Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stephen Kelly, a prisoner at HMP Whatton, on 9 October 2022

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

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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 Stephen Kelly died in hospital from heart failure on 9 October 2022, while he was a prisoner at HMP Whatton. He was 56 years old. I offer my condolences to Mr Kelly's family and friends.

The clinical reviewer concluded that the health care Mr Kelly received at Whatton was partially equivalent to that which he could have expected to receive in the community. She was concerned that Mr Kelly's clinical observations were not recorded in the days leading up to his death when it was clear that his physical presentation was deteriorating. She also found that he had no care plan in place for his lung disease.

We are concerned that the staff who found Mr Kelly unresponsive on 9 October did not pass on relevant information to the control room, which meant that the staff member who called for an ambulance was unable to answer key questions about Mr Kelly's condition. As a result, the Ambulance Service did not register the incident as high priority.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman **May 2023**

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Summary

Events

1. On 19 October 2016, Mr Stephen Kelly was sentenced to six years in prison for sexual offences. On 27 February 2018, he was moved to HMP Whatton.

2. In January 2020, Mr Kelly was diagnosed with interstitial lung disease (a condition in which the lungs become scarred and breathing becomes increasingly difficult).

3. At around 2.50pm on 9 October 2022, healthcare staff found Mr Kelly unresponsive in his cell. They called a medical emergency code and the control room called for an ambulance. Staff performed chest compressions until an ambulance arrived and paramedics took over Mr Kelly's care. The paramedics took Mr Kelly to hospital to continue treatment.

4. At around 4.30pm, the ambulance arrived at the hospital and hospital staff continued to treat Mr Kelly. After approximately 30 minutes, hospital staff assessed that Mr Kelly was unable to breathe without the support of a breathing machine and medication. A doctor made the decision to stop treatment and, at 5.31pm, pronounced that Mr Kelly had died.

5. A post-mortem report concluded that Mr Kelly died from heart failure. Pulmonary fibrosis (lung disease) was listed as a contributory factor.

Findings

6. The clinical reviewer found that the care Mr Kelly received was of a reasonable standard and was partially equivalent to that which he could have expected to receive in the community.

7. The clinical reviewer was concerned that Mr Kelly's clinical observations were not recorded in the days leading up to his death when it was clear that his physical presentation was deteriorating. She also found that Mr Kelly did not have a care plan in place for his lung disease.

8. The staff member in the control room who called for an ambulance was unable to answer questions about Mr Kelly's condition. This resulted in a medium priority ambulance being despatched when it should have been a high priority one.

Recommendations

- The Head of Healthcare should ensure that healthcare staff clearly document the outcome of clinical assessments and a future plan of care as appropriate in the SystmOne records.

- The Head of Healthcare should ensure that care plans are created and reviewed for all patients as appropriate.

- The Governor and Head of Healthcare should ensure that when staff use a medical emergency code, they provide relevant information about the prisoner's condition to

the control room without delay and that control room staff are aware of the standard questions asked by ambulance call handlers.

The Investigation Process

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

10. The investigator interviewed one member of staff at HMP Whatton on 19 December 2022.

11. NHS England commissioned a clinical reviewer to review Mr Kelly's clinical care at the prison. The clinical reviewer conducted three interviews with healthcare staff at Whatton on 22 and 23 November.

12. We informed HM Coroner for Nottingham of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

13. The Ombudsman's family liaison officer contacted Mr Kelly's next of kin, his brother, to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond.

14. We shared our initial report with HM Prison and Probation Service (HMPPS). They found two factual inaccuracies, which have been amended in this report.

15. Mr Kelly's next of kin did not wish to be involved in the investigation and did not want a copy of our report.

Background Information

HMP Whatton

16. HMP Whatton is a category C prison and currently holds approximately 815 men convicted of sexual offences. Care UK provided physical and mental health and substance misuse treatment services until October 2022, when Practice Plus Group took over these services. The healthcare unit also includes an end-of-life suite and a dementia care suite.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Whatton was in 2020. Inspectors reported that a change in health provider to Care UK in 2020 initially brought some challenges however, overall patient outcomes were not affected by this. They reported that although there were staff shortages, essential services to primary care including nurse triage and access to a GP were not affected. They reported that the team showed resilience and care and were led by strong clinical leadership.

Independent Monitoring Board

18. 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 ending 31 May 2022, the IMB reported that healthcare services continued to be under great pressure but that the service provided was equivalent to that which would be provided in the community. They noted that the shortage of healthcare staff increased the risk to the wellbeing of prisoners, however that every effort was made by the on-site team to provide care and support to all prisoners.

Previous deaths at HMP Whatton.

19. Mr Kelly was the eighteenth prisoner to die at Whatton since October 2020. Of the previous deaths, 16 were from natural causes and one was self-inflicted. There are no similarities between our findings in the investigation into Mr Kelly’s death and our investigation findings for the previous deaths.

Key Events

20. On 19 October 2016, Mr Stephen Kelly was sentenced to six years in prison for sexual offences. He was moved to HMP Whatton on 27 February 2018.

21. On 30 January 2020, following multiple chest infections and a CT scan, Mr Kelly was diagnosed with interstitial lung disease (a condition in which the lungs become scarred and breathing becomes increasingly difficult).

22. Over the next two years, Mr Kelly remained under the care of the hospital respiratory consultant. He was given follow up appointments every six months where his condition was assessed. The respiratory consultant said that although Mr Kelly's lung disease was deteriorating, it was stable, and he did not yet require treatment or oxygen.

23. In June 2022, staff noted that Mr Kelly was not eating much and had lost a lot of weight. In July, staff noted that he was having difficulty getting to the toilet and was frequently soiling his bed. From the end of July, healthcare staff visited him daily to assist with his personal care needs.

24. In October, Mr Kelly had increasing incontinence, was not eating, and was not interacting with staff. Healthcare staff continued to visit him daily to assist with his personal care needs.

Events of 9 October 2022

25. At around 9.00am on 9 October, a nurse saw Mr Kelly in his cell after prison staff told her that he had soiled himself. She helped Mr Kelly to clean himself and his cell and reminded him to use the commode next to his bed.

26. At around 1.40pm, an officer noticed an unpleasant smell coming from Mr Kelly's cell. She asked for healthcare staff to attend as Mr Kelly had soiled himself again. A nurse attended and helped Mr Kelly to clean himself and gave him clean clothing.

27. At around 2.50pm, two nurses visited Mr Kelly's cell as part of their routine checks. They found Mr Kelly lying unresponsive on his bed. At 2.52pm, a nurse called a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties).

28. Healthcare staff responded to the code blue and attended Mr Kelly's cell. They moved him from his bed onto the floor and started CPR. Staff applied a defibrillator (a device that send an electric pulse or shock to the heart to restore a normal heartbeat) and searched for a shockable pulse. While waiting for paramedics to arrive, prison officers assisted healthcare staff in giving chest compressions to Mr Kelly.

29. In the meantime, at 2.54pm, an Operational Support Grade (OSG) rang the emergency services. When the call handler asked her if the patient was breathing, she said she did not know. She said that staff were using a defibrillator and giving CPR. The call handler then asked her to get closer to the patient to see if he was breathing. She told the call handler that she did not know, as she was calling from

the prison's control room to report a code blue. She then repeated that there was a code blue, and that CPR was actively being given. The call handler replied by saying "so a code blue, are you saying that's a category 2?" She replied with "if you say so". (A category 2 ambulance is for a serious condition, such as stroke or chest pain, which may require rapid assessment and/or urgent transport, with an approximate 18 minute wait time. A category 1 ambulance is an immediate response to a life-threatening condition, such as cardiac or respiratory arrest, with an approximate seven minute wait time.)

30. At 3.05pm, paramedic first responders entered Whatton, followed by an ambulance at 3.15pm. Once the paramedics arrived at Mr Kelly's cell, they took over care from the prison staff. The paramedics used a specialist machine that gave chest compressions to Mr Kelly.

31. At 4.15pm, after the paramedics found a shockable pulse, they transferred Mr Kelly to hospital in an ambulance.

32. At 4.33pm, the ambulance arrived at the hospital where hospital staff continued to give treatment to Mr Kelly for approximately 30 minutes.

33. At 5.06pm, hospital staff agreed that Mr Kelly was unable to breathe without the support of adrenaline and a breathing machine. The hospital staff made the decision to stop treatment.

34. At 5.31pm, a hospital doctor pronounced that Mr Kelly had died.

Contact with Mr Kelly's family

35. After Mr Kelly's death, the prison appointed a family liaison officer (FLO). Mr Kelly had no nominated next of kin, but the FLO found details of Mr Kelly's half-brother and notified him of Mr Kelly's death. Mr Kelly's half-brother did not wish to have any further contact.

Support for prisoners and staff

36. After Mr Kelly's death, a prison manager 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.

37. The prison posted notices informing other prisoners of Mr Kelly's death.

Post-mortem report

38. The post-mortem concluded that Mr Kelly died of a heart failure caused by ischaemic heart disease. Pulmonary fibrosis (lung disease) was also listed as a contributing factor.

39. At the inquest held on 19 October 2023, the coroner concluded that Mr Kelly died of natural causes.

Findings

Clinical care

40. The clinical reviewer found that the care Mr Kelly received was of a reasonable standard, which was partially equivalent to that which he could have expected to receive in the community.

41. The clinical reviewer was concerned that in the days leading up to Mr Kelly's death, staff did not record his clinical observations in his medical record (SystmOne) when it was clear that his health was deteriorating. We recommend:

    The Head of Healthcare should ensure that healthcare staff clearly document the outcome of clinical assessments and a future plan of care as appropriate in the SystmOne records.

42. The clinical reviewer also found that Mr Kelly did not have a care plan in place for his lung disease or his unexplained weight loss. We recommend:

    The Head of Healthcare should ensure that care plans are created and reviewed for all patients as appropriate.

Call to ambulance service

43. Prison Service Instruction (PSI) 03/2013, Medical Emergency Response Codes, says that the member of staff using the medical emergency code must also provide relevant information about the condition of the prisoner to the control room staff, so that they can pass it on to the ambulance service for use in the triage process.

44. We are concerned that the OSG, who called for an ambulance, was not given this information and therefore was unable to answer the question, "Is the patient breathing?" We note that on two separate occasions, she told the call handler that CPR was underway, which would have indicated that Mr Kelly was not breathing. However, it appears that her inability to say whether Mr Kelly was breathing led to confusion about how life threatening Mr Kelly's condition was and resulted in a category 2 ambulance being despatched (standard response time 18 minutes) when it should have been a category 1 ambulance (standard response time 7 minutes). We recommend:

    The Governor and Head of Healthcare should ensure that when staff use a medical emergency code, they provide relevant information about the prisoner's condition to the control room without delay and that control room staff are aware of the standard questions asked by ambulance call handlers.

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