacted the NHS 111 telephone service for medical advice regarding Mr Jennings, in line with prison policy during 'out of hours'. At 2.56am, '111' put in a request for an ambulance to be sent to the prison.

9. At 4.26am, the ambulance arrived at the prison. At 5.22am, paramedics transferred Mr Jennings to hospital, where he was admitted. Mr Jennings was restrained when he was transferred to hospital. His restraints were removed on 24 April 2019.

10. On 8 May, Mr Jennings was transferred to the cardiac intensive care unit at another hospital. Mr Jennings was critically ill and, on 27 May, his care became palliative.

11. Mr Jennings died on 1 June at 9.50pm.

Medical Hold

12. From 15 September 2018, Mr Jennings was placed on medical hold against transfer as he had an ulcer on his left foot and was being treated at hospital. He would remain subject to medical hold until his foot had healed.

13. Mr Jennings wanted to be transferred to HMP Stamford Hill (a category D prison), on the Isle of Sheppey. If he had been transferred to Stamford Hill before being taken off medical hold, he would have had to be transported from Stamford Hill to hospital for treatment (86 miles) for each outpatient appointment.

14. When a prisoner is transferred to a category D prison, they must wait three months before they are sent out of the prison to medical appointments. This is to allow them to get used to open conditions.

15. On 13 February 2019, Mr Jennings was taken off medical hold and was waiting to be transferred to Stamford Hill. Sadly, he died before there was a place at the prison.

Post-mortem report

16. The Coroner conducted a post-mortem and established that that Mr Jennings died of coronary heart failure.

Findings

Clinical Findings

6. The clinical reviewer concluded that the care Mr Jennings received at Coldingley was of a good standard and equivalent to that which would have expected to receive in the community. He found that Mr Jennings' clinical care was consistent throughout his detention, and that he received appropriate and timely care for both acute and chronic conditions in prison and in hospital. He made no recommendations.

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