Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of David Kendall, a prisoner at HMP Frankland, on 24 July 2020

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T I 020 7633 4100
F I 020 7633 4141

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*

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. My 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 David Kendall died on 24 July 2020 of lung cancer at HMP Frankland. He was 55 years old. I offer my condolences to Mr Kendall's family and friends.

4. The clinical reviewer concluded that the care that Mr Kendall received at HMP Frankland after his cancer diagnosis was not wholly of the required standard. It was, in parts, not equivalent to that which he could have expected to receive in the community. She made six recommendations about Mr Kendall's care.

5. We found no non-clinical issues of concern. We make no recommendations.

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

Recommendations

- The Head of Healthcare should ensure that processes are in place to identify prisoners who have not attended a second stage screening to ensure that care provided is holistic and will identify any unmet health needs, in line with National Guideline (NG) 57.

- The Head of Healthcare should ensure that there are processes in place to enable timely receipt of hospital discharge letters, for timely planning of care at the prison.

- The Head of Healthcare should ensure that there are processes and training in place for all healthcare staff to complete risk assessments when clinically needed in order to allow ongoing monitoring and early intervention of care needs.

- The Head of Healthcare should ensure that there are processes and training in place for all healthcare staff to ensure that referrals to partner agencies are completed in a timely manner.

- The Head of Healthcare should ensure that the mental health team complete mental capacity assessments as part of the assessment process when needed.

- The Governor and Head of Healthcare should consider and facilitate the secure use of video conferencing to enable prisoners to be seen by external professionals when visiting the prison is restricted, to allow for timely medical and social care assessments.

The Investigation Process

7. NHS England commissioned an independent clinical reviewer to review Mr Kendall's clinical care at HMP Frankland.

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

9. The PPO family liaison officer wrote to Mr Kendall's next of kin, to explain the investigation and to ask whether he had any matters he wanted the investigation to consider. He had no questions but asked for a copy of our report.

10. Mr Kendall's family received a copy of the initial report. They did not make any comments.

11. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Previous deaths at HMP Frankland

12. Mr Kendall was the 11th prisoner to die at HMP Frankland since July 2018. Of the ten previous deaths, all were from natural causes. There are no similarities between our findings in the investigation into Mr Kendall's death and our investigation findings for the previous deaths.

Key Events

13. On 15 February 2008, Mr David Kendall was sentenced to an Indeterminate Sentence for Public Protection (ISPP) for sexual offences, with a minimum tariff of six years. He was sent to HMP Peterborough.

14. On 27 June 2012, Mr Kendall arrived at HMP Frankland on transfer from HMP Belmarsh. In November, Mr Kendall was diagnosed with ulcerative colitis (a long-term condition where the colon and rectum become inflamed), and in October 2016, he was diagnosed with high blood pressure.

2019

15. On 31 August 2019, a nurse saw Mr Kendall walking unsteadily and bumping into walls. She reviewed him and then spoke with an out of hours GP, who advised that Mr Kendall needed to go to hospital. Mr Kendall was taken to University Hospital of North Durham (UHND). Staff there diagnosed vitamin B deficiency and discharged Mr Kendall from hospital on 1 September. He was sent back to Frankland. Later that day, a nurse saw Mr Kendall and was concerned about his mobility and his slow speech. Mr Kendall said that his cognitive thinking had slowed up. She requested a GP appointment.

16. That afternoon, Mr Kendall saw a prison GP. The GP was unable to view the discharge letter, requested it and set a review on its arrival. On 5 September, Mr Kendall saw a prison GP. The GP was concerned that some abnormal blood test results had not been investigated by UHND and requested further blood tests.

17. On 13 September, Mr Kendall saw another prison GP. She noted that Mr Kendall had abdominal tenderness, weight loss and iron deficiency, as well as tremor in his hands. Mr Kendall was referred to the colorectal cancer pathway and to the neurology department at the hospital.

18. On 9 October, Mr Kendall had a chest x-ray. The results showed that he needed an urgent CT scan. On 24 October, Mr Kendall had the CT scan and was told it was likely he had lung cancer, but that further tests were needed.

19. On 15 October, Mr Kendall saw a neurologist for an MRI scan of his brain.

20. On 11 November, Mr Kendall had ultrasound to look into the lungs and a biopsy was taken. On 20 November, a prison GP was told that Mr Kendall had lung cancer. She told Mr Kendall of his diagnosis.

21. On 4 December, Mr Kendall saw a prison GP, who noted that Mr Kendall appeared vacant and was not completing his sentences. Through December both Mr Kendall and staff noted issues with his memory and signs of confusion. There was enough concern that a nurse referred him to the prison's mental health team. On 19 December, a prison GP requested a multi-disciplinary team (MDT) meeting to discuss Mr Kendall's condition.

22. By 24 December, healthcare staff and prison staff decided that for Mr Kendall's safety he should be moved to the prison's healthcare unit. On 27 December, healthcare staff and prison staff acknowledged that because of his memory loss and confusion a referral to adult social care was needed.

23. The MDT meeting was held on 30 December and it was concluded that Mr Kendall did have the mental capacity to make decisions about his care and treatment. It was agreed that he could return to A Wing with residential support assistant (RSA) care, staff supervision and daily nursing visits.

2020

24. Mr Kendall returned to A Wing on 7 January 2020. However, his mental capacity appeared to fluctuate. Some nursing staff assessed him as lacking capacity and an MRI scan did not go ahead because Mr Kendall could not give informed consent.

25. Mr Kendall's cognitive health continued to decline. Prison staff found him wandering the wing and getting into arguments. On 29 January, Mr Kendall had another MRI scan of his brain. Hospital staff were concerned that his cancer had spread to his brain. However, tests showed this was not the case and Mr Kendall began a course of radiotherapy treatment.

26. On 31 January, his dental appointment was stopped because he could not give informed consent. On 3 February, he was suspended from work in the sewing shop as he had hidden a needle on his person while leaving.

27. On 21 February, two nurses saw Mr Kendall. They raised safeguarding concerns and one nurse sent an urgent referral for an adult social care assessment.

28. By March, his cognitive health had declined further. Staff assessed it was no longer safe for Mr Kendall to remain on A Wing. On 11 March he was noted to be unable to communicate verbally. The same day, an initial palliative care MDT meeting for Mr Kendall was held. It was agreed that Mr Kendall did not have mental capacity to give informed consent. It was agreed that healthcare staff would contact Mr Kendall's adult social worker to arrange an advocate for Mr Kendall. On 12 March, Mr Kendall was moved to the prison's healthcare unit.

29. On 19 March, a palliative care consultant signed a Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) order on Mr Kendall's behalf because he was assessed as not to have capacity to give informed consent about his care and treatment.

30. On 3 April, a Best Interests meeting was held in the prison by the MDT. The MDT decided that given his terminal diagnosis and mental state that symptom relief for Mr Kendall would be the priority. They also decided that Mr Kendall could have a test for motor neurone disease (MND - a condition that affects the brain and nerves). The consultant had raised MND as a possible cause for Mr Kendall's mental state.

31. On 17 April, following a further CT scan, healthcare staff assessed that Mr Kendall's cancer had reduced in size following his radiotherapy treatment.

32. On 18 May, a nurse saw Mr Kendall at the request of his adult social worker. The meeting was to ask for Mr Kendall's consent for an advocate. However, he felt that Mr Kendall did not have the capacity to understand the information being shared with him. The next day, on 19 May, at the palliative care MDT meeting

for Mr Kendall, his adult social worker reported that she was completing a mental capacity assessment and would be referring him for an advocate.

33. Mr Kendall remained relatively stable and was able to care for himself. However, on the 19 June, Mr Kendall had started to have difficulty swallowing medication, had lost weight and was spending more time in bed. On 23 June, a Care Act advocate was appointed. She said that she had not been appointed as Mr Kendall's Independent Mental Capacity Advocate as a referral was needed from Mr Kendall's GP for her to be appointed.

34. Mr Kendall's health continued to deteriorate. On 15 July, a palliative care MDT meeting for Mr Kendall was held. It reported that Mr Kendall was struggling to eat, was getting weaker and was struggling with personal care. At this time neither the adult social worker nor the Care Act advocate had seen or met Mr Kendall.

35. On 22 July, Mr Kendall saw a Macmillan nurse. She reviewed his condition and opened an end of life care plan.

36. In the early hours of 24 July, Mr Kendall died in the palliative care suite in the healthcare centre at Frankland.

Post-mortem report

37. The Coroner accepted the cause of death provided by a prison doctor and no post-mortem examination was carried out. The doctor gave cause of death as metastatic squamous cell carcinoma of the lung (lung cancer).

Lisa Burrell
Prisons and Probation Assistant Ombudsman **March 2021**

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PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141