Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Alpha Kalay, a prisoner at HMP Hull, on 19 January 2021

A report by the Prisons and Probation Ombudsman

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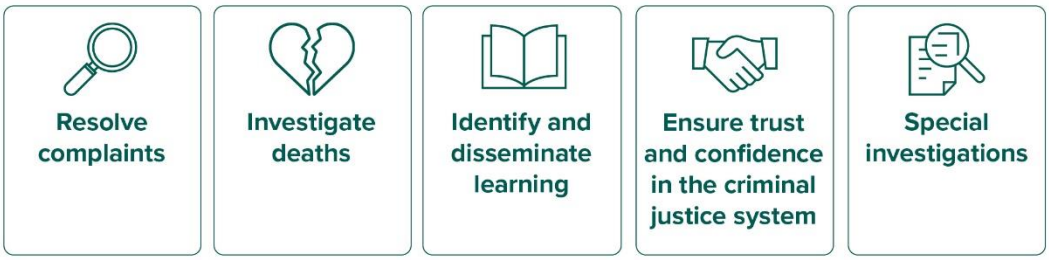
OUR VISION

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

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 Alpha Kalay died in hospital from COVID-19 pneumonia on 19 January 2021, while a prisoner at HMP Hull. He was 74 years old. I offer my condolences to Mr Kalay's family and friends.

I am very concerned at the unacceptably poor care Mr Kalay received from both prison and healthcare staff.

Mr Kalay had very limited mobility and a weak bladder and bowels due to spinal cord damage. He used a wheelchair and needed help with his personal care. He received visits from healthcare staff three times a week and had a wing buddy to help him with tasks such as collecting his meals and cleaning his cell.

Although Mr Kalay's medical conditions and age put him in a high-risk group for complications from COVID-19, healthcare staff failed to identify this, and he was never offered the opportunity to shield.

At the end of December 2020, Mr Kalay's wing buddy tested positive for COVID-19 and Mr Kalay was placed into isolation. All support provided to him stopped. In early January 2021, Mr Kalay also tested positive for COVID-19.

Once Mr Kalay had tested positive, he should have had daily wellbeing checks, but these were not done. Clinical observations were not done correctly, which meant that signs of deterioration were missed.

On 13 January, an officer noticed faeces smeared in Mr Kalay's cell. Staff treated this as a dirty protest and the next morning took Mr Kalay to the segregation unit.

A nursing associate who had been involved in Mr Kalay's social care insisted on seeing Mr Kalay in the segregation unit and realised how unwell he was. She escalated her concerns, and Mr Kalay was taken to hospital on the evening of 14 January. He died there five days later.

I am shocked and appalled that staff considered that Mr Kalay's incontinence should be treated as a dirty protest, and that a nurse assessed that he was fit for segregation. I consider that Mr Kalay's treatment was totally unacceptable.

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 **November 2021**

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Summary

Events

1. On 30 August 2019, Mr Alpha Kalay was convicted of assault and sent to HMP Hull. He was subsequently sentenced to four and a half years in prison.

2. Mr Kalay had reduced mobility, along with a weak bladder and bowels, due to spinal damage. He used walking sticks and a wheelchair for longer distances. He had a wing buddy to help with tasks such as collecting his meals and cleaning his cell. Healthcare staff visited him three times a week to help with personal care.

3. Towards the end of December 2020, Mr Kalay's wing buddy tested positive for COVID-19. Mr Kalay was placed in isolation. His regular visits from healthcare staff stopped after 31 December.

4. Mr Kalay was tested for COVID-19 on 8 January 2021, and four days later staff noted in his prison record that he had tested positive.

5. During the first two weeks of January, officers noticed that Mr Kalay's cell was becoming increasingly messy, and he had dirty bedding and clothes. Mr Kalay repeatedly asked for a shower but was told this was not permitted as he was positive for COVID-19.

6. On 11 January, an officer asked for a nurse to see Mr Kalay because he was concerned at the state of his cell and that he had refused his lunch. The nurse recorded that Mr Kalay was struggling to breathe and had a headache. He could not take Mr Kalay's temperature as there was no thermometer available. The nurse booked a follow up appointment, but this was not actioned.

7. On 13 January, an officer noticed faeces smeared around Mr Kalay's cell. Staff treated this as a 'dirty protest' and the next morning they moved Mr Kalay to the segregation unit. A nurse assessed that Mr Kalay would be able to cope with a period of segregation.

8. A nursing associate, who had been involved in Mr Kalay's social care, was surprised to learn that Mr Kalay had been taken to the segregation unit and went to see him later that afternoon. She found him cold, dehydrated, confused, unable to communicate and wearing only a t-shirt covered in faeces. She asked a nurse to see him, and the nurse moved him to the wellbeing unit for observation.

9. That evening, the nursing associate and another nurse checked on Mr Kalay. They found he was short of breath, shaking and confused. He was naked from the waist down and was unaware he had been incontinent. His clinical observations showed that he was very unwell, and the nurse called an ambulance.

10. Mr Kalay died in hospital on 19 January. A hospital doctor recorded his cause of death as COVID-19 pneumonia.

Findings

11. The clinical reviewer considered that Mr Kalay's medical conditions and age put him at high risk of complications from COVID-19 and he should have been offered shielding. There was no evidence that Mr Kalay's vulnerability to COVID-19 was ever assessed by healthcare staff at Hull and he was never offered the opportunity to shield. We have recently made a recommendation to Hull on this issue so do not repeat it.

12. It is unacceptable that a thermometer was unavailable when a nurse saw Mr Kalay on 11 January. This meant that the full range of clinical observations was not taken and a NEWS2 was not calculated. (NEWS2 is a tool to assess clinical deterioration.)

13. Mr Kalay should have been seen for a follow up appointment, but this was missed.

14. It is unclear when the prison received Mr Kalay's positive test result following the COVID-19 testing on 8 January. His record was updated on 12 January. He was not seen by healthcare staff that day or the day after. He was only seen on 14 January because he was being moved to the segregation unit. Prisoners who have tested positive for COVID-19 should have daily wellbeing checks, particularly those in a high-risk group, like Mr Kalay.

15. It is unacceptable that Mr Kalay was not permitted to have a shower because he had tested positive for COVID-19. The prison needs to find a safe way of enabling infectious prisoners to shower.

16. We are appalled at the way Mr Kalay was treated from 13 January onwards. Mr Kalay had poor mobility and a weak bladder and bowels and had had all personal and social care support taken away from him. He was also COVID-19 positive and in a high-risk group for complications. It is shocking enough that wing staff decided to treat his incontinence as a dirty protest, but we struggle to understand how a nurse could have allowed this to happen and how she assessed that Mr Kalay was fit to cope with segregation. (We would have recommended an investigation into the actions of the nurse, but she has been suspended pending investigation by the Nursing and Midwifery Council.)

17. We commend the actions of the nursing associate who persisted in asking to see Mr Kalay in the segregation unit and then escalated her concerns about his welfare.

Recommendations

- The Head of Healthcare should ensure that clinic rooms are correctly equipped.
- The Head of Healthcare should ensure that staff consistently use the National Early Warning Score (NEWS2) tool to ensure the appropriate and timely escalation of unwell prisoners.

- The Head of Healthcare should ensure that follow up appointments booked through the electronic system are actioned.
- The Head of Healthcare should ensure that the results of COVID-19 tests are entered promptly in prisoners' medical records.
- The Head of Healthcare should ensure that prisoners who have tested positive for COVID-19 have daily wellbeing checks, particularly those who are clinically vulnerable.
- The Governor should ensure that there is a policy in place that enables prisoners isolating with infectious diseases to have showers.
- The Governor should share this report with the duty governor and chaplain who visited the segregation unit on 14 January, and with the staff who worked that day, to ensure they are aware of the Ombudsman's findings.
- The Head of Healthcare should share this report with the nursing associate so she is aware of the Ombudsman's findings.

The Investigation Process

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

19. The investigator obtained copies of relevant extracts from Mr Kalay's prison and medical records.

20. NHS England commissioned a clinical reviewer to review Mr Kalay's clinical care at the prison.

21. The investigator and clinical reviewer jointly interviewed two prison officers and four healthcare staff. Due to restrictions imposed during the COVID-19 pandemic, they conducted the interviews by telephone.

22. We informed HM Coroner for Hull and the East Riding of Yorkshire of the investigation. He gave us the cause of death. We have sent the Coroner a copy of this report.

23. The Ombudsman's family liaison officer contacted Mr Kalay's daughter to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not raise any issues but asked for a copy of our report.

24. The initial report was shared with Mr Kalay's daughter. She responded to part of the report, but subsequently engaged solicitors who responded on her behalf. While they did not find any inaccuracies in the report, there were several points which they felt could be emphasised differently. These matters have been addressed in separate correspondence. However, paragraph 39 has been amended to clarify that it reflects reported interpretations from officers and not intentionality from Mr Kalay.

25. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS identified a name inaccuracy relating to the debrief in paragraph 56, and a transcription error in one of the staff interviews, relating to a location name. These have been corrected in this report.

Background Information

HMP Hull

26. HMP Hull is a local prison that holds up to 1,056 men in ten wings. The prison has a wellbeing unit to support prisoners with complex needs, which are difficult to meet in the normal prison environment. City Healthcare Partnership (CHCP) provides health services at the prison. GP surgeries are held four days a week, with an out of hours service at other times.

HM Inspectorate of Prisons

27. The most recent inspection of HMP Hull was in April 2018. Inspectors found that health provision was reasonable, and governance was mostly effective, but some health services had deteriorated since the last inspection. Staff in the wellbeing unit provided compassionate support to prisoners and, although joint working with health services was good, the diverse mix of prisoners meant it was not sufficiently therapeutic.

Independent Monitoring Board

28. 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 March 2020, the IMB reported that healthcare was generally as good, and for some prisoners better, than they might experience outside prison. The IMB noted that there were two dedicated wings for vulnerable prisoners, many of whom were elderly with ongoing medical conditions. Several ground floor cells had been adapted for prisoners with disabilities, including wheelchair access and in-built shower facilities.

Previous deaths at HMP Hull

29. Mr Kalay was the 12th prisoner at Hull to die since January 2019. Of the previous deaths, five were from natural causes, five were self-inflicted, and one was drug related. Mr Kalay's was the second of three COVID-19 deaths at Hull.

30. We have previously found that healthcare staff at Hull failed to identify that a prisoner was clinically vulnerable to COVID-19 and failed to offer him the opportunity to shield as they should have done.

COVID-19 (coronavirus)

31. COVID-19 is an infectious disease that affects the lungs and airways. It is mainly spread through droplets when an infected person coughs, or sneezes. The first reported case of COVID-19 in the UK was in February 2020. On 11 March, the World Health Organisation (WHO) declared COVID-19 as a worldwide pandemic.

32. COVID-19 can make anyone seriously ill, but some people are at higher risk of severe illness and developing complications from the infection. People at high risk (clinically extremely vulnerable) include those who have had an organ transplant; have severe lung or kidney disease; or are having certain types of cancer or other treatment which significantly increases the risk of infection. Examples of those at moderate risk (clinically vulnerable) are people over 70;

people under 70 with an underlying health condition, such as diabetes, or chronic respiratory, heart, liver or kidney disease; those with a weakened immune system; or who are very overweight. (These lists are not exhaustive.)

33. In response to the initial pandemic outbreak, HM Prison and Probation Service (HMPPS) introduced several measures to try to contain the outbreak - to be implemented at local level, depending on the needs of individual prisons. (An outbreak is defined as two or more prisoners, or staff, in a prison who are clinically suspected, or have tested positive for COVID-19 within 14 days.) A key strategy is 'compartmentalisation' to cohort and protect prisoners at high and moderate risk; isolate those who are symptomatic; and separate newly-received prisoners from the main population. Other measures include social distancing and the use of personal protective equipment (PPE).

Key Events

34. On 30 August 2019, Mr Alpha Kalay was convicted of assault against a minor and was sent to HMP Hull. On 4 October, he was sentenced to four and a half years in prison.

35. Mr Kalay had spinal nerve damage following osteomyelitis (bone infection) in 2005, resulting in only 20% movement in his legs. He used a walking stick and a wheelchair for longer distances. He had a weak bladder and bowels due to the spinal damage and needed to be near a toilet. Mr Kalay also had renal artery stenosis (narrowing of the arteries supplying blood to the kidneys), high blood pressure, and was clinically obese.

36. Mr Kalay had a wing buddy who helped him with tasks like collecting his meals and cleaning his cell. Since May 2020, following a social care assessment, Mr Kalay received personal care assistance from healthcare staff to help with his hygiene and to apply cream to dry skin on his legs three times a week.

37. On 28 December 2020, after Mr Kalay's wing buddy showed symptoms of COVID-19, Mr Kalay was put into precautionary isolation. His last social care visit took place on 31 December.

38. On 1 January 2021, Mr Kalay was tested for COVID-19. The following day the results showed he was negative for the virus, but his isolation period was still in force until 7 January.

Events of 10-14 January 2021

39. On 10 January, an officer recorded that Mr Kalay's cell was in an unacceptable state with food and debris on the floor. He also had dirty bedding and clothes. The officer noted that on several occasions Mr Kalay had been told to stop exposing himself, as he had been lying on his bed with little or no clothing on. Staff gave him clean clothes and bedsheets, but it was recorded by staff that he continued to expose himself.

40. On 11 January, an officer was concerned about Mr Kalay because he had refused his lunch and because of the state of his cell which was untidy and full of stale food. He cleared away the food and tidied up the cell and asked for a member of healthcare staff to come and see Mr Kalay.

41. A nurse saw Mr Kalay at 2.25pm. He recorded that Mr Kalay was struggling to breathe, was lacking energy and had a splitting headache. He recorded his respiratory rate and blood pressure but wrote that he did not have a thermometer so could not take Mr Kalay's temperature and was unable to obtain a blood oxygen reading. He booked a follow up check on Mr Kalay through the electronic system, but it was never picked up.

42. On 12 January, following mass testing for COVID-19 on Mr Kalay's wing on 8 January, staff noted in both his prison and healthcare records that he was COVID-19 positive and isolating. (It is unclear when the prison received the result.)

43. On 13 January, staff recorded that Mr Kalay had been frequently asking for a shower. At around 6.00pm, an officer went to collect Mr Kalay's food tray and noticed that there were faeces smeared around Mr Kalay's cell and that Mr Kalay failed to engage with him. Staff treated the incident as a dirty protest (a dirty protest is where a prisoner has chosen to either defecate or urinate in a cell without using the facilities provided). Prisoners on a dirty protest are housed in the prison's segregation unit.

44. At 9.20am on 14 January, before Mr Kalay was moved to the segregation unit, Nurse A assessed him. She had only been working at Hull for a few days. (An experienced mental health nurse had delegated the task to her.) Nurse A recorded that Mr Kalay's observations were within normal ranges, but she did not record the readings. She noted that he appeared to be breathing with no difficulties, and that he was not fully dressed and was covered with a blanket in his wheelchair.

45. At around 10.00am, staff moved Mr Kalay to the segregation unit. Healthcare staff must complete an Initial Segregation Health Screen to assess whether there are any reasons why a prisoner should not be segregated. Nurse A refused to complete the form because she had not been trained to do so. The experienced mental health nurse completed the form at 10.10am without seeing Mr Kalay.

46. At 1.30pm, an officer recorded in Mr Kalay's segregation log that he tried to engage with Mr Kalay, but that Mr Kalay ignored him. At about 5.30pm, he recorded in Mr Kalay's electronic prison record that Mr Kalay had not engaged much with staff since his arrival in the segregation unit. Notes in the segregation log from the duty governor and the chaplain only say that no issues were raised.

47. By chance, a nursing associate, who had previously been involved in Mr Kalay's social care, overheard that he was in the segregation unit as he was on a dirty protest. She was surprised by this as it seemed out of character, and, although it was not part of her duties, at about 5.00pm she decided to go to see him in the segregation unit.

48. An officer on the unit was initially reluctant to let the nursing associate into Mr Kalay's cell because of his COVID-19 status and because he was deemed to be on a dirty protest. She challenged the officer, and when he let her into Mr Kalay's cell, she found he was dehydrated, cold, confused, unable to communicate properly and wearing only a t-shirt which was covered in faeces. His breathing rate and heart rate were raised. She was unable to get a blood oxygen reading because Mr Kalay's fingers were too cold. She wrapped Mr Kalay in blankets and gave him some water which he drank very quickly. She was very concerned about him. She did not know if she had the authority to call an ambulance, so she telephoned the healthcare reception to ask for the experienced mental health nurse to come down and see Mr Kalay, which she did while the nursing associate got on with her medication round.

49. At 7.30pm, on the instructions of the experienced mental health nurse, prison staff took Mr Kalay to the wellbeing unit to be kept under observation. The nursing associate said she was surprised to learn this as she had been expecting to hear that he had been taken to hospital. She was uneasy with this as she

thought Mr Kalay was very unwell and she therefore asked Nurse B to go with her to the wellbeing unit to see him.

50. When Nurse B and the nursing associate arrived at the wellbeing unit at around 8.00pm, prison officers were still insistent that Mr Kalay was on a dirty protest. At interview the nursing associate said that she repeatedly told them she did not think he was, and that he was incontinent because he was unwell. There was no drinking water he could access, and he was again very thirsty. Nurse B recorded that he was very short of breath and shaking. He was confused and drowsy, and not aware that he had been incontinent. He was still naked from the waist down and the blanket he had been supplied with had slipped off his wheelchair and he was unable to retrieve it. Nurse B recorded that Mr Kalay's breathing rate and heart rate were raised but she was unable to obtain a blood oxygen reading. She gave him oxygen anyway given his shortness of breath. She calculated a National Early Warning Score (NEWS) of 8, which indicates that an emergency response is needed.

51. Nurse B called an ambulance. When the paramedics arrived, prison staff told them that Mr Kalay was on a dirty protest, although Nurse B and the nursing associate insisted this was not the case.

52. The ambulance staff were able to get a stable blood oxygen reading for Mr Kalay. It fluctuated between 64-78% which is extremely low (a normal reading is 95-100%). Mr Kalay was taken to hospital.

53. Mr Kalay remained in a confused state in hospital, and on 15 January he was sedated in order to facilitate his treatment as he kept taking his oxygen mask off. Mr Kalay did not respond to treatment, and he had problems with his kidneys and a blood clot in his right foot. He was too ill to be treated for these. His condition deteriorated rapidly on 18 January. Mr Kalay died on 19 January and his death was certified at 3.37pm.

Contact with Mr Kalay's family

54. On 14 January, after Mr Kalay was taken to hospital, prison staff telephoned his daughter, but there was no answer and no facility to leave a message. The prison passed on her phone number to hospital staff on the morning of 15 January, so they could inform her of her father's condition.

55. An interim family liaison officer (FLO) contacted Mr Kalay's daughter on 18 January to let her know that her father's situation was critical and that it would be advisable to visit him. Mr Kalay's daughter travelled to the hospital on 19 January and, on the way, was contacted by the new FLO to update her about her father's condition. The FLO spoke to her again later that day and maintained contact over the following days to explain the processes following Mr Kalay's death. The funeral took place on 17 February, and the prison contributed financially, in line with national guidance.

Support for prisoners and staff

56. On the day of Mr Kalay's death, the Duty Governor carried out a hot debrief for the bedwatch staff who had been present. He provided them with the opportunity

to discuss their experience and to access support. He followed this up with them individually two days later to check if they needed any support.

Cause of death

57. The coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Kalay's cause of death as COVID-19 pneumonia. The doctor listed hypertension (raised blood pressure), acute kidney injury (sudden damage to the kidneys that causes them to not work properly), diverticular disease (changes to the large intestine, usually associated with ageing, which can cause discomfort), and deep vein thrombosis (a blood clot) as underlying conditions which contributed to his death but did not cause it.

Findings

Clinical Findings

58. The clinical reviewer considered that the care Mr Kalay received at Hull, most significantly between 31 December 2020 and 14 January 2021, was not of a good standard and was not equivalent to that which he could have expected to receive in the community.

Management of Mr Kalay's risk of catching COVID-19

59. Mr Kalay had not left the prison in the weeks before he tested positive for COVID-19 and so it appears that he caught COVID-19 in prison. We have therefore looked at whether the prison took adequate steps to protect him.

60. Following the national lockdown announced on 21 March 2020, Hull introduced a restricted regime in line with national guidance, including advice to the extremely vulnerable to shield. Along with shielding, the prison adopted other measures, including reverse cohorting (a period of isolation for new prisoners), prison track and trace, and temperature checks on arriving prisoners and prior to moves. In addition, direct contact between prisoners and healthcare staff was limited to strict clinical need. The areas of the healthcare centre were risk assessed and the numbers of people present were limited to facilitate social distancing and prisoners only attended and left with escorting officers. Clinics were planned by wing to prevent cross wing mixing.

61. The clinical reviewer considered that, because of his pre-existing conditions, Mr Kalay was at high risk of complications if he caught COVID-19 ('clinically extremely vulnerable'). As he was in the high-risk group, he should have been offered the opportunity to shield. However, there is nothing in Mr Kalay's health records to show that staff ever assessed his vulnerability to COVID-19 or offered him shielding.

62. This is very similar to what we found in our investigation into the death of another Hull prisoner who also died of COVID-19 in January 2021. In that case, we recommended that prisoners with conditions that increased their risk of serious illness from COVID-19, should be informed of this and of their options for shielding and that this should be recorded in their medical record. The prison accepted this recommendation and in June 2021, reminded healthcare staff of the procedures that they must follow to identify and inform the clinically vulnerable. We do not, therefore, repeat the recommendation here.

Monitoring of Mr Kalay after he contracted COVID-19

63. Mr Kalay's prison record was updated on 12 January to say he had tested positive for COVID-19. He had been tested on 8 January, but it is not clear when the prison received the positive result.

64. An officer asked a nurse to see Mr Kalay on 11 January because he was concerned about him. A nurse saw Mr Kalay that day and noted that he was struggling to breathe. He was not aware that Mr Kalay was COVID-19 positive because Mr Kalay's medical record had not been updated. He failed to take the

full range of clinical observations and did not calculate a National Early Warning Score (NEWS2 – a tool used to assess clinical deterioration based on a standardised set of observations: heart rate; blood oxygen level; breathing rate; temperature; blood pressure; and level of consciousness). He did not take Mr Kalay's temperature because there was no thermometer in the clinic room, and he was unable to take a blood oxygen reading. This meant that there was an incomplete baseline set of observations and no overall score against which to measure future observations.

65. The nurse booked a follow up appointment through the electronic system, but no one picked this up. The Head of Healthcare said at interview that the task was not picked up by the senior nurse who would have been monitoring the tasks at the time, and that because the nurse had not handed over the information verbally in addition to electronically, the oversight went unnoticed. We consider that electronic tasks should be actioned and should not have to rely on an oral handover.

66. Despite staff recording on 12 January that Mr Kalay was COVID-19 positive, no one from healthcare saw him that day, or the day after. Healthcare staff did not see him until 14 January, and that was only because he was being moved to the segregation unit. As Mr Kalay was COVID-19 positive, he should have had daily wellbeing checks. It is particularly concerning that he did not, given he was in a high-risk group. This was very poor practice.

67. When Mr Kalay was moved to the wellbeing unit on the evening of 14 January, his clinical observations, with the exception of his blood oxygen level, were taken, but a NEWS2 was not calculated. The clinical reviewer noted that Mr Kalay's observations showed he was not improving, and this was a missed opportunity to call an ambulance.

68. We recommend:

The Head of Healthcare should ensure that clinic rooms are correctly equipped.

The Head of Healthcare should ensure that staff consistently use the National Early Warning Score (NEWS2) tool to ensure the appropriate and timely escalation of unwell prisoners.

The Head of Healthcare should ensure that follow up appointments booked through the electronic system are actioned.

The Head of Healthcare should ensure that the results of COVID-19 tests are entered promptly in prisoners' medical records.

The Head of Healthcare should ensure that prisoners who have tested positive for COVID-19 have daily wellbeing checks, particularly those who are clinically vulnerable.

Stopping of Mr Kalay's social care and move to segregation unit

69. Mr Kalay had been receiving regular personal care from healthcare staff for a long time. He had also been getting daily help from a wing buddy. All this

stopped abruptly on 31 December 2020. He would have struggled in normal circumstances, but once he became ill with COVID-19 he appears to have gone into crisis.

70. We are appalled at how Mr Kalay was treated when an officer saw faeces smeared in his cell on 13 January. Mr Kalay, who had poor mobility and a weak bladder and bowels due to spinal damage, had had no social care visits for two weeks by this point, and no longer had the help of a wing buddy. He had been asking to have a shower, but this was not permitted because he had tested positive for COVID-19. His positive status should have been a cause for concern given that he was in a high-risk group for developing complications from COVID-19. Instead, staff responded by treating the incident as a dirty protest and sending Mr Kalay to the segregation unit.

71. Hull's local policy on dirty protests says that "every effort must be made to ascertain the reasons for the protest". There is no evidence that this was done or that prison staff considered whether there might be health reasons why Mr Kalay was defecating in his cell or that they asked healthcare staff whether there might be health reasons.

72. We are also very concerned that healthcare staff simply accepted that Mr Kalay was on a dirty protest and did not consider whether, given Mr Kalay's known medical issues, whether the problem might be health-related incontinence and not a deliberate action.

73. We recognise that the nurse who was asked to assess if Mr Kalay was fit for segregation had been working in the prison for less than two weeks. She had not been trained in carrying out the Initial Segregation Health Screen and refused to complete the form. It was completed by an experienced mental health nurse, who did not even see Mr Kalay. We are shocked that she did not query why a man with COVID-19, with social care needs, was being sent to the segregation unit for being incontinent. We were unable to interview the nurse as she had been suspended pending investigations by the Nursing and Midwifery Council.

74. Mr Kalay spent at least some of 13 January, and almost all of 14 January, in an unclean state and without trousers. He was provided with a blanket early in the day which he had difficulty keeping in place. He was cold, confused and dehydrated. We recognise that this occurred during an exceptionally difficult period for the prison, with high COVID-19 infection rates, pressures on staff resources and restricted regimes. However, we consider that it is unacceptable that Mr Kalay was not afforded more dignity or treated with more compassion.

75. We are also concerned that, although Mr Kalay was in the segregation unit from 10.00 am to 7.30pm on 14 January, it did not occur to any of the staff who saw him during the day, including the duty governor and the chaplain, that he might be unwell, despite the fact that he was known to have tested positive for COVID-19. They simply recorded that he did not engage.

76. The notable exception was a nursing associate, who should be commended for her proactive and compassionate response. If she had not intervened and persisted in doing so, it is likely that Mr Kalay would have spent the night in the segregation unit ill, cold, dehydrated, confused and incontinent.

77. We note that she had the confidence to insist that prison staff in the segregation unit unlock Mr Kalay's cell so she could examine him in person. We see too many cases where healthcare staff accept without question that they can only see prisoners from outside their door in segregation units. While healthcare staff must obviously listen to the advice of prison staff and should not take unnecessary risks, there are times when they need to exercise their clinical judgement – and this was one of them.

78. The Head of Healthcare said at interview that lessons had been learnt from Mr Kalay's case and the stopping of his social care. She said that with any new COVID-19 positive cases, the prisoner's underlying conditions are reviewed, and social care and clinical needs are weighed up with the COVID-19 risks and the need for isolation. She conceded the right balance was not struck with Mr Kalay. She said that COVID-19 protocols for vulnerable prisoners had since been improved.

79. We recommend:

The Governor should ensure that there is a policy in place that enables prisoners isolating with infectious diseases to have showers.

The Governor should share this report with the duty governor and chaplain who visited the segregation unit on 14 January, and with the staff who worked that day, to ensure they are aware of the Ombudsman's findings.

The Head of Healthcare should share this report with the nursing associate so she is aware of the Ombudsman's findings.

Inquest

80. The inquest concluded on 8 January 2024. The Coroner determined that Mr Kalay died from COVID-19 pneumonia. He set out his concerns in a narrative verdict, and they echo those raised in this report.

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