

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Frederick Kelly, a prisoner at HMP Durham, on 29 May 2019

A report by the Prisons and Probation Ombudsman

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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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.

The Ombudsman's 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 Frederick Kelly died of ischaemic colitis (an inflammation of the large intestine) on 29 May 2019 while a prisoner at HMP Durham. He was 67 years old. I offer my condolences to Mr Kelly's family and friends.

I am satisfied that the sudden deterioration in Mr Kelly's health could not have been predicted or prevented and that, overall, Mr Kelly received a good standard of care at HMP Durham equivalent to that which he could have expected to receive in the community.

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

Sue McAllister CB
Prisons and Probation Ombudsman

January 2021

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Summary

Events

1. On 16 May 2019, Mr Frederick Kelly was recalled to prison after breaching his bail conditions. He was sentenced to three days in prison for breach of bail and was sent to HMP Durham. After serving the three days in prison, he was held on remand charged with sexual offences.
2. Mr Kelly arrived into prison with a number of pre-existing medical conditions for which he received prescribed medication. He also had a long history of alcohol misuse. He was referred to the prison's Drug and Alcohol Recovery Team (DART), but refused to engage. Mr Kelly had no further significant contact with healthcare staff.
3. On 28 May 2019, a prison officer asked a nurse to review Mr Kelly because he was too unwell to get out of bed and collect his prescribed medications. A nurse took his observations and used her radio to call an emergency code blue. Other healthcare staff attended and the prison control room called an emergency ambulance immediately.
4. Paramedics arrived and administered intravenous fluids. Once Mr Kelly's condition had stabilised, he was taken to hospital by emergency ambulance.
5. After he arrived at hospital, Mr Kelly's condition quickly deteriorated. Hospital staff placed him on a ventilator to help him to breathe. However, Mr Kelly's condition continued to deteriorate and at 11.58pm, hospital staff decided to remove him from the ventilator and to withdraw any further active treatment.
6. At 10.40am on 29 May, it was confirmed that Mr Kelly had died.
7. The post-mortem report gave Mr Kelly's cause of death as ischaemic colitis (an inflammation of the large intestine).

Findings

8. The sudden deterioration in Mr Kelly's health could not have been predicted or prevented.
9. Healthcare staff responded quickly when Mr Kelly's health deteriorated on 28 May, and he was appropriately taken to hospital by emergency ambulance for review.
10. We are satisfied that overall Mr Kelly received a standard of clinical care at Durham that was equivalent to that which he could have expected to receive in the community.
11. The clinical reviewer did, however, identify some departures from good practice:
 - Mr Kelly's blood pressure was not monitored after it was found to be high when he arrived at Durham;

- he did not have a second health screen within seven days; and
- there is no evidence that healthcare staff contributed to the risk assessment on the use of restraints when he was admitted to hospital.

Recommendations

- The Head of Healthcare should ensure that clinical staff are aware of the relevant guidance on caring for patients with elevated blood pressure, namely, *NICE Guidance Hypertension in Adults: diagnosis and management*, to ensure that they are able to diagnose high blood pressure accurately and treat it effectively if clinically indicated.
- The Health of Healthcare should ensure that a second stage health screen is completed within seven days of the first health screen in line with *NICE Guidance Physical Healthcare for Prisoners*.
- The Governor and Head of Healthcare should ensure that all staff completing and authorising risk assessments on the use of restraints on prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Durham informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
13. The investigator obtained copies of relevant extracts from Mr Kelly's prison and medical records.
14. NHS England commissioned an independent clinical reviewer to review Mr Kelly's clinical care at the prison.
15. We informed HM Coroner for Durham and Darlington of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
16. We wrote to Mr Kelly's next of kin to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond to our letter.
17. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Durham

18. HMP Durham is a reception prison serving the courts of Tyneside, Durham and Cumbria. It holds approximately 1,000 men, most of whom are either on remand or subject to recall. G4S provides primary healthcare. The prison's inpatient unit has six beds with 24-hour healthcare.

HM Inspectorate of Prisons

19. The most recent full inspection of HMP Durham was in October 2018. Inspectors reported that the governance of healthcare services at the prison continued to be a complex task due to the number of service providers within the healthcare unit. However, they considered that the inpatient-unit at the prison was well managed and the regime within the inpatient-unit had been enhanced since their last inspection. Effective arrangements had also been put in place for those prisoners needing social care, and the prison had made good links with local social services.

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 October 2018, the IMB reported that the recent change in the role of the prison had meant an increase in the workload of healthcare staff. In addition to the increased workload, the healthcare department continued to experience staff shortages.

Previous deaths at HMP Durham

21. Mr Kelly was the eighteenth prisoner to die at Durham since May 2017. Four of those deaths were from natural causes, eight were self-inflicted and five of the deaths were drug-related. There are no similarities between Mr Kelly's death and the previous deaths.
22. There have been two further deaths since Mr Kelly's death, one of those deaths was from natural causes and the other was a self-inflicted death.

Key Events

23. On 16 May 2019, Mr Frederick Kelly was recalled to prison after breaching his bail conditions. He was sentenced to three days in prison for breach of bail and was sent to HMP Durham. After serving the three days in prison, Mr Kelly was held on remand, charged with sexual offences.
24. On his arrival at Durham, a prison nurse carried out a reception health screen. She noted that Mr Kelly had arrived into prison custody with medication in his possession including amitriptyline (used to treat depression), pregabalin (used to treat anxiety) and simvastatin (to control cholesterol).
25. The nurse noted that Mr Kelly had type 2 diabetes and that at the time of the health screen his blood pressure was raised at 160/104 (a normal blood pressure is between 90/60 and 120/80). The nurse asked Mr Kelly to provide a urine sample to test for illicit substances. He told her that he was unable to give her a sample at that time, but that he was not a drug user.
26. Mr Kelly had a long history of alcohol misuse. He was referred to the drug and alcohol recovery team (DART) at the prison the following day, but he refused to engage.
27. Mr Kelly was scheduled to have a second health screen on 18 June. He had no further significant contact with healthcare staff.
28. On 28 May, the nurse was dispensing prescribed medications on the wing where Mr Kelly was located. A prison officer told the nurse that Mr Kelly felt unwell and was unable to get out of bed to collect his medication. She asked the nurse if she would check on his wellbeing and take his medication to him.
29. When the nurse arrived at Mr Kelly's cell, she noted that he was sitting on a chair and was alert and responsive. However, he was showing signs of intermittent confusion and had become incontinent of faeces. The nurse took Mr Kelly's observations (the level of oxygen in the bloodstream, temperature and blood pressure used as an indicator of a patient's physical condition) but was unable to obtain his oxygen saturation level. She noted that his temperature was 35.2°C (normal body temperature ranges from 36.1° to 37.2°) and his blood pressure was 62/71 (low). She administered oxygen therapy to support his breathing and helped him into bed.
30. Because of Mr Kelly's abnormal observations and deteriorating condition, the nurse radioed a code blue emergency (indicating a prisoner is unconscious or having difficulty breathing) to summon help from other healthcare staff. The prison control room called an emergency ambulance immediately.
31. Three other prison nurses responded immediately and attempted to take Mr Kelly's observations. One of the nurses noted that his oxygen saturation level was only 72%, despite having received oxygen therapy. She also noted that despite Mr Kelly being alert and responsive, he became confused during conversation.

32. Mr Kelly told a prison nurse that he had been experiencing pain in the right side of his lower abdomen for the previous two days. There is no evidence in his medical records to suggest that Mr Kelly had told healthcare staff about his pain before.
33. Paramedics arrived at Mr Kelly's cell and administered intravenous fluids to stabilise his condition. At 10.10am, once his condition had been stabilised, Mr Kelly was taken to University Hospital of North Durham by emergency ambulance. Mr Kelly was accompanied to hospital by two officers and was restrained using an escort chain.
34. Mr Kelly's condition quickly deteriorated in hospital. Hospital staff told prison healthcare staff that Mr Kelly's prognosis was poor. They placed him on a ventilator to help him to breathe.
35. At 6.40pm, Mr Kelly's condition worsened and the escort officers removed the restraints.
36. At 11.58pm, hospital staff decided to remove Mr Kelly from the ventilator and to withdraw all active treatment. They told the escort officers that he was not expected to survive the night.
37. Mr Kelly's condition continued to deteriorate and he died at 10.40am on 29 May. At 12.00pm, a hospital doctor confirmed his death.

Post-mortem report

38. The post-mortem report gave the cause of death as ischaemic colitis (an inflammatory condition of the large intestine as a result of inadequate blood supply).

Contact with Mr Kelly's Family

39. At 1.00pm on 28 May, the prison appointed a family liaison officer (FLO).
40. Before the FLO could contact Mr Kelly's ex-wife, his next of kin, she telephoned the prison and told him that Mr Kelly's solicitor had told her about his condition.
41. The FLO offered to meet Mr Kelly's ex-wife at the hospital to offer her support. He agreed to telephone her back to make arrangements once he had more information. However, when he tried to telephone Mr Kelly's ex-wife, she did not answer the telephone. He left her a message with his contact details and offered to pay the cost of a taxi to the hospital.
42. When hospital staff decided to stop all treatment, they telephoned Mr Kelly's ex-wife to tell her that Mr Kelly's condition had deteriorated. They also told her that he was not expected to survive the night. Hospital staff offered her the opportunity to visit Mr Kelly in hospital. Mr Kelly's ex-wife said that she felt pressured by hospital staff and was unsure if she wanted to visit him before he died. She decided not to visit Mr Kelly.

43. At 11.40am the following morning, the FLO went to Mr Kelly's ex-wife's home to tell her that Mr Kelly had died. Despite being at home, she did not answer the door. Concerned for her safety, he telephoned the police for assistance.
44. arrived thirty minutes later and managed to gain a response from her. She told the police that she wished to be left alone as she was grieving. The FLO told her that she could contact him for support whenever she wanted. He then returned to the prison.
45. At 1.55pm, Mr Kelly's ex- wife's daughter telephoned the prison and told the FLO that she had spoken with her mother and that they had agreed they would like him to visit the family on 3 June.
46. As arranged, the FLO visited Mr Kelly's ex-wife and returned Mr Kelly's property to her. He remained in contact, offering support to the family.
47. Mr Kelly's funeral was held on 21 July. The family had requested that no one from the prison attend the funeral. In line with national guidance, the prison offered a financial contribution to the funeral costs.

Support for prisoners and staff

48. After Mr Kelly's death, a prison manager debriefed the staff who were accompanying him at the hospital when he died, giving them the opportunity to discuss any issues arising and to offer support. The staff care team also offered support.
49. The prison posted notices informing other prisoners of Mr Kelly'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 Kelly's death.

Findings

Clinical care

50. The clinical reviewer concluded that, overall, the clinical care Mr Kelly received at Durham was equivalent to that which he could have expected to receive in the community. She was satisfied that healthcare staff responded promptly and appropriately when called to see Mr Kelly on 28 May and identified that he needed to be transferred to hospital urgently. She was also satisfied that, as Mr Kelly had not previously reported pain in his abdomen, his sudden deterioration could not have been predicted or prevented.
51. However, the clinical reviewer did identify some concerns.
52. Mr Kelly's blood pressure was high at his initial health screen on 16 May. Under the National Institute for Health and Care Excellence (NICE) guidelines for the diagnosis and management of hypertension (high blood pressure), Mr Kelly should have had his blood pressure monitored over a twenty-four-hour period to confirm whether he had high blood pressure. This did not happen.
53. In addition, NICE guidance NG57 on the physical healthcare of prisoners recommends that a second stage health assessment should be completed within seven days of the first. This did not happen. The Head of Healthcare at Durham, said that Mr Kelly was scheduled to have a second stage health screen on 18 June (a month after the first screen) and would have had a further blood pressure check then.
54. We make the following recommendations:

The Head of Healthcare should ensure that clinical staff are aware of the relevant guidance on caring for patients with elevated blood pressure namely, *NICE Guidance Hypertension in Adults: diagnosis and management*, to ensure that they are able to diagnose high blood pressure accurately and treat it effectively if clinically indicated.

The Health of Healthcare should ensure that a second stage health screen is completed within seven days of the first health screen in line with *NICE Guidance Physical Healthcare for Prisoners*.

Restraints, security and escorts

55. When prisoners must travel outside the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public but this must be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk considering factors such as the prisoner's health and mobility.
56. When Mr Kelly was taken to hospital by emergency ambulance on 28 May 2019, he was escorted by two officers and was restrained using an escort chain. There is no evidence that healthcare staff contributed to the risk assessment that determined the need for Mr Kelly to be restrained.

57. At 6.40pm, as Mr Kelly's condition worsened, the escort officers removed his restraints. He remained unrestrained until his death the following day.
58. We are satisfied that staff removed Mr Kelly's restraints when it became clear his condition was deteriorating, but we are concerned that the initial decision to restrain him appears to have been made without input from healthcare staff about his state of health. We recommend:

The Governor and Head of Healthcare should ensure that all staff completing and authorising risk assessments on the use of restraints on prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

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