Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Patrick Kettle, a prisoner at HMP Stocken, on 6 October 2018

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 l 020 7633 4100

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

© Crown copyright, 2023

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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.

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.

Mr Patrick Kettle was found unresponsive in his cell at HMP Stocken on 6 October 2018, having died of the toxic effects of a synthetic cannabinoid. Mr Kettle was 39 years old. I offer my condolences to his family and friends.

Mr Kettle had a significant history of substance misuse and was a frequent user of illicit substances. Although he engaged with substance misuse services at Stocken and the prison took action to limit his access to illicit drugs, I am concerned that he was clearly able to obtain and use them without difficulty.

Mr Kettle was found dead at almost the same time as another prisoner at Stocken who lived on a different wing. Their deaths appear not to be connected but staff were stretched in responding to both emergencies.

I acknowledge their efforts to deal with two challenging situations simultaneously but I am very concerned that, as in previous investigations at Stocken, we found failings in the emergency response in both cases. These included staff acting without urgency, failures to identify clear signs that the prisoner's life was at risk, delays in entering the cell, inadequate use of the emergency code system and a considerable delay in paramedics accessing Mr Kettle's cell. These are all unacceptable.

I had already escalated my concerns to the Prison Group Director for the North Midlands in an earlier case and I am copying this case to him as well.

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

Sue McAlister CB
Prisons and Probation Ombudsman **March 2020**

Contents

Summary 1

The Investigation Process.....4

Background Information.....5

Key Events.....8

Findings 14

Summary

Events

1. On 28 July 2017, Mr Patrick Kettle was remanded to prison for possession of drugs and an offensive weapon in a public place. Two months later, he was sentenced to four years and six months imprisonment.

2. On 2 February 2018, Mr Kettle was transferred to HMP Stocken. At Stocken, staff found him under the influence of psychoactive substances (PS) on many occasions. Mr Kettle was found guilty of taking illicit drugs in five separate disciplinary hearings. He was punished with a number of further days added to his prison sentence and was made subject to closed visits. His privileges were also downgraded to basic level.

3. On 9 May, a substance misuse worker assessed Mr Kettle and added him to the team's case load. Mr Kettle subsequently had four sessions with his keyworker who offered him advice on substance misuse and created a substance misuse care-plan for him.

4. On 15 May, Mr Kettle was given an intelligence-led drug test and, two days later, a random drug test. Both tests showed positive for PS. Mr Kettle was not given any other drug tests while at Stocken.

5. On 1 and 2 October, two GPs reviewed Mr Kettle. They noted that Mr Kettle appeared to be well with no signs of withdrawal or intoxication. Healthcare staff regularly reviewed his health and medication and advised him on the risks of taking PS.

6. On 5 October, at around 5.00pm, an officer noted that Mr Kettle was possibly under the influence of drugs, and asked a nurse to check him. The nurse assessed Mr Kettle and concluded that he was fine and that he did not need to go to hospital. She did not ask staff to keep Mr Kettle under observation.

7. On 6 October, at around 5.30am, an operational support grade saw Mr Kettle unresponsive in his cell during a roll check. He left the cell to continue with other checks, returning to try to obtain a response from Mr Kettle on three occasions. At 6.00am, he called for assistance over the radio and at around 6.20am, officers entered Mr Kettle's cell. At 7.00am, paramedics arrived at Mr Kettle's cell and pronounced him dead at 7.03am. It appears that Mr Kettle had been dead for some time and showed clear signs of rigor mortis.

8. The post-mortem report gave synthetic cannabinoid (PS) toxicity as the most likely cause of Mr Kettle's death.

Findings

Clinical Care

9. The clinical reviewer found that the healthcare Mr Kettle received at Stocken was equivalent to that he would have received in the community. Healthcare staff thoroughly reviewed Mr Kettle and frequently advised him against using PS. Staff appropriately referred Mr Kettle to the substance misuse team which supported him well.

10. We consider, however, that the nurse who examined Mr Kettle on 5 October did not record that she had done so. As a result, night staff were not aware that Mr Kettle had appeared to be under the influence of drugs earlier that day. As Stocken does not have 24-hour healthcare, this would have been good practice and would have helped the officer on duty to judge Mr Kettle's presentation better.

11. The nurse did not immediately record her interaction with Mr Kettle in his medical records either. This was a significant oversight.

Drug Strategy

12. Mr Kettle was able to obtain and use PS at Stocken without difficulty. Although we recognise that staff took action in line with local policy to deal with Mr Kettle's PS use, these actions were evidently insufficient in the face of his determination to consume drugs.

Emergency Response

13. We are concerned that the member of staff who found Mr Kettle unresponsive on 6 October, did not act with any sense of urgency. Staff delayed entering Mr Kettle's cell, even when three officers were present, and no one called an emergency medical code.

14. There was a delay of about 25 minutes in paramedics reaching Mr Kettle's cell from the prison's gate. In all, paramedics did not reach Mr Kettle's cell until around an hour and 30 minutes after an OSG made his first observation. This is unacceptable, particularly at a prison without 24-hour healthcare.

15. These delays did not affect the outcome for Mr Kettle who appeared to have been dead for some time when he was found on 6 October. In other cases, however, delays in the emergency response could make the difference between life and death. We are concerned that this is now the fourth investigation since January 2017 where we have found significant deficiencies in the emergency response at Stocken.

Recommendations

- The Head of Healthcare should ensure that:
    - healthcare staff ensure that prison staff are made aware of recent reviews of patients suspected of having taken drugs; and
    - healthcare staff make accurate records in SystmOne of their interactions with patients as soon as they take place.

- The Governor should ensure that:
    - effective supply and demand reduction strategies are properly implemented to help reduce the availability and abuse of drugs, including PS;
    - staff are vigilant to signs of drug use and take appropriate action; and
    - frequent drug-testing of prisoners with relevant substance misuse intelligence is carried out.

- We made recommendations to improve the emergency response at Stocken following our investigation into another death which also occurred at Stocken on 6 October 2018. We have not, therefore, thought it necessary to repeat those recommendations in this case.

The Investigation Process

16. The investigator issued notices to staff and prisoners at HMP Stocken informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

17. The investigator visited Stocken on 18 October 2018 and obtained copies of relevant extracts from Mr Kettle's prison and medical records. He also interviewed a prisoner.

18. The investigation was suspended pending the results of the toxicology examination. The investigator interviewed six members of staff in June 2019.

19. NHS England commissioned an independent clinical reviewer to review Mr Kettle's clinical care at the prison. The clinical reviewer jointly conducted two interviews with the investigator.

20. We informed HM Coroner for Rutland and North Leicestershire area of the investigation. The coroner gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.

21. One of the Ombudsman's family liaison officers contacted Mr Kettle's family to explain the investigation and to ask whether they had any matters they wanted the investigation to consider. The family did not raise any concerns.

22. Mr Kettle's family received a copy of the initial report. They made comments which we addressed in separate correspondence.

23. The prison service also received a copy of the initial report. They did not make any accuracy comments. Their response to our recommendations and action plan is annexed to this report.

Background Information

HMP Stocken

24. HMP Stocken is a medium security prison in Rutland which holds up to 853 men. Care UK provides healthcare services. Mental health services are sub-contracted to Northamptonshire Foundation NHS Trust. Inclusion – managed by Midlands Partnership NHS Foundation Trust - provides substance misuse services. The healthcare service operates from Monday to Friday from 7.30am to 6.30pm and from 8.00am to 5.30pm at weekends. Two GPs provide 10 GP sessions per week.

HM Inspectorate of Prisons

25. The most recent inspection of HMP Stocken was carried out in February 2019. Inspectors noted that the use of illicit drugs, particularly PS, remained a serious problem. Although there was a good reactive approach to supply reduction, the strategy to provide a whole-prison approach to limiting illicit drugs was underdeveloped.

26. Inspectors found serious weaknesses in healthcare provision, with some poor practice evident in medicines management, stock control and unsafe storage. There was also a worrying lack of managerial and clinical supervision of primary care staff. Staff shortages, including vacant posts and sickness absence, had affected the delivery of mental health services. The waiting time for a routine assessment was too long but the team responded promptly to urgent referrals. There was an effective weekly team meeting and good interaction with prison staff.

Independent Monitoring Board

27. 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 April 2018, the IMB reported that the inadequacy of the mental health provision at Stocken remained a concern. The IMB reported that while the prison had been successful in reducing the level of violence and drug trading through searches and local intelligence-led initiatives, the level of drug and substance misuse remained high.

Previous deaths at HMP Stocken

28. Mr Kettle was the fifth prisoner to die at Stocken since October 2016. Three of the previous deaths were from natural causes and the cause of the other death has not been determined. In addition, another prisoner died at Stocken from natural causes on the same day as Mr Kettle's death. Mr Kettle was pronounced dead only two minutes before the other prisoner. In both investigations we found very significant delays in the emergency response, including unacceptable delays in the access of the ambulances to the prison.

29. In January 2019, another prisoner killed himself at Stocken. In that case too, the member of staff who found the prisoner unresponsive, did not act with any sense of urgency and did not call an emergency medical code. As a result, there was a

significant delay of about 15 minutes before the medical emergency code was called. There was also a delay of 12 minutes in paramedics reaching the prisoner's cell from the prison's gate. We recommended that the Governor of Stocken should improve the prison's response to medical emergencies, and that the Prison Group Director for the North Midlands should provide the Ombudsman with an account of the action he is taking to improve the response to medical emergencies at Stocken.

30. In August 2019, the prison responded to our recommendations. They said that all members of staff had been provided with pocket cards and speed training on emergency code responses. The prison committed to providing scenario-based training to operational support grade (OSG) staff to improve their confidence in entering a cell during night state. The prison published a notice to staff in June 2019 reminding them of the emergency code procedures. The prison also committed to ensuring prompt access for ambulance staff.

31. The Prison Group Director said in August 2019 that the Governor had provided assurance to him of actions taken to improve the response to medical emergencies at Stocken. Assurance discussions have been added to his monthly bi-laterals with the Governor, to the Quarterly Performance and Assurance Review meetings and through the online assurance framework (Insight). The Group Safety Team have also added medical response to their monthly assurance visits. Reports are produced at each visit and fed back directly to the Group Director.

Psychoactive Substances (PS)

32. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

33. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at the time NPS) and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

34. HM Prison and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements.

Incentives and Earned Privileges (IEP) Scheme

35. Each prison has an Incentives and Earned Privileges scheme which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme,

prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and to wear their own clothes. There are three levels, basic, standard and enhanced.

Key Events

36. On 28 July 2017, Mr Patrick Kettle was remanded to HMP Woodhill for possession of drugs and of an offensive weapon in public place. He had been in prison before. Two months later, he was given a sentence of four years and six months imprisonment. Mr Kettle had a history of opioid, crack cocaine, benzodiazepines and alcohol abuse in the community. While in custody, he took PS on regular basis and staff at Woodhill submitted at least ten intelligence reports related to Mr Kettle's substance misuse.

37. On 2 February 2018, Mr Kettle was transferred to HMP Stocken. At his initial health screening, the nurse noted that Mr Kettle was taking pregabalin for anxiety and mirtazapine, an antidepressant. A prison GP re-prescribed this medication the same day. Mr Kettle did not undertake any detoxification programme at Stocken but was referred to the substance misuse team for assessment. Mr Kettle was given a single cell in H wing where he lived for three months.

38. On 6 February, a member of staff from the substance misuse team arranged to assess Mr Kettle but Mr Kettle did not attend the appointment. He gave Mr Kettle another appointment in March but Mr Kettle failed to attend this too. Mr Kettle eventually engaged with the substance misuse team in May.

39. On 13 February, an officer noted during a search that a tablet of pregabalin fell from Mr Kettle's hand. The officer submitted an intelligence report. Pregabalin is often abused and traded in prison. As Mr Kettle was not allowed to keep his pregabalin prescription in his possession, he had to attend the wing's medicine hatch to receive the pills and to take them under the supervision of a nurse. Healthcare staff progressively stopped prescribing pregabalin to Mr Kettle as he continued trying to divert it elsewhere.

40. On 22 February, Mr Kettle said that he was going to kill himself. An officer placed him on ACCT monitoring. During ACCT reviews Mr Kettle told an officer that he could not go to L or M wing as he would "get stabbed up". Mr Kettle also said that he was in debt. Staff included an action in the ACCT caremap for Mr Kettle to be referred to the safer custody department to discuss his violence reduction issues.

41. On 27 February, an officer in the safer custody team spoke to Mr Kettle. Mr Kettle told him that he had issues with a Somalian gang involved in drug dealing. He gave the name of two prisoners (living on L and M wings) who he claimed would assault him if he was found in the hallways. The officer placed Mr Kettle on victim support procedures - in line with the prison's violence reduction strategy. This would allow Mr Kettle to go to work or attend other activities within the prison outside regular times.

42. On 7 March, a nurse assessed Mr Kettle's mental health. He noted that Mr Kettle had a history of heroin, cannabis, amphetamine, cocaine and alcohol misuse in the community. The nurse assessed that Mr Kettle presented with generalised anxiety and low mood. He provided him with self-help guides. He reviewed Mr Kettle again four weeks later and discharged him from the mental health team caseload as he assessed that Mr Kettle did not present with mental disorders. On 8 March, staff ended Mr Kettle's ACCT monitoring.

43. On 22 March, staff suspected that Mr Kettle had received PS in his mail and submitted a security intelligence report. Two weeks later, staff found two prisoners in Mr Kettle's cell under the influence of drugs. One was on the floor having a fit. Mr Kettle appeared to be unaffected but told staff that the other two prisoners had taken PS. Prison intelligence reports suggested Mr Kettle had provided PS to the prisoners.

44. On 23 April, staff searched Mr Kettle's cell but did not find any illicit substances. No further cell searches were carried out on Mr Kettle's cell at Stocken. The prison conducted a full search of his wing in August but nothing was found in relation to Mr Kettle.

45. On 26 April, staff moved Mr Kettle to K wing, where he remined until he died. Three days later, an officer recorded that Mr Kettle appeared to be under the influence of drugs and submitted a security intelligence report. Mr Kettle was placed on closed visits (where prisoners and their visitors are in two adjacent rooms, separated by a glass screen, to prevent the passing of drugs and other contraband).

46. On 9 May, Mr Kettle told a substance misuse worker that he had been the "recovery champion" at Woodhill although he had been using PS on a daily basis and continued to do so. Mr Kettle said that he started to use tablets when he was 11 and had used heroin daily from the ages of 18 to 34. He said that after being sent to prison, he started to take crack cocaine on daily basis, then PS. The substance misuse worker added Mr Kettle to the substance misuse team's caseload and planned further reviews.

47. On 15 May, an officer gave Mr Kettle an intelligence-led mandatory drugs test (MDT) and, two days later, an officer, gave Mr Kettle a random MDT. Mr Kettle did not have any more drug tests while at Stocken. Two weeks later, Mr Kettle's closed visits were extended for a further month as staff had found him under the influence of drugs.

48. On 31 May, an officer received the results of the MDTs which showed positive results for PS. The officer placed Mr Kettle on two separate disciplinary charges. A month later, Mr Kettle was found guilty and punished with a further day added to his prison sentence.

49. On 11 June, Mr Kettle spoke to his substance misuse keyworker. Mr Kettle told him that he had been taking PS at Stocken. The substance misuse keyworker spoke to him about harm reduction techniques and PS awareness. He created a substance misuse care plan for Mr Kettle including further work on his PS addiction. Mr Kettle told him that he was eager to stop taking PS and he referred him to relapse prevention group sessions.

50. On 12 June, an officer saw Mr Kettle "clearly" under the influence of drugs. He recorded that Mr Kettle was a quiet individual who did not associate with others and spent a lot of time in his cell on his own. The officer submitted an intelligence report and placed Mr Kettle on a disciplinary charge. The next day, staff downgraded Mr Kettle's IEP level to basic. Mr Kettle was found guilty of taking drugs and was punished with 12 additional days on his prison sentence.

51. On 18 June, an officer noted that Mr Kettle was under the influence of drugs in the workshop. The officer submitted an intelligence report and placed Mr Kettle on a

disciplinary charge. Mr Kettle admitted he had taken PS and was found guilty at a disciplinary hearing. He was punished with five days cellular confinement and 28 days forfeiture of privileges.

52. On 27 June, Mr Kettle's closed visit restriction was continued given his recent substance misuse and positive MDTs.

53. On 2 July, an officer upgraded Mr Kettle's IEP level to standard, but the next day another officer saw Mr Kettle under the influence of drugs. Healthcare staff confirmed that he may have taken an illicit substance. Mr Kettle's IEP level was downgraded back to basic. The officer placed Mr Kettle on a disciplinary charge but these charges were dismissed when they could not be proved beyond doubt.

54. On 4 July, Mr Kettle told his substance misuse keyworker, during a substance misuse session, that he had been taking PS. He said that he needed counselling to address past issues which he thought could have influenced his decision to take drugs. His substance misuse keyworker referred Mr Kettle to counselling services and the mental health team. He planned to meet him again a week later, but Mr Kettle did not attend the appointment.

55. On 8 July, an officer found Mr Kettle under the influence of drugs. He submitted a security intelligence report and placed Mr Kettle on a disciplinary charge. Mr Kettle admitted having taken drugs and was punished with seven days forfeiture of canteen (purchases from the prison shop) and association.

56. On 9 July, a nurse recorded that Mr Kettle went to the healthcare department and said that he was very distressed and wanted to see a mental health nurse. The nurse referred him for a mental health review.

57. On 11 July, Mr Kettle joined the English and maths classes. Seven days later, a tutor recorded that Mr Kettle attended class looking pale and grey. She said that Mr Kettle was "slurring his words" and was not very responsive to questions. She recorded that Mr Kettle admitted that "last night I was stoned". She made a note in Mr Kettle's NOMIS records and submitted an intelligence report.

58. On 20 July, a mental health nurse reviewed Mr Kettle. He told her that he was "in crisis" and was hearing voices and feeling paranoid. He also told her that he had been taking 'spice' (a form of PS). She recorded that Mr Kettle was able to hold a conversation, however, and did not present obvious signs of experiencing auditory hallucinations or distress. She planned to discuss his case with the mental health team although there is no record that this took place.

59. On 24 July, Mr Kettle's closed visits restriction was reviewed and kept in place as he had been found under the influence of drugs in July.

60. On 2 August, staff submitted an intelligence report about Mr Kettle which linked him with a gang outside the prison. Intelligence suggested that Mr Kettle was threatening another prisoner at Stocken who was in debt to the gang. Eight days later, a chaplain noted that Mr Kettle appeared to be under the influence of drugs and submitted an intelligence report.

61. On 23 August 2018, Mr Kettle was removed from closed visits, following a review. Mr Kettle had an improved period where he excelled at his classes. He was nominated as 'learner of the month' and his IEP level was upgraded to standard.

62. On 2 September, Mr Kettle told staff that a prisoner was being given drugs free by a dealer who “wanted to have a laugh when he smoked it”. Mr Kettle admitted that he would also take the drugs if they were given to him for free. Staff submitted an intelligence report and investigated the prisoners involved.

63. A prisoner told the police that Mr Kettle had a large debt at Stocken for PS which he had helped him to pay in full. He also said Mr Kettle often took part in “mamba challenges”. These involved somebody giving him a large quantity of PS for free, for the amusement of seeing its effects on him.

64. On 25 September, a nurse reviewed Mr Kettle who complained of an irregular heartbeat. Mr Kettle said that he had smoked PS the day before. The nurse advised Mr Kettle to stop taking PS and asked him to inform healthcare staff if he had further chest pains. A prison GP later carried out an ECG on Mr Kettle but this found no abnormality.

65. On 1 October, a prison GP reviewed Mr Kettle. Mr Kettle told her that he used PS “now and then”. She assessed that Mr Kettle was fit and well but advised him to stop taking PS. The same day, his substance misuse keyworker spoke to Mr Kettle. Mr Kettle told him that “he had regained control over his substance misuse” but had the “odd smoke”. His substance misuse keyworker recorded that Mr Kettle looked well and spoke to him about harm prevention and PS awareness. He referred Mr Kettle to further substance misuse interventions and group sessions.

66. On 2 October, a prison GP reviewed Mr Kettle. The prison GP noted that Mr Kettle appeared to be well with no signs of withdrawal or intoxication. She explained to Mr Kettle the risk to his health in taking PS. She examined Mr Kettle and concluded that his heart and lungs were healthy.

67. On 5 October, at around 5.00pm, an officer started to lock prisoners on K wing into their cells. When she arrived at Mr Kettle’s cell, she saw Mr Kettle behaving oddly and became worried about his welfare. She asked Nurse A, who was also on the wing at the time, to check on Mr Kettle. The officer told the police that she did not see any drug paraphernalia in Mr Kettle’s cell. Nevertheless, she suspected Mr Kettle may have taken drugs.

68. At around 5.30pm, Nurse A reviewed Mr Kettle. She told the police that Mr Kettle was on his bed and was slurring his speech but was able to speak to her. She said that she did not notice any smell of drugs or see drug paraphernalia in his cell. She said that Mr Kettle’s heart rate was “a little high” initially, but it fell shortly afterwards. She said that Mr Kettle’s blood pressure was slightly high for his age but that it was not concerning.

69. Nurse A told the police that when she left the cell, around ten minutes later, Mr Kettle’s condition had improved. She said that Mr Kettle was not slurring his words as much and his pupils were reacting to the light of her torch. She assessed that Mr Kettle did not need to go to hospital. She did not ask the officer or any other officer to keep Mr Kettle under observation. Nurse A and the officer, who left the cell together, were the last members of staff to speak to Mr Kettle.

70. At 8.30pm, an Operational Support Grade (OSG), started to carry out the night roll check. He told the investigator that he had not been made aware that Mr Kettle might have taken drugs earlier. When he arrived at Mr Kettle’s cell, he saw him

sitting on the side of the bed with his hands behind his head. The OSG said that he was not concerned about Mr Kettle's position as he thought he was sleeping. He told the investigator that the light in Mr Kettle's cell was on, which he did not find concerning either "as many prisoners' sleep with the light on". Mr Kettle was not checked again overnight.

Events of 6 October

71. The investigator reviewed CCTV footage, relevant staff statements, the communication room log and the ambulance service logs for 6 October. The CCTV footage did not have a time-stamp.

72. At around 5.30am, the OSG started to do the morning roll check. When he arrived at Mr Kettle's cell, he looked through the observation panel. He told the investigator that Mr Kettle was in the same position as he had been at 8.30pm the evening before. The OSG subsequently wrote in a statement he provided to the Governor that Mr Kettle had a "strange way of sleeping". The light in Mr Kettle's cell was still on.

73. The OSG remained outside the cell trying to obtain a response from Mr Kettle for around one minute and forty seconds. He told the investigator that he thought that "something was not right" but was not overly concerned as "some people may take a lot to wake up". He left and continued checking other prisoners.

74. About two minutes later, the OSG returned to Mr Kettle's cell and watched him for another 30 seconds through the observation panel. He then left and continued with the roll check. About 18 minutes later, he returned to Mr Kettle's cell. He remained in front of the cell door for about three minutes, looking through the observation panel. He knocked at Mr Kettle's door then left again. Four minutes and 30 seconds later, he returned to Mr Kettle's cell and looked through the observation panel for another minute and 20 seconds.

75. At around 6.00am, the OSG radioed the night orderly officer, a custodial manager (CM), for assistance. The CM told the police that the OSG said over the radio that "a prisoner was lying in a strange position and was not responding". The CM asked two officers to go to K wing. Around six minutes later, the officers arrived outside Mr Kettle's cell but did not enter. An officer saw that Mr Kettle's chest was not moving and thought it was possible he was not breathing.

76. At around 6.20am, an officer radioed that Mr Kettle was not breathing and requested an ambulance. A minute later, the ambulance service received the request from the prison. It appears that no-one called an emergency medical code at any point.

77. An officer asked the CM for permission to enter the cell, and this was granted. An officer said that when they entered the cell, she noted that Mr Kettle's body was cold and rigid, showing clear signs of rigor mortis, indicating he had been dead some time. An officer said that Mr Kettle was lying face down, on his pillow, in his own vomit. They decided not to start CPR. The clinical reviewer confirmed that this was the correct decision.

78. At around 6.36am, paramedics arrived at the prison's gate. A paramedic told the police that there was a delay in reaching Mr Kettle's cell from the entrance as they

had to “drive around the outside with a prison guard escorting us at walking pace”. At 7.00am, paramedics arrived at Mr Kettle’s cell. At 7.03am, they pronounced Mr Kettle dead.

Investigations after Mr Kettle’s death

79. After Mr Kettle’s death, the police found parts of a vape pen, a number of pieces of white paper and some leafy vegetable matter. The forensic analysis of these items showed the presence of PS.

80. The Head of Safer Custody and Head of Security told the investigator that following the death of Mr Kettle, the security team and the police identified five prisoners who were heavily involved in the supply of illicit drugs at Stocken. Staff located the prisoners in the segregation unit to disrupt the supply channels. The police also supported Stocken by conducting a search of cells, where they retrieved drugs.

Contact with Mr Kettle’s family

81. On 6 October at 2.15pm, an officer and prison chaplain went to the address they had on record for Mr Kettle’s mother to break the news of her son’s death. When they arrived, nobody responded. They later found that Mr Kettle’s mother no longer lived there.

82. At 4.15pm, the chaplain telephoned Mr Kettle’s next of kin and broke the news of Mr Kettle’s death to her. She agreed to pass the message on to her mother. Another next of kin later took over as Mr Kettle’s official next of kin. The prison continued offering her support.

83. Mr Kettle’s funeral took place on 31 October 2018. The prison contributed to the funeral costs in line with national policy.

Support for prisoners and staff

84. In line with PSI 02/2018, Post-incident care, the Head of Safer Custody spoke individually to all staff involved in the emergency response and offered them support. The staff care team also offered support to staff. No hot debrief was carried out, which would have been good practice.

85. The prison posted notices informing other prisoners of Mr Kettle’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 Kettle’s death.

Post-mortem report

86. The post-mortem examination found that the most likely cause of Mr Kettle’s death was the toxic effects of synthetic cannabinoid (PS) exposure.

Findings

Clinical Care

Healthcare and substance misuse services

87. The clinical reviewer found that the care Mr Kettle received at Stocken was equivalent to that he would have received in the community.

88. Healthcare staff regularly reviewed Mr Kettle and monitored his medication. Nurses and GPs advised Mr Kettle on many occasions about the dangers to his health of taking PS. A prison GP thoroughly examined Mr Kettle and advised him against using PS, including two days before he died. Staff also appropriately referred Mr Kettle to the substance misuse team.

89. Although Mr Kettle missed many appointments, he did engage with the service from May 2018. His substance misuse keyworker, held four sessions with Mr Kettle where he discussed harm reduction techniques, referred him to group therapies and counselling, and spoke about the dangers of taking PS. He told the investigator that Mr Kettle genuinely wanted to give up PS but struggled to do so. He thought Mr Kettle was making progress and was less dependent on PS during the months leading up to his death. We consider that his interactions with Mr Kettle were thorough and appropriate.

Nurse A's review on 5 October

90. Nurse A was the last person to examine Mr Kettle before he died. The clinical reviewer said that Nurse A carried out a thorough physical examination of Mr Kettle. The clinical reviewer also said that the blood pressure, breathing and oxygen levels taken before the nurse left the cell were normal. Nurse A was satisfied that Mr Kettle did not need any further investigation and treatment in hospital and did not ask staff to check Mr Kettle again.

91. Although the clinical reviewer raised no concerns about Nurse A's actions, we consider that she missed an opportunity to ensure that prison staff were aware that Mr Kettle had been under the influence of PS that evening. If the OSG had known this, he may have taken a different view of Mr Kettle's presentation. We consider that as 24-hour healthcare at Stocken is not available, this would have been good practice.

92. We also note that Nurse A did not record her interaction with Mr Kettle in his medical records until three days later (on 8 October), by which time she knew he was dead. We consider that this was a significant oversight. We make the following recommendation:

The Head of Healthcare should ensure that:

- **healthcare staff ensure that prison staff are made aware of recent reviews of patients suspected of having taken drugs; and**
- **healthcare staff make accurate records in SystmOne of their interactions with patients as soon as they take place.**

Drug Strategy

93. Stocken operates a 'zero-tolerance policy' on PS and had a PS strategy in place at the time of Mr Kettle's death. The strategy sets out measures to target PS trafficking, including advice to staff when they suspect a prisoner is under the influence of PS, and use of the IEP scheme, the adjudication process and closed visit sanctions.

94. One of the key objectives of the strategy is to reduce the availability of PS in the establishment. The strategy outlines the use of drug-testing and intelligence to identify prisoners taking and dealing PS. It acknowledges ongoing concerns about the consequences of PS in prison, including, debt, violence, mental health issues and self-harm.

95. Mr Kettle was a prolific user of PS during his time at Stocken. He also tried to divert prescribed medication during his first months at the prison. (Healthcare staff correctly stopped prescribing him this medication as a consequence.) Staff frequently punished Mr Kettle's behaviour but also offered him good substance misuse support and advice.

96. The prison had a range of intelligence to assist staff in understanding the nature of Mr Kettle's drug issues. Mr Kettle frequently presented under the influence of PS and was open with staff about his consumption. He often told adjudicators, healthcare staff and officers that he had taken PS. Staff responded by placing Mr Kettle on the basic IEP regime, sharing intelligence reports, introducing closed visits and bringing disciplinary charges. He was punished by adding days to his prison sentence, restricting his privileges and giving him cellular confinements. However, this did not deter Mr Kettle, who took PS regularly at Stocken until it killed him.

97. Mr Kettle was apparently able to obtain and use PS at Stocken without difficulty. Although we recognise that staff had taken actions in line with local policy to deal with Mr Kettle's PS use, these actions were evidently insufficient in the face of his determination. In the light of Mr Kettle's death, we are concerned about the apparent ease with which prisoners are able to obtain and use PS at Stocken.

Mandatory Drug Tests

98. We found that, despite the extensive intelligence available describing Mr Kettle's PS use, staff only carried out one intelligence-led MDT (in May 2018). The Head of Security told the investigator that MDTs are crucial in assisting the ongoing monitoring of drug dealing. They are important, not only to identify consumers of illicit drugs, but also to deter them. We consider that Mr Kettle should have been given more MDTs at Stocken. The absence of drug testing gave him further opportunity and encouragement to continue taking PS.

99. We make the following recommendation:

The Governor should ensure that:

- **effective supply and demand reduction strategies are properly implemented to help reduce the availability and abuse of drugs, including PS;**

- **staff are vigilant to signs of drug use and take appropriate action; and**
- **frequent drug-testing of prisoners with relevant substance misuse intelligence is carried out.**

Safer Custody Issues

100. In February 2018, Mr Kettle disclosed to officers that he was under threat from prisoners belonging to a gang involved in drug dealing. He provided the name and location of the prisoners. Officers rightly placed Mr Kettle in victim support protection, in line with the prison's violence reduction policy. They ensured that Mr Kettle was not inadvertently moved to a wing where he might be placed in danger. Staff from the safer custody team managed Mr Kettle's concerns appropriately.

Emergency Response

Entering the cell

101. PSI 24/2011 on management and security at nights requires that all prisoners are locked in their cells while the prison is in night state. Under normal circumstances, the night orderly officer must give authority to unlock a cell during night state and no cell should be opened unless at least two or three members of staff are present. One of these should be the night orderly officer. However, the PSI states that the preservation of life must take precedence. It says that where there is, or appears to be, immediate danger to life, cells may be unlocked without the authority of the night orderly officer and an individual member of staff may go into the cell on their own, following an on-the-spot risk assessment. Night staff should not take action which they feel would place themselves or others in unnecessary danger.

102. The PSI also says that before going into a cell, staff should make every effort to gain a verbal response from the prisoner. This, together with what the member of staff observes through the observation panel and any knowledge of the prisoner, should inform a dynamic risk assessment of the situation and inform any decision as to whether to enter immediately or wait for assistance.

103. In line with the PSI, Stocken's own security strategy states that the preservation of life overrides security concerns in the case of a life-threatening emergency. It says that a member of staff may enter a cell with caution, ensuring his or her own safety, in these circumstances.

104. We are very concerned that the OSG did not act with sufficient urgency and ignored indications that Mr Kettle's welfare could have been at risk on 6 October. These indications included:

- finding Mr Kettle in a "strange" position at 5.35am;
- the fact that Mr Kettle had been in the same position since 8.30pm the evening before;
- the light in Mr Kettle's cell being on all night; and
- the fact that the OSG could not obtain any response from Mr Kettle despite many attempts.

105. While we do not say that the OSG should necessarily have entered the cell alone when he could not get a response from Mr Kettle, we are concerned that he thought that he was “not allowed” to enter any cell on his own at all. In all, 30 minutes passed between the OSG suspecting something was wrong with Mr Kettle and calling the night orderly officer for assistance. This was not acceptable.

106. We are also very concerned that it took a further 20 minutes before a member of staff entered Mr Kettle’s cell. When two officers arrived at about 6.06am, they quickly realised that Mr Kettle’s life was in danger. There were now three officers present and they still did not enter the cell until they had asked the orderly officer’s permission at about 6.20am. We consider this was unacceptable. An officer told the investigator that he would only enter a cell if he had “good knowledge of the prisoner” but did not mention doing so in life-threatening situations.

107. We are concerned that staff at Stocken do not understand the national and local policy on entering cells or the need to act with urgency.

Calling a medical emergency code

108. We are also very concerned that at no point did any member of staff, including the CM, call a code blue emergency to communicate the emergency to the control room. The code system is designed to make communication more effective and efficient in an emergency but was not used adequately at Stocken.

Getting paramedics to the scene

109. There was also an unacceptable delay of about 25 minutes in paramedics reaching Mr Kettle’s cell from the prison gate. An officer said this distance should take between five and ten minutes walking.

110. We note that paramedics did not reach Mr Kettle’s cell until around an hour and 30 minutes after the OSG made his first observation. For a prison without 24-hour healthcare provision, this is simply unacceptable.

111. We recognise that on 6 October, staff had to respond to two major incidents simultaneously occurring on two different wings. This clearly placed a considerable burden on staff. However, we are very concerned that this is the fourth investigation since January 2017 in which we have found significant delays during the emergency response. We consider that there is a systemic failure in this regard at Stocken.

112. Although the delays in this case did not affect the outcome for Mr Kettle (as he appears to have been dead for some time when he was found), they could be crucial in other cases.

113. Our investigation into the death of another prisoner at Stocken in January 20189, identified the same failings in the emergency response. As a result, we escalated our concerns to the Prison Group Director (PGD) for the North Midlands and asked him to act to improve the prison’s response to medical emergencies. The prison and the PGD accepted our recommendations and responded with an action plan in August 2019.

114. We subsequently reported on our investigation into the other death that occurred on 6 October 2018, and made further recommendations about improving the response to medical emergencies and ensuring easy access for ambulances. The prison told us in November 2019 that it was taking the following actions in response:

- A scoping exercise will be delivered in partnership with East Midlands Ambulance Service to time the most efficient route to each location in the prison with emergency response vehicles (by February 2020).

- Staff consultation groups would take place in November and December 2019 to re-iterate the importance of effective medical emergency response and the precedence of preservation of life. This consultation would include all operational staff including Night OSGs.

- A Governor's Order will be published every four months to remind staff of the emergency codes protocol.

- Speed training that has previously been delivered around emergency response codes will now be delivered every four months to all grades including Night OSGs, with the first event in November 2019. A training record of these sessions will be kept by the Safer Custody Team.

- A dedicated Safer Custody training day is scheduled for January 2020. This will include a session around responding efficiently to emergencies.

115. In the light of that response we have not thought it necessary to make further recommendations.

Inquest conclusion

116. The inquest, which was heard from 22 to 25 May 2023, found that Mr Kettle voluntarily took synthetic cannabinoids with no clear intent to kill or harm himself and concluded that he died by misadventure.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

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

T l 020 7633 4100