Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Kevin Kane, a prisoner at HMP Grendon, on 29 January 2024

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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Kevin Kane died after he was found hanging in the wing toilet block on 29 January 2024 at HMP Grendon, a therapeutic community. He was 57 years old. I offer my condolences to Mr Kane's family and friends.

Mr Kane had been at Grendon since 2017. He was assessed as a risk to himself for a short period in December 2023 and managed under prison suicide and self-harm support measures. Around this time, Mr Kane's relationships on the wing deteriorated and he removed himself from therapy. This resulted in him losing two of his significant forms of support and my investigation found that the impact of these factors on his risk to himself was not holistically assessed. A lack of consistent and open information sharing compounded this. In addition, staff failed to effectively follow Grendon's safeguarding policy when a vulnerable prisoner made allegations against Mr Kane.

Cells at Grendon do not have toilets and prisoners are unlocked on request during the night. The night sanitation system relies on staff to monitor alarms, and ensure prompt action is taken when a prisoner is out of their cell too long. The failure of staff to identify that the alarm had been activated meant that Mr Kane was not found for 44 minutes. I am satisfied that Grendon has since taken action to improve the response time of staff if an alarm sounds.

Grendon operates very differently from standard prisons but that makes it all the more important that appropriate safeguards and robust quality assurance processes are in place.

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

Adrian Usher
Prisons and Probation Ombudsman **September 2024**

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Summary

Events

1. In March 2016, Mr Kevin Kane was charged with serious sexual offences and remanded to prison. In June, he was sentenced to life imprisonment. He spent time in several prisons before he transferred to HMP Grendon in May 2017. Mr Kane moved to A wing and joined therapy group four. He had a history of suicide attempts. However, he seemed to settle at Grendon.

2. In March 2020, Mr Kane withdrew from therapy. Grendon then became subject to COVID-19 lockdown procedures, resulting in a restricted regime. Mr Kane started therapy again in December.

3. In October 2023, another prisoner alleged that Mr Kane had made sexual comments towards him. Mr Kane's relationships with other prisoners began to deteriorate.

4. In December, prisoners raised further concerns about Mr Kane's conduct towards others on the wing. In a group meeting, Mr Kane disclosed he had written a suicide note and make a noose. Staff started Prison Service suicide and self-harm monitoring and support procedures, known as ACCT. Staff closed the ACCT after eight days.

5. On 3 January 2024, Mr Kane said he no longer wanted to attend therapy and he attended his final session. He isolated in his cell between 8 and 13 January for medical reasons. On 22 January a psychologist assessed Mr Kane. She noted he was low in mood and frustrated as he had withdrawn himself from therapy. She had no concerns he was a risk to himself. On 23 January, he asked staff for information about moving to another prison.

6. At 4.46am on 29 January, Mr Kane was let out of his cell so that he could use the toilet. (There is no in-cell sanitation at Grendon so prisoners must use the toilet block on the wing. When a prisoner is locked in their cell, they have to press a button to request access to the toilet block and then their cell is unlocked remotely.) Eight minutes later, the sanitation system recognised that Mr Kane had not returned to his cell and an alarm sounded in the control room and wing office. This alarm went unnoticed until 5.29am, when wing staff alerted the control room.

7. Control room staff tried to contact Mr Kane via his intercom, but he did not respond. They radioed other staff who went to the wing and found Mr Kane hanging in the toilet block at 5.38am. Staff radioed a medical emergency code and started CPR. Control room staff called an ambulance but due to the lack of information provided this was not dispatched as the highest priority. At 6.19am, staff called 999 again and told them that CPR was in progress. The priority of the ambulance was increased, and paramedics arrived at 6.43am. They pronounced that Mr Kane had died at 7.28am.

Findings

8. Prison staff did not consider Mr Kane's risk as whole when he withdrew from therapy. There is not a comprehensive out of therapy policy governing the management of Grendon's out of therapy population.

9. Staff did not appropriately safeguard Prisoner A. Staff did not investigate alleged repeated comments of a sexual nature made to Prisoner A by Mr Kane. Staff failed to deal with or challenge the alleged conduct of Mr Kane. This resulted in Mr Kane becoming isolated on A wing.

10. We are not satisfied that staff accurately and appropriately recorded and shared information. Without an open and transparent approach to information sharing, it is difficult to see how staff could have effectively assessed Mr Kane's risk.

11. On the morning of 29 January, there was a 35 minute delay before staff realised that Mr Kane had been out of his cell over the allotted eight minutes. This was completely unacceptable. The initial ambulance call gave insufficient information for the ambulance service to appropriately prioritise the call leading to a further delay in paramedics attending. It was nearly two hours from when Mr Kane left his cell to paramedics arriving to treat him.

Recommendations

- The Governor and Head of Healthcare should update the out of therapy policy, ensure staff are familiar with it and that it includes guidance on:
    - How to ensure that a prisoner's risk to himself is explicitly considered holistically once they stop therapy;
    - The regime that an out of therapy prisoner will have access to; and
    - How the therapy team should engage with a prisoner when they stop therapy.
- The Governor should ensure that staff are aware of, and effectively implement, Grendon's safeguarding policy and that potential allegations of abuse are not solely dealt with in group meetings.
- The Governor and Head of Healthcare should ensure that all relevant information about a prisoner is documented and shared appropriately and that there are robust quality assurances process in place to check this is happening routinely.

The Investigation Process

12. HMPPS notified us of Mr Kevin Kane's death on 29 January 2024.

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

14. The investigator visited HMP Grendon on 5 February. She obtained copies of relevant extracts from Mr Kane's prison and medical records and interviewed a prisoner.

15. The investigator interviewed 14 members of staff at Grendon and one via MS Teams in March.

16. NHS England commissioned a clinical reviewer to review Mr Kane's clinical care at the prison. She attended eight joint interviews with the investigator at Grendon.

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

18. The Ombudsman's office contacted Mr Kane's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond.

19. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

20. Mr Kane's next of kin were informed the draft report was available but did not wish to receive a copy or make any comment.

Background Information

HMP Grendon

21. HMP Grendon is a category B adult male training prison and is one of only two prisons in England and Wales that undertake accredited therapy in democratic therapeutic communities. Practice Plus Group provides physical healthcare services. Oxford Health NHS Foundation Trust provides mental healthcare services. Healthcare staff are not on duty overnight.

22. The cells at Grendon (all single cells) do not have in-cell sanitation. Instead, they have communal toilet and washroom blocks. An automated unlocking system allows prisoners to access the toilets during lock-up periods. A prisoner must press the sanitation button and his door will be unlocked automatically, provided that no other prisoner is out of his cell. The prisoner has eight minutes to complete his visit and, on return to his cell, must enter a code to confirm his return. The system automatically locks his door and the next prisoner waiting can be let out. If the prisoner does not return to his cell, an alarm rings in the control room and the wing office and the control room operator will take steps to check on that prisoner's wellbeing, including using the intercom system to ask the prisoner to return to their cell and contacting A wing officer to check on them.

HM Inspectorate of Prisons

23. The most recent inspection of Grendon was in May 2023. Inspectors reported relationships established within the wing community developed a sense of belonging and trust, and prisoners learned to manage their behaviour positively. Prisoners were encouraged to take responsibility for the consequences of their behaviour, and sanctions for breaches of rules were made collectively, as a group. The therapeutic process and excellent supportive relationships among prisoners and staff also made sure that adult safeguarding issues were identified and could be addressed appropriately. Relationships between staff and prisoners, and prisoners and their peers, were excellent. The therapeutic environment helped foster good communication, respect and trust, and allowed prisoners and staff to challenge each other's behaviour constructively.

24. Inspectors noted that most prisoners did not have in-cell sanitation. They found this outdated, and the alternative offered, a plastic pot, was unhygienic.

25. Inspectors found that many prisoners who had finished or discontinued participation in therapy (referred to as 'out of therapy') were not able to move elsewhere within a reasonable timescale, primarily due to population issues at a national level.

Independent Monitoring Board

26. 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 2022, the IMB reported that night sanitation continued not to meet basic decency levels on too many occasions. During busy periods, prison staff provided prisoners with pots to use without running water in the cell to wash their

hands or meet basic hygiene needs. The IMB also found that too many men spent too long out of therapy, with their presence becoming disruptive for those in therapy. However, they found that staff prisoner relationships were generally excellent, with 92% of prisoners reporting that they felt treated with respect.

Previous deaths at HMP Grendon

27. Before Mr Kane's death, there had not been any deaths at Grendon since a self-inflicted death in December 2019. In that investigation, we made recommendations about the processes following a prisoner failing to return to their cell after using the sanitation system, and information shared with the ambulance service to minimise delay in the emergency services response.

Assessment, Care in Custody and Teamwork (ACCT)

28. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide and self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.

29. As part of the process, staff put in place a care map (plan of care, support, and intervention). The ACCT plan should not be closed until all the actions of the care map have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Therapeutic Community

30. Prisoners in the therapeutic community belong to a community (a wing), and a specific therapy group within that community. A wing, where Mr Kane was located, is a wing specifically for men convicted of sexual offences.

31. Men in therapy attend two community meetings per week. Monday is a therapeutic community meeting (for those in therapy), and Friday is the business community meeting where out of therapy individuals also attend. These meetings provide an open forum for communication to discuss issues and debate the standards and expectations for the wing.

32. Group therapy occurs three times a week in smaller groups. The community will assemble for group feedback following group therapy.

33. Every person (prisoners and staff) should challenge inappropriate, disruptive or threatening behaviour, or any behaviour that goes against community rules.

Group Special

34. Group specials are meetings that are called by prisoners to meet with their small therapy group to discuss any urgent issue that is troubling them. These are meetings outside of the usual community meetings and group therapy meetings.

Wing Special

35. Like a group special, however this calls the entire wing to a meeting to discuss any urgent and/or exceptional issue.

Grouping

36. Groupings are meetings to challenge inappropriate and/or offence related behaviour of an individual within a particular group. Any individual, including staff or a prisoner can request a group with another community member.

Winging

37. Wingings are like a grouping but allow the whole community to challenge the inappropriate and/or offence related behaviour of an individual.

Commitment

38. If a prisoner breaches the rules of the community they can be placed on commitment. The whole community, including staff, will vote on whether the prisoner should be placed on commitment. If placed on commitment, the individual will have the opportunity to present their case to the community. The community will then vote on whether the individual can remain in the community, or not.

Out of therapy

39. A prisoner is out of therapy if they are no longer engaging in the therapeutic programme. This may be because they have withdrawn from therapy, completed therapy, or been voted out during a commitment vote.

40. An out of therapy prisoner will not attend group therapy sessions, but will attend Friday community meetings, wingings, and wing specials. These prisoners are expected to transfer to another prison. However, this is difficult due to population pressures across the prison estate. In January 2024, 11% of Grendon's population were out of therapy.

The Parole Board

41. A prisoner can apply to the Parole Board for release from prison and/or a move to a different category prison. They can only apply for release from prison if they have served the minimum tariff on their sentence. Reports will be produced by the prisoner's prison offender manager, community offender manager, and any other involved professional as requested by the Parole Board to assist their decision

making. A prisoner may also be assessed by a psychologist for a Parole Risk Assessment.

Key Events

42. In March 2016, Mr Kevin Kane was charged with serious sexual offences against a child. He was remanded to prison and taken to HMP Forest Bank. In April, he transferred to HMP Altcourse. In June, Mr Kane was convicted and sentenced to life imprisonment with a tariff (minimum time he would spend in prison) of six years and 263 days.

HMP Grendon

2017 – 2022

43. Mr Kane transferred to Grendon on 8 May 2017. Following three months on the assessment wing, Mr Kane transferred to A wing and was assigned to his small therapy group (group four). Entries on the digital prison system up to August 2019, show that Mr Kane settled well on A wing and engaged with therapy, staff and peers. In August, Mr Kane informed the group that he was intending to leave Grendon as he 'couldn't stand it' anymore. Following support from the community, he remained in therapy at Grendon.

44. In February 2020, Mr Kane withdrew from therapy due to difficulties with another prisoner in the group. This meant that Mr Kane could no longer remain at Grendon and needed to transfer to another prison. In March, Grendon became subject to COVID-19 lockdown procedures, resulting in a restricted regime and increased time in-cell. In addition, all transfers were put on hold.

45. In November, Mr Kane applied to return to his therapy group. He returned to therapy in December. In June 2021, the community supported Mr Kane to become Vice Chair of the wing, and he progressed to Wing Chair in November. Prison records were positive about Mr Kane's conduct over this period.

46. In September 2022, Mr Kane attended a wing meeting to explore allegations that he had 'been sexual' towards several prisoners. Mr Kane engaged with the therapeutic process regarding this issue. (The therapeutic approach taken at Grendon means that issues relating to alleged inappropriate behaviour are dealt with through the community approach rather than being subject to a more formal investigation by staff, as might take place in a standard prison.)

47. In December, Mr Kane received the Parole Board decision that he should remain in closed conditions and was not suitable for transfer to a lower security prison. Mr Kane accepted this and said it was what he had expected. However, he called a group special on the 14 December as he felt irritated and was struggling following this decision. The group supported and reassured Mr Kane.

2023

48. In February 2023, Mr Kane engaged with his eighth interim assessment. These occurred every six months and assessed Mr Kane's therapeutic progress and goals. Mr Kane said he wanted to progress and move on from Grendon within 12 months.

49. On 13 October, Prisoner A, a substantially younger prisoner, described feeling unsafe due to alleged sexual comments made towards him by Mr Kane. Mr Kane called a group special to share his upset at causing distress to Prisoner A.

50. Mr Kane had requested the chaplaincy service contact his siblings via the Samaritans service. On 15 November, the chaplaincy department informed Mr Kane that his siblings had declined contact with him. (Mr Kane made no phone calls and received no visits at Grendon.)

51. At the beginning of December, therapy notes refer to Mr Kane as conflicted and angry. Mr Kane referred to himself as 'withdrawing from people and not functioning socially'. Other prisoners felt that Mr Kane was manipulative, asserting influence over and excluding others. Mr Kane had been holding informal debrief sessions with several members of group four in his cell following group meetings, contrary to the A wing Constitution (a set of agreed rules governing the A wing community). The therapy manager told us that she believed Mr Kane 'groomed' other prisoners and possibly some of the staff.

52. On 8 December, group four faced a group winging. A group special was held following the winging, with Mr Kane stating that he wanted to withdraw from therapy.

53. On 11 December, Mr Kane attended healthcare due to stomach pain and a sore throat. He also disclosed that he had an issue but would not share what the problem was. Healthcare staff shared this information with wing staff.

54. On 12 December, Mr Kane attended group therapy and appeared 'quiet and defeated'. He did not want to share his reasons for leaving therapy.

55. On 13 December, during group four's winging, prisoners raised further concerns about Mr Kane's conduct towards others in the community. Mr Kane declined to attend the winging. The winging resulted in a wing special to share concerns about Mr Kane's conduct. Mr Kane initially declined to attend; however, he attended the meeting shortly after it began. When challenged about his conduct, Mr Kane disclosed that the previous night he had made a noose and written a suicide note. The meeting concluded by the community voting to put Mr Kane on commitment. An officer started Prison Service suicide and self-harm monitoring procedures, known as ACCT, for Mr Kane. He was subject to three observations per hour.

56. An officer did Mr Kane's ACCT assessment. He noted that Mr Kane '*said that his emotions had built up for quite some time, he knew that he was due to be put on the spot within group therapy and his answer to this was to escape by being out of this life…Kevin's answer to everything was to be away from this world by taking his own life*'. A Supervising Officer (SO) relocated Mr Kane to C wing, in the safer cell (which has fewer ligature points and is more easily observed), due to the frequency of his ACCT observations.

57. The SO chaired the first ACCT review the next day. Mr Kane, a nurse from the mental health team, an officer, a representative from the Independent Monitoring Board and from the chaplaincy department also attended. The panel agreed to reduce Mr Kane's observations to one every two hours in the day, and one every hour in the night. Mr Kane reported having no current thoughts of suicide or self-harm

and said he would try not to isolate himself. The panel wanted to continue monitoring Mr Kane on his return to A wing which happened later that day.

58. After the ACCT review, the nurse completed a mental health assessment with Mr Kane. Mr Kane said he had, gone through a 'bad patch' with interpersonal issues but was working on this. He did not feel the mental health team could assist him and declined their services. The nurse followed up with a visit to Mr Kane on the wing the next day. Mr Kane declined a further visit from him on 16 December.

59. The SO chaired an ACCT review on 18 December, which was also attended by a nurse, an officer and a trainee forensic psychologist. The panel agreed to reduce Mr Kane's observations to three meaningful conversations in the day and observations every two hours during lock up and overnight. The panel discussed Mr Kane's view that the ACCT should be closed but advised caution. They noted that there had been no issues around suicide or self-harm. Mr Kane referred to a 'secret' that he would like to speak to the therapy manager about, but said he had no thoughts of suicide or self-harm. During interview, the therapy manager could not recall if she had been made aware of this or not.

60. On 19 December, a Custodial Manager (CM) and the therapy manager told Mr Kane that staff had backed his commitment vote and he was suspended from his red-band job (employment reserved for trusted prisoners), in line with the normal local policy. Mr Kane had been suspended as his commitment to therapy was in question. Mr Kane accepted the decision.

61. The SO chaired an ACCT review on 21 December. Mr Kane, an officer, and a representative from chaplaincy and the mental health team attended. All agreed to close the ACCT as there had been positive progress with Mr Kane engaging with the community and no reported issues of self-harm. Mr Kane denied any thoughts of suicide or self-harm. He explained that his risk indicators would include isolation, not showering, and him struggling to speak with anyone.

62. On 29 December, the SO and Mr Kane completed the ACCT post closure review. Mr Kane stated he felt, 'done with the community and feels he will not survive his upcoming commitment vote'. He also said he was unhappy about being suspended from his red-band job.

January 2024

63. Mr Kane attended group therapy on 3 January 2024. He told the group that he was 'done' and had felt unsupported by the community. Mr Kane did not attend any further group therapy sessions. Staff we interviewed were unclear about how an individual officially leaves therapy. To leave therapy a prisoner should complete transfer papers (a request to transfer to another prison establishment). However, Mr Kane did not complete these.

64. On 8 January, Mr Kane told staff that he felt unwell. Healthcare staff advised him to isolate in his cell for 48 hours. A nurse recorded that Mr Kane had provided an inconsistent story and staff had shared concerns that the allegations made by another prisoner about Mr Kane may have been having an impact on Mr Kane's isolating. During interview, the wing therapist questioned whether Mr Kane's isolation was due to his situation on the wing rather than ill health. However, two SOs were

satisfied that Mr Kane was experiencing genuine physical illness. On 11 January, an officer checked how Mr Kane was feeling. Mr Kane told him that he felt physically ill but was mentally well. The officer discussed opening an ACCT with Mr Kane, but they both agreed it was not necessary. During interview, a SO felt Mr Kane was being genuine. Mr Kane stopped isolating on 13 January.

65. On 22 January, Mr Kane met a psychologist to discuss his parole risk assessment (a psychological assessment of an individual's risk of re-offending). She recorded that Mr Kane presented as low and frustrated because he had decided to withdraw himself from therapy. She had no concerns that he was a risk to himself.

66. On 23 January, Mr Kane met his Prison Offender Manager (POM). Mr Kane told her that he was out of therapy as he could not engage with the community. She told us that Mr Kane was aware that his community offender manager continued to recommend to the Parole Board that he remain in closed conditions. (It is not clear when Mr Kane was told about this recommendation.) Mr Kane's parole hearing was due in February 2024. He requested information regarding a transfer to another prison.

67. As A wing was being refurbished, prisoners living there were due to move to B wing on the 29 January. On 27 January, prisoners helped clean B wing. Staff told us that Mr Kane was helpful in doing so and interacted with prisoners normally throughout the day.

68. On 28 January, Mr Kane asked the Wing Chair whether he was going to be subject to a winging the following day. The Wing Chair told Mr Kane that he would be informed before a winging took place. Staff told us that it would depend on what else was scheduled for that week and they would prioritise accordingly whether there would be a winging. As part of a routine check of all prisoners at 9.00pm, an Operational Support Grade (OSG) checked Mr Kane. She told us that she could not recall doing so but if there had been an issue, she would have reported this.

Events of 29 January

69. There is no CCTV on A wing. The investigator watched body worn video camera (BWVC) footage and listened to prison radio transmissions from 13 October. She also obtained information from the local ambulance service. The following account has been taken from all sources.

70. On 29 January at 4.46am, Mr Kane's cell was automatically unlocked via the sanitation system. Mr Kane had eight minutes to return to his cell before an alarm would alert in the control room and the wing office. Control room staff can either accept the alarm by pressing a button which stops the auditory alarm for the control room and wing office, but the screen would still flash, or reset the alarm which stops both the auditory and visual alarm. The wing office cannot accept or reset the alarm for the control room. During interview, the OSG stated that she was making her breakfast and then watching TV at the time the alarm would have sounded. She did not hear the alarm and did not check the sanitation screen. She said she would not normally do this regularly.

71. Another OSG was working alone in the control room that night. She could not recall her exact movements at the time Mr Kane was let out of his cell but believed she had

made breakfast and had used the bathroom; she did not recall hearing the auditory alarm or seeing the visual alarm.

72. At 5.29am, the wing OSG noticed the sanitation alarm flashing on her screen and radioed the control room asking the other OSG to contact Mr Kane as she could not enter the landing while a prisoner was out of his cell. The control room OSG attempted to contact Mr Kane via the intercom in his cell, but he did not respond. At 5.33am, the wing OSG radioed the CM and two officers, asking them to attend A wing 2s landing. Officer A and the CM had already made their way to the control room having heard the OSG raise the concern about the sanitation alarm over the radio. They went straight to the landing and got there at 5.37am. They went to Mr Kane's cell where they noted that he had used bedding and pillows to make it look like he was in his bed. As he was not in his cell, staff went to the toilet block where they found Mr Kane hanging from a pipe on the ceiling. He had used torn bedsheets as a ligature.

73. At 5.38am, the CM radioed a code blue (an emergency code indicating that a prisoner is either having difficulty or not breathing). Officer A cut the ligature and, along with the other officer, supported Mr Kane to the floor. The CM began CPR. The wing OSG immediately called an ambulance and told the 999 operator that there was a code blue at the prison, but she had no further information. The ambulance call handler stated an ambulance had been dispatched.

74. At 6.19am, the CM radioed the SG to check the status of the ambulance. She called 999. She told the operator that CPR was in progress. The ambulance had recently been dispatched but on the basis of this information the operator upgraded it to the highest priority. Paramedics arrived at Mr Kane at 6.43am and took over treatment. They pronounced Mr Kane dead at 7.28am.

Contact with Mr Kane's family

75. The prison appointed a family liaison officer. Mr Kane had no next of kin recorded in his prison record. Having made contact through the Salvation Army family tracing service, Mr Kane's next of kin was informed of Mr Kane's death at 4.20pm on 29 January 2024. Grendon contributed to Mr Kane's funeral costs in line with national instructions.

Support for prisoners and staff

76. An officer said that following the event, he and the other staff went to an office to complete statements and wait for the police. At approximately 10.00am, a senior manager told them to go home.

77. Emergency response staff interviewed said that they did not attend a hot or cold debrief with the management team. There is no record of any debrief. Several members of staff interviewed stated that they would have liked to attend a debrief. The staff care team offered support to those involved. The Governor told us that a debrief took place on 29 January. However, it did not include the emergency response staff who had already left the prison.

78. The wing therapist told prisoners on A wing about Mr Kane's death that morning. The community held a wing special where prisoners and staff were able to share their thoughts and feelings around Mr Kane's death.

79. The prison posted notices informing other prisoners of Mr Kane'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 Kane's death.

Post-mortem report

80. The pathologist concluded that Mr Kane died as a result of hanging. They also noted that Mr Kane tested positive for COVID-19 which they concluded may have contributed to his state of mind when he died.

Findings

Risk of suicide and self-harm

81. Prison Service Instruction (PSI) 64/2011, which governs ACCT suicide and self-harm prevention procedures, requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures. Mr Kane had some risk factors for suicide and self-harm. He had attempted suicide in the past. In addition, Mr Kane had previously suffered from depression, presented as hopeless and withdrawn in the days before his death and had no social support outside of prison.

82. Mr Kane engaged with therapy at Grendon for over six years. Staff told us that Mr Kane's primary protective factor was being in therapy. A SO also said that his other protective factors were his small group, his relationships with his peers and staff, the wing, and his red-band job.

83. From October 2023, there was a notable decline in Mr Kane's presentation and relationships with other prisoners on the wing. Mr Kane was alleged to have made sexually inappropriate comments to another prisoner, was considered to be manipulative, and had possibly 'groomed' other prisoners and staff. Staff opened an ACCT for eight days in December, after Mr Kane said he had made a noose and written a suicide note. Staff assessed that Mr Kane saw ending his life as an alternative when faced with a situation he feared. Mr Kane attended his final therapy group on 3 January 2024. He self-isolated between 8 January and 13 January, stating he was physically unwell. Some staff considered that Mr Kane's isolation may not have been due to a genuine physical sickness.

84. At this point, Mr Kane presented as withdrawn, had left therapy abruptly, and his POM had told him that his community offender manager had recommended to the Parole Board that he remain in closed conditions. Mr Kane had no support outside the prison and knew that the transfer from Grendon would be difficult due to a shortage of appropriate prison spaces.

85. We conclude that in the weeks leading to his death, staff did not sufficiently, or holistically, consider the impact of Mr Kane's withdrawal from therapy, worsening relationships on his wing and in his small group, upcoming winging and the move to B wing (which was apparently causing apprehension for the whole community) on his risk of suicide.

Out of therapy

86. When Mr Kane left therapy, he was considered an 'out of therapy' prisoner. The out of therapy regime is like that for prisoners in therapy apart from that out of therapy prisoners are locked up when the Monday community meeting and small group therapy meetings are taking place. At the time of writing in May 2024, approximately 11% of Grendon's population were out of therapy. Once prisoners are out of therapy they should be transferred to another prison but there can be significant delays in finding them suitable places.

87. Grendon's out of therapy policy focuses primarily on the initial process following the decision to end therapy but does not reflect the regime an out of therapy prisoner will be subject to.

88. When issues are raised within the community, prisoners are encouraged to take these to their group. It is unclear where those who are out of therapy can raise issues, other than a brief slot at a Friday community meeting. Those interviewed said that Mr Kane would have been able to call a wing special. However, given Mr Kane had left therapy abruptly, possibly due to relationships on the wing, this may not have felt possible for him.

89. We are concerned that there is not a comprehensive out of therapy policy governing the management of these prisoners. While the support offered is significantly more than in non-therapeutic prisons, out of therapy prisoners have lost a source of considerable support. Both HMIP and the IMB reported that those out of therapy can be disruptive, possibly caused by a lack of support, activity, or awareness of their next steps.

90. The clinical reviewer also concluded that when Mr Kane withdrew from therapy, his risk factors were not sufficiently considered. She recommended that the therapy team should review the period immediately after a prisoner withdraws from therapy to consider if there are any further opportunities to monitor a prisoner's well-being. We make the following recommendation:

    The Governor and Head of Healthcare should update the out of therapy policy, ensure staff are familiar with it and that it includes guidance on:

    - **How to ensure that a prisoner's risk to himself is explicitly and holistically considered once they stop therapy;**
    - **The regime that an out of therapy prisoner will have access to; and**
    - **How the therapy team should engage with a prisoner when they stop therapy.**

Safeguarding

91. There were three documented instances where Mr Kane was alleged to have made inappropriate comments of a sexual nature to other prisoners. Following allegations in September 2022 and October 2023, there is little evidence of any action being taken in relation to Mr Kane. In December 2023, Prisoner A disclosed further information about Mr Kane's behaviour during a wing special. The alleged comments made by Mr Kane were overtly sexual.

92. During interview, the therapy manager recalled that Prisoner A had also previously disclosed to her specific instances where Mr Kane had allegedly made inappropriate comments and had 'scared' Prisoner A.

93. The ethos at Grendon is for prisoners in therapy to bring any issues or concerns to their group to discuss openly and to work through therapeutically. Challenge, Support, and Intervention Plans can be opened if necessary (CSIP – used to support perpetrators of or victims of violence).

94. There were ongoing concerns of sexual harassment and/or inappropriate comments of a sexual nature from Mr Kane towards a vulnerable prisoner. The therapy manager thought that this should not be dealt with or challenged until Prisoner A, the alleged victim, could confront Mr Kane, the alleged abuser, in the group setting. Staff did not open a CSIP, which would have allowed the safer custody team to monitor and manage the issues, and it does not appear that any proper discussion or intervention took place prior to the special on 13 December. Mr Kane's personal officer did not speak directly with Mr Kane about the allegations as he thought the matter should be explored in the group.

95. It is difficult to see how either Prisoner A or Mr Kane was appropriately safeguarded by staff on A wing. Prisoner A's disclosures were serious and offence paralleling, and Mr Kane was not challenged until the group special on the 13 December. Notably, the therapy manager had not shared Prisoner A's disclosures with other members of A wing staff, nor were they recorded anywhere, so staff were not aware that they may need to consider increased monitoring of contact between Mr Kane and Prisoner A.

96. Grendon's *Safeguarding Vulnerable Adults and Children Strategy*, states that all prisoners are considered vulnerable adults and are therefore covered by the policy. It details the parameters of abuse, and we consider that the allegations made by Prisoner A about Mr Kane fell within this. It instructs that if staff have concerns about prisoners, they should ensure they are confronted, and appropriate disciplinary action is instigated. It notes that it is important that all reports are taken seriously and followed up effectively to prevent further abuse. It details that staff should record the information on the prisoner's record and make an adult safeguarding referral to the safer custody team. The safer custody manager should then action this and interview the relevant prisoner(s). This could lead to no action being taken, further discussion at the safer custody meeting or an immediate meeting being convened if urgent. The prisoner should also be appropriately supported. We conclude that prison staff did not follow the safeguarding strategy. It appears that staff had limited awareness of this policy. We make the following recommendation:

The Governor should ensure that staff are aware of, and effectively implement, Grendon's safeguarding policy and that potential allegations of abuse are not solely dealt with in group meetings.

Information Sharing/Recording

97. Staff recorded information about Mr Kane in several places including handwritten therapy notes, community meeting minutes held in a folder in the wing office, the wing observation book, his computerised prison record, interim assessments and within his case file. The therapy manager also held regular one to ones with Mr Kane which were not recorded. She accepted during interview that record keeping needed improvement.

98. Staff discussions appear to have taken place primarily at a weekly business meeting. Therapeutic staff, prison staff, and staff from the offender management unit attend this meeting. However, information sharing between departments, particularly the wing and offender management unit, was insufficient. For example, the POM was unaware that Mr Kane was on an open ACCT and was unaware of the allegations

made by Prisoner A against Mr Kane. Once Mr Kane was out of therapy, there was very little information recorded about him. Mr Kane's risk to himself and others could not be holistically assessed without an open and transparent approach to information sharing.

99. The clinical reviewer shared our concerns about documentation and information sharing commenting that within the therapeutic team this appeared to be informal and lacked the necessary structure to ensure key information was always shared. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all relevant information about a prisoner is documented and shared appropriately and that there are robust quality assurances process in place to check this is happening routinely.

Sanitation System

100. On 29 January at 4.46am, Mr Kane was released from his cell by the automatic sanitation system. At 4.54am, eight minutes later, an auditory alarm sounded in the control room and wing office alerting staff that Mr Kane had not returned to his cell.

101. There was a significant and unacceptable delay between the sanitation alarm sounding at 4.54am and Mr Kane being found at 5.38am. The wing OSG said that she was out of the wing office at the time the alarm sounded and thought control room staff were able to deal with it. The control room OSG said that she did not remember hearing the alarm but told the investigator that the auditory alarm did not always sound in the control room.

102. The Governor of Grendon commissioned an investigation into these events, which concluded that the sanitation system was working, and the alarm should have sounded. The investigation concluded that the only reason for the alarm not to sound would be if the sound were turned down or the mute button pressed. The control room OSG said she did not use the mute button. The investigation recommended a disciplinary hearing for her. She resigned before this could take place. No investigation took place into the wing OSG's actions. We are concerned that the wing OSG was the control room operator in the most recent previous self-inflicted death at Grendon when there was also a delay in finding the prisoner unresponsive related to the sanitation system. She told us no one had spoken to her at all about her actions. We bring this to the Governor's attention.

103. Following Mr Kane's death, Grendon has introduced a new system which ensures that, if the audible alarm is cancelled but the prisoner has not returned to his cell, the alarm will resound after 15 minutes. The prison told us that there had been no missed alarms since the new system had been introduced. The Governor will want to continue to monitor this.

Emergency Response

104. PSI 03/2013, Medical Emergency Response Codes, contains mandatory instructions that staff must use emergency codes to clearly convey the nature of the medical situation and that on hearing a code blue, control room staff must call an ambulance

immediately. The HMP Grendon and South Central Ambulance Service Emergency Call Out Protocol (2016-17) and Mandatory Code System set out that as much information as possible must be given to the control room and that this must be passed on to the ambulance service. The CM radioed a code blue at 5.38am. The control room OSG immediately called an ambulance and told the 999 operator that there was a code blue at the prison. The operator said an ambulance would be dispatched. This was classed as a category two priority (meaning an emergency or potentially serious condition). The ambulance was dispatched at 6.09am.

105. The OSG was unable to recall during interview when she became aware that CPR was in progress. At 6.19am, after the CM asked for an update on the ambulance, she called 999 again, 41 minutes after the initial call, and told the operator that CPR was in progress. At this point, the operator graded the call as a category one (meaning a life-threatening situation or resuscitation is in progress).

106. HMPPS has acknowledged that policy and practice with regard to calling ambulances in precisely circumstances such as these, is not optimal. At a conference hosted by the PPO in January 2024 and attended by HMPPS and representatives from the ambulance service, HMPPS made a commitment to tangible improvements in this policy area. In these circumstances, we make no recommendation, but HMPPS will want to reflect on another case that highlights the seriousness of the problem.

Clinical Care

107. The clinical reviewer concluded that overall, the healthcare Mr Kane received was of a reasonable standard and therefore equivalent to that which he could have expected to receive in the wider community. Mr Kane received appropriate support from the mental health team. The clinical reviewer made some recommendations in relation to the delay in the emergency response which the Head of Healthcare will wish to consider.

Good Practice

108. The CM and Officer A acted swiftly when they found Mr Kane. They continued to deliver chest compressions for over 70 minutes despite being distressed, in shock and exhausted. Even after paramedics arrived, they continued to provide support. Their actions should be recognised and commended.

Inquest

109. At the inquest, held from 21 to 24 July 2025, the jury concluded that Mr Kane died by suicide. The jury noted that the time taken to identify Mr Kane to be out of his cell possibly contributed to his death.

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