

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

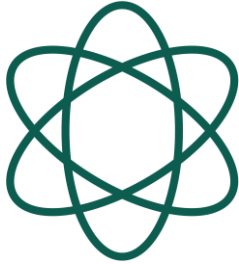
# **Independent investigation into the death of Mr Phillip Kelly, a prisoner at HMP Garth, on 17 September 2021**

**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

**OGI**

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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.

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 Phillip Kelly died on 17 September 2021, having been found hanged in his cell at HMP Garth. Mr Kelly was 41 years old. I offer my condolences to Mr Kelly's family and friends.

Mr Kelly had been in prison since 2016 and had been subject to Prison Service suicide and self-harm support measures several times. I am concerned that opportunities to support Mr Kelly at HMP Frankland two months before he died were missed. However, I am satisfied that it was reasonable that staff at HMP Garth did not assess him as a risk to himself while he was there.

Mr Kelly's post-mortem found that there were anti-depressants that he had not been prescribed in his system, as well as amphetamines. He had also admitted to taking PS in the week before his death. I am concerned that he was able to access these drugs in Garth. However, I am satisfied that the prison is taking all appropriate steps to try to reduce the supply of and demand for drugs.

I am also concerned that, having found Mr Kelly hanging, there was around a minute's delay before staff entered the cell. This delay did not make a difference for Mr Kelly but may do in other situations.

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 McAllister, CB**  
**Prisons and Probation Ombudsman**

**May 2022**

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# Summary

## Events

1. In December 2016, Mr Phillip Kelly was recalled to prison, having committed an offence of wounding with intent. In December 2017, he was sentenced to twelve years imprisonment. In 2018, he was diagnosed with hyperthyroidism and prescribed medication. He was also prescribed medication for back pain and depression. There was intelligence that he took psychoactive substances (PS) in prison.
2. Mr Kelly was subject to Prison Service suicide and self-harm support measures, known as ACCT, on several occasions. In 2018, he cut his wrists three times in response to bereavements and wanting to die. In 2019 and 2020, he was subject to ACCTs due to feelings of low mood, wanting to die and medication issues. In April 2021, Mr Kelly refused his food over medication issues. Again, staff opened an ACCT.
3. In July, Mr Kelly's suspected PS use increased. He also refused to eat or take medication for several days and was taken to hospital as a result. After returning to the prison, he told staff that he was in substantial debt and had suicidal thoughts. He refused to be located on a standard wing and transferred to HMP Garth on 3 August.
4. Initially, Mr Kelly said that he was abstaining from drug misuse but, on 13 September, said that he had been using PS. Holes were found in his window which were suspected to have been made to receive illicit items, including drugs, from drones.
5. On 17 September, Mr Kelly refused his medication and lunch. He did not come out of his cell. At 2.09pm, an officer discovered Mr Kelly hanged in his cell. She shut the door, radioed an emergency code and shouted to staff. They went into Mr Kelly's cell a minute later, cut him down and began chest compressions. Healthcare staff attended, assessed Mr Kelly and instructed that the compressions should stop since CPR was futile. Paramedics attended and a prison GP pronounced Mr Kelly had died at 2.29pm.

## Findings

6. We are concerned that an ACCT was not opened at Frankland when Mr Kelly refused all food and medication and when he said he had thoughts of suicide. However, after he arrived at Garth, we are satisfied that it was appropriate that Mr Kelly was not subject to an ACCT.
7. We are concerned that Mr Kelly could obtain amphetamines, illicit venlafaxine and PS at Garth. However, the prison is taking proactive steps to reduce the supply of and demand for illicit drugs and we therefore make no recommendation in this regard.
8. The clinical reviewer concluded that the healthcare Mr Kelly received was reasonable and, in the main, equivalent to that which he could have received in the

community. She has highlighted some omissions in Mr Kelly's physical care which we draw the Head of Healthcare's attention to.

9. When an officer found Mr Kelly hanged, they shut the door briefly before going in with other staff around a minute later. Although this did not make a difference for Mr Kelly it may do in other situations.

## **Recommendations**

- The Governor and Head of Healthcare at Frankland should ensure that staff:
  - open an ACCT if a prisoner expresses suicidal thoughts;
  - start ACCT monitoring procedures when a prisoner has significant risk factors, or record their reasons for not doing so; and
  - consider opening a CSIP when prisoners disclose that they are in debt or appear fearful of other prisoners.
- The Governor of Garth should remind staff that, subject to a risk assessment, staff enter cells as quickly as possible if there is reason to consider that a prisoner may be at risk.

## The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Garth informing them of the investigation and asking anyone with relevant information to contact her. One prisoner contacted the investigator, and they were subsequently interviewed.
11. Due to the COVID-19 pandemic, the investigator was unable to visit the prison. She obtained copies of relevant extracts from Mr Kelly's prison and medical records via post and email.
12. The investigator interviewed 13 members of staff and one prisoner. NHS England commissioned a clinical reviewer to review Mr Kelly's clinical care at the prison. The clinical reviewer and investigator jointly interviewed healthcare staff. The interviews were conducted by video-link and telephone because of the COVID-19 restrictions in place.
13. We informed HM Coroner for Lancashire and Blackburn of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
14. One of the Ombudsman's family liaison officers contacted Mr Kelly's brother to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He had no questions but wanted a copy of this report.
15. Mr Kelly's brother received a copy of the draft report. He did not make any comments.
16. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

## Background Information

### HMP Garth

17. HMP Garth holds up to 846 prisoners serving sentences of four years or longer or indeterminate sentences. Primary care services are provided by Bridgewater NHS Foundation Trust, mental health and clinical substance misuse services by Greater Manchester Mental Health NHS Foundation Trust and psychosocial substance misuse services are provided by Delphi Drug and Alcohol Recovery Service (DARS).

### HM Inspectorate of Prisons

18. The most recent inspection of HMP Garth was in December 2018 and January 2019. Inspectors reported that levels of self-harm were significantly higher than at the last inspection and compared with other Category B training prisons. However, the standard of ACCT suicide and self-harm prevention measures was reasonably good.
19. Inspectors found that interactions between prisoners and staff were respectful and courteous overall. However, they noted that some staff did not consistently enforce basic rules in residential units.
20. Inspectors found that there was still a significant issue with the availability of illicit drugs, particularly PS, at Garth. 60% of prisoners said it was easy to obtain drugs, 30% tested positive and around a quarter had developed a drug habit since arriving at Garth. They noted that drug use and associated debt were contributing to much of the violence and victimisation at the prison. Inspectors found that a wide-ranging supply reduction action plan was reviewed at drug strategy meetings but many initiatives to reduce illicit drug use had not been fully embedded. They also noted that the lack of security netting over exercise yards was a significant problem which enabled drugs to directly enter the prison.

### Independent Monitoring Board

21. 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 November 2020, the IMB reported that prisoners were treated with respect and that the disruption caused by the COVID-19 pandemic had been made bearable with the adjustments the Governor had introduced, such as the provision of in-cell telephones.
22. The IMB reported that during December 2019 to February 2020, the keyworker scheme operated as normal. However, due to staff shortages, it was effectively put on hold during the COVID-19 pandemic.

### Previous deaths at HMP Garth

23. Mr Kelly was the eighth prisoner to die at Garth since September 2019. Four of these previous deaths were due to natural causes, two were due to drugs and one

was self-inflicted. In a previous investigation into a death due to PS use, we recommended that the prison identified the key weaknesses in reducing the supply of drugs at Garth and revised their drug strategy. Four prisoners have died at Garth since Mr Kelly, all due to natural causes.

## **Assessment, Care in Custody and Teamwork**

24. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be made at irregular intervals to prevent the prisoner anticipating when they will occur.
25. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*.

## **Psychoactive Substances (PS)**

26. Psychoactive substances (PS), previously known as 'legal highs', are an increasing 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.
27. In July 2015, we published a Learning Lessons Bulletin about the use of PS 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.

## Key Events

28. On 3 December 2016, Mr Phillip Kelly committed an offence of wounding with intent. He had been on licence, having been released from prison in February and was recalled to custody. On 8 December, Mr Kelly was taken to HMP Nottingham. Mr Kelly told a nurse that he suffered from depression. He said he had been prescribed methadone (an opiate substitute) in the community but had also been misusing heroin and crack cocaine. He also suffered from back pain. The prison continued his prescription of gabapentin (for back pain), mirtazapine (for depression and anxiety), omeprazole (to prevent gastric reflux) and methadone. He engaged with the substance misuse team and mental health team. Mr Kelly subsequently spent time in several prisons including HMP Lindholme, HMP Nottingham, HMP Dovegate and HMP Lowdham Grange.
29. On 13 December 2017, Mr Kelly was sentenced to twelve years imprisonment. In 2018, Mr Kelly was diagnosed with hyperthyroidism (an overactive thyroid gland). He was prescribed propranolol and carbimazole. In April and August, Mr Kelly cut his wrists in response to bereavements and was subject to Prison Service suicide and self-harm support measures, known as ACCT. Mr Kelly also intermittently used PS.
30. In September, the Parole Board decided that Mr Kelly would stay in custody until his conditional release date in 2029. Mr Kelly was informed of this and said he was okay. Mr Kelly later cut his wrists and said he did not want to live anymore. His wounds were treated in hospital and he was subject to ACCT support.

### 7 November 2018 - 3 August 2021, HMP Frankland

31. On 7 November, Mr Kelly transferred to Frankland. He was assessed by the mental health team and told them he had no thoughts of suicide or self-harm. He said he felt low and engaged with a psychological wellbeing practitioner until March 2019.
32. In 2019, Mr Kelly had his thyroid removed and was prescribed levothyroxine. He was subject to an ACCT for a month due to his low mood. Mr Kelly's mirtazapine was gradually reduced and stopped in September.
33. In February 2020, Mr Kelly made deep cuts to both his wrists over medication issues and said he would end his life as soon as he could. He was subject to ACCT support until the following month. In September, Mr Kelly was subject to an ACCT for four days when he refused to engage with healthcare staff and stopped eating.
34. In April 2021, Mr Kelly began refusing food due to the GP reducing his prescription of gabapentin. After 72 hours of food refusal, staff opened an ACCT. He declined mental health support. Staff closed the ACCT on 17 May once the medication issues had been resolved.
35. In July, Mr Kelly's suspected use of PS increased. On 5 July, Mr Kelly denied substance misuse and said he would now refuse all his food and medication in protest at the accusation. On 8 July, Mr Kelly said he had chest pain and had stopped taking his thyroid medication. He moved to healthcare and was taken to hospital by ambulance for assessment the next day. He returned to the prison the same day and was located in healthcare. On 10 July, Mr Kelly began eating again.

36. On 11 July, staff submitted an intelligence report that Mr Kelly was potentially in debt to two other prisoners on J wing. On 12 July, Mr Kelly refused to relocate to a standard wing from healthcare. He admitted that he was using PS. He said that he hoped to transfer to Garth in early August for a fresh start.
37. On 13 July, staff submitted an intelligence report that Mr Kelly was in £600 of debt and had suicidal thoughts. Mr Kelly said that he would not move back to the standard wing from healthcare. The report noted that there had been a large amount of drugs on the wing where Mr Kelly had been located and prisoners had encouraged him to take it.
38. On 15 July, Mr Kelly moved to the segregation unit as he still refused to go to a standard wing. No issues were raised after he moved there. On 29 July, Mr Kelly moved to healthcare to make more room in the segregation unit. During an adjudication hearing, Mr Kelly said that he did not want to go to a standard wing as he had got himself into a lot of debt.
39. On 30 July, a nurse from the mental health team tried to assess Mr Kelly. Mr Kelly said he did not want to be assessed and his mental health issues were related to his use of PS, refusal of his medication and family bereavements. He said he was transferring to HMP Garth soon and would try not to use drugs. On 3 August, Mr Kelly told a nurse that he was happy but anxious about transferring to Garth that day. He said he had no thoughts of suicide or self-harm.

### **3 August onwards, HMP Garth**

40. On 3 August, Mr Kelly transferred to HMP Garth. His Person Escort Record (PER) noted that he had cut himself while being in prison. It also noted that, "*They have said they will self-harm or commit suicide - he is heavily in debt*". It also noted that Mr Kelly was involved in the "*drug culture*".
41. Mr Kelly told a nurse that he had tried to take his own life six weeks ago by not eating and using PS. The nurse noted that Mr Kelly now appeared stable. He said he had last used PS six weeks ago. They referred Mr Kelly to substance misuse services. They noted he had hyperthyroidism and booked him for a long-term condition review on 9 August. The nurse also sent a task to the mental health team asking them to review him. Staff assessed that Mr Kelly should not be in possession of his medication but should collect it daily.
42. Mr Kelly told an officer that he had no previous or current thoughts of self-harm but had previously been on an ACCT. He said he had no immediate concerns about being located at Garth. On 8 August, healthcare staff noted that Mr Kelly had not taken his medication for several days since staff had not escorted him to collect it as required.
43. On 9 August, a nurse from the mental health team assessed Mr Kelly. Since Mr Kelly was still isolating due to being a new arrival at Garth, the nurse spoke to him at his cell door. Mr Kelly said he had no thoughts of suicide or self-harm. Mr Kelly said that he had not received omeprazole since arriving at Garth and would refuse all his medication if he did not receive it that day. The nurse explained that the situation would hopefully be resolved within the next two days. Mr Kelly was not happy with this and asked the nurse to leave. The nurse sent a task to the GP to

prescribe omeprazole. They did so. The nurse told the investigator that they did not think that Mr Kelly needed any further mental health input at that time.

44. On 9 August, Mr Kelly's review with a nurse regarding his hyperthyroidism did not take place as he was still isolating following his recent arrival at Garth. It was rebooked for 17 August but there is no evidence that this appointment took place either.
45. On 10 August, a recovery practitioner called Mr Kelly on his in-cell telephone. Mr Kelly said that he had last used PS five weeks ago and usually used PS due to being angry at others' decisions. He was added to the substance misuse team's caseload and allocated to another recovery practitioner. She had no concerns that Mr Kelly was a risk to himself.
46. On 14 August, the pharmacy department completed a medication reconciliation. This ensures that a prisoner's medication list is up to date and should have taken place within three days of Mr Kelly arriving at Garth.
47. On 21 August, an officer introduced himself to Mr Kelly as his key worker. He noted that when Mr Kelly had arrived at Garth, he had a few issues with his medication but that these had since been resolved. Mr Kelly said he had no further issues.
48. On 23 August, the recovery practitioner assessed Mr Kelly. He said that he had not used drugs for seven weeks. He said that he was motivated to abstain from using drugs and progress in the prison. Mr Kelly said that his mood could fluctuate but that at that moment it was good. She noted that Mr Kelly had good support from his brother and was focussed on his future. Mr Kelly said he had no thoughts of suicide or self-harm and she told the investigator that she had no concerns that Mr Kelly was a risk to himself. She planned to see Mr Kelly again on 22 September.
49. On 29 August, Mr Kelly telephoned his brother. He asked if someone had sent him a message the other day and told him that when he got paid this time, instead of giving the money to Mr Kelly, he should "put two five into that". His brother said he would have to go to the bank, and Mr Kelly said that if it was going to be hard work he would "do it differently" and "just keep it safe anyway"
50. A prisoner who had known Mr Kelly when he was in HMP Dovegate in 2018 said that when he met him again in Garth, he was very different. He had been a bubbly, lively prisoner in Dovegate, but was very depressed in Garth. He said that Mr Kelly hated it in Garth and told him that he wished he had stayed at Frankland. He said that Mr Kelly felt unsupported but also felt unable to talk to staff about his concerns. He said that Mr Kelly became increasingly low in mood during his time at Garth. He never had any concerns that Mr Kelly was a risk to himself.
51. On 5 September, staff found a hole in Mr Kelly's window. Holes in windows are a security concern as they can be used to retrieve illicit items, such as mobile phones or drugs. On 7 September, during an adjudication hearing about the hole, Mr Kelly told staff that the hole was already there, and he had not made it.
52. On 10 September, staff found another hole in Mr Kelly's window which had been covered with a CD case. On 13 September, Mr Kelly again told staff during an adjudication hearing that he had not made the hole. At 8.00pm, Mr Kelly telephoned his brother. They had a general conversation about what they were doing, their upbringing and what their lives would have been like if they had not

taken drugs. His brother said that he would “put some money in” when he got paid as he could not do what Mr Kelly had asked.

53. On 12 September, a Supervising Officer (SO) held an Incentives and Earned Privileges (IEP) review with Mr Kelly, as he had been disciplined twice for having holes in his windows. (The IEP scheme has three levels: basic, standard and enhanced and allows prisoners different privileges according to their level.) An officer was also present. Mr Kelly said that the holes in his windows were done as a decoy, to move attention from elsewhere on the wing and he had not received any parcels. He said that prisoners made a hole in the appropriate window just before the drone was due.
54. The SO told the investigator that, due to Mr Kelly’s response, he was concerned that Mr Kelly might have been pressurised or bullied into having the holes in his windows. The SO said that he was sure he had asked Mr Kelly about this but could not recall what his response was. However, the SO said that he was satisfied that, as he had not taken any further action, he had not had any concerns that Mr Kelly was being bullied. The SO downgraded Mr Kelly from the enhanced level of the IEP scheme to the standard level due to the damage to his cell window.
55. After the review, the officer submitted an intelligence report indicating that she had received information that the holes in Mr Kelly’s windows were being placed there by someone else as a decoy as the drones were concentrated elsewhere on the wing.
56. Another intelligence report submitted on 12 September suggested that Mr Kelly, along with other prisoners, was under the influence of illicit drugs. The intelligence assessment noted that there were a substantial number of cells in the prison with holes in the windows, thought to have been made using the kettle heating elements. Numerous drones had also been sighted and several packages retrieved by prisoners which had led to an increase in prisoners under the influence of illicit drugs.
57. On 13 September, a recovery practitioner went to see Mr Kelly due to him being reported as being under the influence of drugs the day before. Mr Kelly admitted he had been using PS. They spoke about harm reduction. Mr Kelly said that he did not need any further support. In general, wing staff the investigator spoke to said that Mr Kelly was a quiet, polite prisoner. They had no concerns that Mr Kelly was being bullied or that he was a risk to himself.
58. On 16 September, Mr Kelly was unlocked during the morning. CCTV shows that he associated with other prisoners and collected his medication and lunch. At 11.30am, he collected hot water, returned to his cell and was locked in. Due to the restricted regime during COVID-19, Mr Kelly was not allowed out of his cell again that day.

## **Events of 17 September**

59. On 17 September at 8.00am, a security analyst picked up the intelligence report from 12 September. They noted that there were lots of windows on C wing with holes which may have been acting as a decoy. They noted that that Mr Kelly might be in debt and that he should be interviewed to see if he wanted to move wings.

60. At 8.19am, an officer did a welfare check on Mr Kelly, along with the other prisoners on the wing. He told the investigator that this was to check Mr Kelly was in his cell, alive and well. He cannot specifically remember checking Mr Kelly but had no concerns at the time. At 9.10am, another officer unlocked Mr Kelly's cell to allow him to get his medication. However, Mr Kelly declined his medication, did not come out of his cell and the officer locked the door.
61. At 11.51am, the officer was unlocking all the cells on the landing. He recalled that Mr Kelly was in bed. After unlocking Mr Kelly's cell, he continued down the landing before returning to Mr Kelly's cell as he had not come out of his cell. He woke Mr Kelly up, who said that he did not want his lunch. Mr Kelly told the officer that he was fine, and the officer had no concerns about him. The officer stood in the doorway briefly and then locked the door.
62. A prisoner said that he spoke to Mr Kelly through his observation panel around this time. He asked if Mr Kelly was okay as he knew he had not collected his lunch and Mr Kelly replied that he was "alright". He had no concerns about Mr Kelly.
63. At 12.07pm, the officer did a roll check of the landing. He said that Mr Kelly was still in bed and appeared to be asleep.
64. Around 2.05pm, Officer A began unlocking the landing. At 2.09pm, she got to Mr Kelly's cell and looked through the observation panel. He had covered the panel with a towel. She unlocked Mr Kelly's door and could see he was hanging from the light fitting by a torn bed sheet. She pulled the door closed and told Officer B that they urgently needed to lock prisoners away. Officer A radioed a code blue (an emergency code which indicates a prisoner is not breathing or is having difficulty breathing) and shouted to nearby staff. Several officers responded and she went into the cell at 2.10pm, with three other officers following closely behind her.
65. Two officers supported Mr Kelly's weight while Officer A cut the ligature. They placed Mr Kelly on his bed and Officer A cut the ligature from his neck. As they were doing so, more staff arrived, and an officer began chest compressions. The officer said that Mr Henderson was cold, and his skin was pale. Other officers took it in turns to assist with the chest compressions. An officer got the defibrillator.
66. At 2.12pm, a nurse got to Mr Kelly's cell. Other healthcare staff followed shortly after with the emergency bag. While the nurse was assessing Mr Kelly, a SO got to the cell and asked staff to move Mr Kelly to the floor to continue chest compressions. The nurse attached the defibrillator. She further assessed Mr Kelly, who she noted was pale, cold to the touch and had post-mortem lividity (when blood settles in the body with gravity). She conferred with her healthcare colleagues, decided that CPR was futile and therefore stopped chest compressions. At 2.26pm, paramedics arrived and did not undertake treatment. At 2.29pm, prison GP pronounced that Mr Kelly had died.
67. At 5.00pm, a security manager picked up the intelligence report regarding Mr Kelly and noted that, had Mr Kelly not died, they would have interviewed Mr Kelly to find out what support he needed and whether he wanted to move wings.

## **Contact with Mr Kelly's family**

68. A prison family liaison officer was appointed. On 17 September, she telephoned Mr Kelly's brother to inform him of his brother's death and offered her condolences. She also offered a contribution to funeral expenses, in line with Prison Service policy. On 20 September, along with another officer, she went to see Mr Kelly's brother at his home address. She stayed in contact with Mr Kelly's brother over the following weeks.

## **Support for prisoners and staff**

69. After Mr Kelly's death, the Deputy Governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
70. 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.

## **Post-mortem report**

71. The pathologist concluded that the circumstances of Mr Kelly's death, together with their examination of his body, were fully consistent with death by hanging.
72. The toxicologist found venlafaxine (an anti-depressant which he had not been prescribed), amphetamine and omeprazole in Mr Kelly's system. They noted that the level of venlafaxine was slightly higher than therapeutic use, but that may have been due to post-mortem redistribution which was more likely when resuscitation had been attempted. Amphetamine was found in Mr Kelly's system, but not in his blood, which the toxicologist concluded suggested that he had not used it in the hours before he died.

# Findings

## Assessment of risk of suicide and self-harm

73. Mr Kelly had been assessed as a risk to himself and supported by ACCT measures several times during his time in prison. In 2018, he cut his wrists in response to bereavements. In 2020, he cut his wrists as he was unhappy about a reduction in his medication. In April 2021, Mr Kelly refused to eat for around ten days due to issues concerning his medication.
74. On 5 July, Mr Kelly began refusing all food and medication in protest over being accused of being under the influence of PS. On 9 July, he was taken to hospital by ambulance. He returned to the prison the same day, was located in healthcare and on 10 July began taking his medication and eating again. We are concerned that staff at Frankland did not open an ACCT during this period. After Mr Kelly transferred to Garth, he told staff there that his refusal of food had been an attempt to take his own life. Furthermore, on 13 July, while still at Frankland, Mr Kelly said he was in debt and had thoughts of suicide. Again, staff did not open an ACCT. They also did not consider opening a Challenge Support Intervention Plan (CSIP) aimed at supporting victims and challenging perpetrators of bullying and violence.
75. When Mr Kelly transferred to Garth, his PER noted that “*They have said they will self-harm or commit suicide – he is heavily in debt*”. There is no further information, and it is not clear when Mr Kelly made this statement, although its reference to being heavily in debt could suggest that it was current at the time of transfer. Again, no ACCT had been opened. We make the following recommendation:

### **The Governor and Head of Healthcare at Frankland should ensure that staff:**

- **open an ACCT if a prisoner expresses suicidal thoughts;**
- **start ACCT monitoring procedures when a prisoner has significant risk factors, or record their reasons for not doing so; and**
- **consider opening a CSIP when prisoners disclose that they are in debt or appear fearful of other prisoners.**

76. After Mr Kelly arrived at Garth, he was not assessed as presenting a risk of harm to himself. Although staff said he was a quiet prisoner, they had no concerns about him, and he appeared to settle well. By his own admission, Mr Kelly had started using PS again, but staff spoke to him and were satisfied that he was not being bullied and had no concerns about him. Issues which had previously caused him to cut himself or refuse food were not ongoing at the time of his death. In these circumstances, we do not consider that staff could have been expected to predict or prevent Mr Kelly’s actions on 17 September. The clinical reviewer also reached the same conclusion.

## Bullying

77. Shortly before his death, holes had been found in Mr Kelly’s windows on two occasions. Mr Kelly told staff that he had not made these holes which led staff to consider whether he was being bullied or pressured. A SO said that he would have opened a CSIP if he had any concerns that Mr Kelly was at risk from other prisoners. The SO said that he thought Mr Kelly was very open about how the drones were coming in, so did not think he was under pressure.

78. An intelligence report submitted on 12 September was processed in the morning of 17 September before Mr Kelly died. The security analyst intended to ensure that Mr Kelly was interviewed to find out whether he wanted to move wings. The Head of Safety told the investigator that intelligence is analysed and acted on within seven days of being submitted. She said that there was a lot of intelligence to analyse at the time but that they had kept to the expected timescale in this case. Mr Kelly had not raised any issues of debt or bullying with staff and we are satisfied that they acted in an appropriate manner to support Mr Kelly.

## **Reducing the supply and demand for illicit substances**

79. Post-mortem toxicology tests detected venlafaxine in Mr Kelly's system, which he had not been prescribed, as well as amphetamines. He told staff that he was in substantial debt at Frankland prison, which is why he had moved to Garth. Staff found holes in his windows twice at Garth, suggesting that he was involved, directly, or indirectly, in the supply or demand of illicit drugs. On 13 September, Mr Kelly admitted to a substance misuse worker that he had started taking PS again.
80. In January 2020, Garth introduced a new Integrated Substance Misuse Strategy, which aims to reduce the supply and demand for illicit substances and to provide support and recovery opportunities for prisoners. This includes instructions to prevent the secretion and diversion of prescribed medication. Staff were not aware that Mr Kelly was taking venlafaxine illicitly while he was at Garth. The clinical reviewer noted that taking venlafaxine can sometimes induce a state of euphoria, which may have been Mr Kelly's motivation for using it illicitly. We note their recommendation that staff are informed about venlafaxine's potential misuse and possible recreational value.
81. During their inspection of Garth in 2019, HMIP found that 60% of prisoners said that it was easy to obtain drugs. During interviews, staff and prisoners agreed that illicit substances, particularly PS, were an issue in the prison. The Head of Security told the investigator that there had been a lot of drones and many windows on the wing had been damaged in connection with retrieving illicit items. He said that the Tactical Tasking Group (TTG) had a monthly meeting to analyse potential routes for illicit items into the prison. They identified prisoners that were potentially involved and moved them within the prison or to another prison. He said that Garth had also employed additional teams at night, when drone activity was most common, to spot the drones and identify potential cells for searching. The prison had also had Geofencing installed which does not allow GPS enabled drones to fly into the prison.
82. Garth was also completing a drone vulnerability assessment to identify where they were most likely to enter the prison. In collaboration with the police, they had also increased patrols round the perimeter of the prison. The prison also tests incoming mail for illicit substances and prisoners can only receive legal mail from a named solicitor. Garth has also improved their gate security and everybody entering the prison has their bag searched. Clothing can only be sent to prisoners directly from the supplier and in their birthday month.
83. At the end of September 2021, the prison also completed a lockdown search on A wing, B wing, C wing and D wing using a combination of local and national

resources. They found 29 weapons, 15 phones, 13 chargers, 8 amounts of drugs, 3 amounts of tobacco and 40 litres of hooch among other things.

84. Given the proactive steps the prison has taken both before and after Mr Kelly's death in addressing the issue of drug misuse at Garth, we make no further recommendation.

## **Transfer to Garth**

85. Mr Kelly was transferred to Garth due to being in debt at Frankland, presumably due to drug misuse, and refusing to locate on a standard wing. It is therefore regrettable that he transferred to a prison and wing which was having significant difficulties with drones and illicit drugs. However, this was the case for all the main wings in Garth at the time (so Mr Kelly could not be better located elsewhere) and proactive steps were being taken to reduce the supply of drugs as outlined above. We recognise the difficulties and constraints surrounding transferring prisoners and, given Mr Kelly's refusal to be located on a main wing at Frankland, consider that his transfer was appropriate.
86. Additionally, the Head of Safety said that Garth had recently amended their induction questionnaire to include a question about whether prisoners were arriving with any specific concerns and listed debt and bullying as a specific discussion point for the interview.

## **Clinical Care**

87. Overall, the clinical reviewer concluded that the healthcare Mr Kelly received was reasonable and, in the main, equivalent to that which he could have received in the community.

## **Physical care**

88. The clinical reviewer concluded that some of Mr Kelly's physical care was below that he could have expected to have received in the community. This was in relation to his review for hyperthyroidism which was booked for 17 August but there was no evidence that it took place. This issue has been raised in supervision with the relevant staff.
89. Furthermore, upon arrival to Garth, Mr Kelly did not receive his medication for three days. This was due to prison staff not being informed he needed to be escorted by healthcare staff and medication reconciliation not taking place within timescales. An action plan has been implemented to avoid this happening in future. The Head of Healthcare should note the clinical reviewer's recommendations about Mr Kelly's physical health.

## Substance misuse and mental healthcare

90. The clinical reviewer concluded that Mr Kelly's substance misuse and mental healthcare were appropriate.

## Emergency response

91. When Officer A checked Mr Kelly and discovered his observation panel was blocked, she opened his door and found Mr Kelly hanging. She pulled the door closed, radioed an emergency code and shouted to nearby staff. Several officers responded and they went into the cell around a minute after she had first opened the door.
92. Officer A said that when she opened the door and saw Mr Kelly hanging, she was in shock and panicked. She told the investigator that she thought this was why she closed the door and tried to "collect" herself. She initially said she would never enter a cell on her own but on further reflection she agreed that if there was a risk to life and she felt it was safe to do so she would go into a cell on her own.
93. The delay of a minute would not have made a difference in the outcome for Mr Kelly, but it may do in other situations. It was clear that Officer A encountered an extremely shocking, unexpected and traumatic situation and it is impossible to know how staff will react in such situations. We are not critical of her for taking a moment to collect her thoughts, particularly as she radioed a code blue straight away. However, we are concerned that she initially said that she would never go into a cell on her own. We therefore make the following recommendation:

**The Governor should remind staff that, subject to a risk assessment, staff enter cells as quickly as possible if there is reason to consider that a prisoner may be at risk.**

94. Once staff entered the cell, an officer began CPR until healthcare staff attended and made an appropriate decision to stop chest compressions.

## Inquest

95. The inquest into Mr Kelly's death concluded on 28 July 2023. The cause of his death was confirmed as suicide.

**Sue McAllister, CB  
Prisons and Probation Ombudsman**

**May 2022**

**Prisons &  
Probation**

**Ombudsman**  
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