Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Christopher Keeling, a prisoner at HMP Doncaster, on 18 September 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

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 Christopher Keeling died from mixed drug (tramadol, morphine, fentanyl and midazolam – all prescription medication) toxicity on 18 September 2022, at HMP Doncaster. He was 63 years old. I offer my condolences to his family and friends.

Mr Keeling had terminal oesophageal cancer and had been prescribed all the medication found in his system, apart from tramadol, which was at four times the lethal range. It is unknown how he obtained and took this medication. Police were satisfied that no one else had administered it to Mr Keeling. The evidence suggests that Mr Keeling took the tramadol with the intention of ending his life.

The clinical reviewer found that the care Mr Keeling received at Doncaster was generally good and was equivalent to that which he could have expected to receive in the community. However, she found that there had been some delays in Mr Keeling receiving his prescribed pain relief medication and in him getting an appropriate diet.

There were long delays in progressing the application for Mr Keeling's early release on compassionate grounds due to the omission of a specialist medical report. More could have been done to progress this and I have recommended that the prison reviews its process to avoid such lengthy delays in future.

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 **August 2024**

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Summary

Events

1. In April 2017, Mr Christopher Keeling was given a life sentence for murder.

2. In November 2021, while at HMP Lindholme, Mr Keeling was diagnosed with cancer of the oesophagus (food pipe). He was not fit enough for surgery or chemotherapy, so doctors fitted a stent (a small tube) in his oesophagus to keep it open. Doctors advised that Mr Keeling should be moved to a prison with 24-hour healthcare.

3. On 11 February 2022, Mr Keeling was moved to HMP Doncaster. He was allocated a care manager, the Palliative Care Lead, who saw him weekly, and he was reviewed regularly at Multi-Professional Complex Care Case (MPCCC) meetings.

4. Mr Keeling was prescribed a range of pain relief medication. On 24 March, he complained that he was going 14 hours (instead of 12 hours) without his medication and asked for a patch so his pain relief could be administered continuously. This was not prescribed until 5 April, and then because of stock issues was not provided to Mr Keeling until 13 April.

5. Mr Keeling needed a soft diet due to his condition. In June, he made three complaints that he was not getting a suitable diet. Healthcare staff addressed this with the kitchen manager.

6. On 25 April, the prison submitted an application for Mr Keeling's early release on compassionate grounds to the Public Protection Casework Section (PPCS) of HMPPS. PPCS responded the same day to say that a specialist medical report with Mr Keeling's prognosis was missing from the application. Healthcare staff tried to get a report from the hospital's palliative care consultant, but he declined to provide one. On 19 August, the prison submitted various hospital letters to PPCS, but none specified a prognosis. PPCS refused the application on 13 September.

7. Mr Keeling's condition deteriorated at the end of August, when he became very weak and unwell. On 9 September, he was admitted to hospital and given two units of blood due to low haemoglobin levels. He was discharged on 11 September. When he returned to Doncaster, he said he wanted to sleep and just slip away as he had had enough. Healthcare staff increased his pain relief medication in line with the hospital discharge letter.

8. Mr Keeling died on 18 September. The post-mortem report concluded that he died from mixed drug (tramadol, morphine, fentanyl and midazolam) toxicity. Mr Keeling had not been prescribed tramadol, which was at four times the lethal range.

Findings

9. It is unknown how Mr Keeling obtained and administered tramadol. The police investigated and were satisfied that no one else administered it to him. There was no medication missing from the prison pharmacy. It appears that Mr Keeling obtained it illicitly, but it is unclear how. Mr Keeling left no note so while it is not

possible to say for sure, the evidence suggests that Mr Keeling took an excessive amount of tramadol with the intention of ending his life.

10. The clinical reviewer concluded that the care Mr Keeling received was generally good and equivalent to that which he could have expected to receive in the community. However, she found that there had been issues with providing Mr Keeling with a suitable diet and delays with prescribing and dispensing medication. The Acting Matron at Doncaster advised that the delays had been due to having an external pharmacist and there was now a pharmacist on site.

11. The application for compassionate release was handled poorly. Staff should have known to attach a specialist medical report, with a prognosis, at the outset. Healthcare staff could have done more to try to obtain this.

Recommendations

- The Head of Healthcare should ensure that the new measures in place are audited at frequent intervals to ensure that pain relief and end of life medications are sourced and dispensed in a timely manner.

- The Head of Healthcare should ensure that when a specific diet is advocated, the healthcare team maintain contact with the kitchen to ensure appropriate food is available, which is varied and balanced.

- The Director and Head of Healthcare should review the process in place for preparing applications for early release on compassionate grounds to ensure that the necessary evidence is obtained as quickly as possible.

The Investigation Process

12. HMPPS notified us of Mr Keeling's death on 18 September 2022.

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

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

15. NHS England commissioned an independent clinical reviewer to review Mr Keeling's clinical care at the prison.

16. We informed HM Coroner for South Yorkshire East District of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

17. The Ombudsman's office contacted Mr Keeling's sister to explain the investigation and to ask if she had any matters she wanted us to consider. She raised some concerns about the healthcare Mr Keeling had received and the family liaison. These issues have been addressed in this report and in the clinical review.

18. Our investigation was suspended from January 2023 to April 2024, firstly to await the post-mortem report and then to await the outcome of the subsequent police investigation.

19. We shared our initial report with HMPPS and with the prison's healthcare provider, Practice Plus Group. They found no factual inaccuracies.

20. We sent a copy of our initial report to Mr Keeling's sister. She responded with some comments which we have addressed in separate correspondence. She did not point out any factual inaccuracies.

Background Information

HMP Doncaster

21. HMP/YOI Doncaster is a local category B prison, operated by Serco, which holds remanded or convicted male prisoners. Practice Plus Group provides healthcare services. There is 24-hour healthcare.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Doncaster was in February and March 2022. Inspectors reported that health services were well led by a strong leadership team and clinical governance processes were robust. Patients were seen promptly for urgent GP and nurse appointments, but clinical oversight of triage arrangements was not sufficient. There was a continuous demand for social care for those with complex needs, but service provision was very good. Medicines management arrangements were good, but there was no on-site pharmacist to provide clinical advice and medicine use reviews.

Independent Monitoring Board

23. 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 31 August 2022, the IMB identified that there were a number of prisoners who were unable to engage effectively with healthcare, which meant that they were not getting the best out of what was being offered by the prison's healthcare provider. They suggested some targeted work to improve the interface between the prisoner and healthcare.

Previous deaths at HMP Doncaster

24. Mr Keeling was the 25th prisoner to die at Doncaster since September 2019. Of the previous deaths, 13 were from natural causes, eight were self-inflicted and three were drug related.

25. We have previously made a recommendation to Doncaster about ensuring applications for early release on compassionate grounds are completed in a timely manner. The prison told us in July 2021, that a process was in place.

Key Events

26. On 28 April 2017, Mr Christopher Keeling was given a life sentence for murder.

27. In November 2021, while at HMP Lindholme, Mr Keeling was diagnosed with cancer of the oesophagus (food pipe). Doctors assessed that Mr Keeling was not suitable for surgery as he was not fit enough to tolerate general anaesthetic for a prolonged period. He was also not suitable for palliative chemotherapy (used to control symptoms rather than cure the cancer). Instead, on 4 January 2022, doctors inserted a stent (a small tube) into Mr Keeling's oesophagus to keep it open. They recommended that Mr Keeling should be transferred to a prison with 24-hour healthcare.

28. On 11 February 2022, Mr Keeling was moved to HMP Doncaster. He was placed in the Annex (Social Care Unit), which housed mainly elderly prisoners with social care needs. Although Mr Keeling did not require social care, he needed support with his symptom control, so staff considered this was the best location for him.

29. On 14 February, Mr Keeling was referred to the Multi-Professional Complex Care Case (MPCCC) register (a multidisciplinary approach to managing patients with complex care needs). The MPCCC reviewed him regularly.

30. The Palliative Care Lead, and Mr Keeling's assigned care manager, saw Mr Keeling for the first time on 15 February (and weekly thereafter). Mr Keeling discussed his dietary preferences and foods which he found difficult to chew and swallow. She noted that Mr Keeling was at risk of weight loss and that a request had been made to the kitchens for extra ice cream, whole milk and some fortified (high calorie and high fat) foods. Staff subsequently added Mr Keeling to the ledger for monthly weight checks (increased to fortnightly checks from 7 April).

31. Mr Keeling was prescribed zomorph, pregabalin, and oramorph for pain relief. Mr Keeling was frustrated with the delays between his medications. Sometimes he did not have medication for 14 hours (instead of 12 hours), which meant that he experienced break through pain. Because of this, on 24 March, Mr Keeling asked for his pain relief medication to be converted to a patch for continuous administration. The Palliative Medicine Consultant at Doncaster and Bassetlaw Hospital agreed that Mr Keeling could have a fentanyl patch. A GP at Doncaster prescribed it on 5 April.

32. On 11 April, Mr Keeling had a new oesophageal stent inserted at hospital. He returned to Doncaster the same day. He was verbally aggressive when staff asked how he was as he had still not received his fentanyl patch. The same day, healthcare staff chased up the pharmacy for the fentanyl patch. It was not provided to Mr Keeling until 13 April.

33. On 25 April, the Head of Offender Management Services submitted an application for Mr Keeling's early release on compassionate grounds to the Public Protection Casework Section (PPCS) of HMPPS. (The application was prompted by a letter from Mr Keeling's solicitor.) PPCS responded the same day to say that the application was missing a medical report from a specialist/consultant showing life expectancy. The next day, she passed this request to healthcare staff.

34. On 29 April, healthcare staff confirmed that they had contacted the Palliative Medicine Consultant for a medical report. On 16 May, he declined to provide a report as he had not had recent face-to-face contact with Mr Keeling, and suggested this should come from a GP at the prison. On 26 May, the Head of Management Services contacted PPCS to say that the consultant would not provide a report and had suggested that a GP report should suffice, which had already been submitted. PPCS responded the same day to say that a GP report did not meet the requirements of the policy and that a specialist report was needed.

35. On 7 June, a GP at Doncaster wrote to the Palliative Medicine Consultant asking for input into the compassionate release application.

36. On 24 June, a family friend called the prison to complain that Mr Keeling was not getting an appropriate diet and was eating only porridge. (In June, Mr Keeling submitted three complaints that he was not receiving his soft food diet.) When the Acting Matron spoke to Mr Keeling about this, he said he had not been getting his two tins of soup that he had been promised but it had since been addressed. She spoke to the kitchen manager about Mr Keeling's dietary requirements.

37. On 20 July, during a GP review, Mr Keeling said he was finding it increasingly difficult to swallow his soft diet and fluids. The GP referred him to the hospital to investigate whether Mr Keeling had a blocked stent.

38. On 21 July, Mr Keeling attended hospital for an endoscopy (a long thin tube with a camera at the end is inserted into the mouth and into the oesophagus). He then had a new oesophageal stent inserted on 25 July. He was discharged back to Doncaster on 26 July.

39. On 28 July, Mr Keeling felt unwell. Healthcare staff found that his blood pressure was low. He was taken to hospital by ambulance but was discharged in the early hours of 29 July. The Acting Matron reviewed him later that morning and he was upset that his sister had not been told that he had been taken to hospital. She apologised and called Mr Keeling's sister.

40. On 8 August, during a regular review, the Palliative Care Lead noted that Mr Keeling was on his maximum oramorph dose for break through pain. Mr Keeling told her that during a telephone review with the Palliative Medicine Consultant, he had said that the pain relief medication could be increased. She asked the consultant for written confirmation, and, on 10 August, he sent an email saying that the fentanyl and pregabalin dose could be increased.

41. On 19 August, the Head of Management Services sent several hospital letters relating to Mr Keeling's care, some from the Palliative Medicine Consultant and some from a gastroenterology specialist, dated from November 2021 to August 2022, to PPCS. They responded the same day and said that the letters did not give any prognosis as required, but they would refer for independent medical advice in the meantime. The Deputy Head of Healthcare responded to PPCS on 22 August to say that a GP at the prison had written to the consultant for an update.

42. On 30 August, Mr Keeling told the Palliative Care Lead that his pain relief was okay but that he felt weak and unwell.

43. On 1 September, a nurse noted that Mr Keeling had reported a loss in appetite and abdominal pain. She noted that Mr Keeling's presentation had deteriorated over the previous few days. Healthcare staff increased his pregabalin dose and prescribed morphine.

44. During a GP review on 6 September, Mr Keeling said he felt wiped out. The GP ordered blood tests which showed low haemoglobin levels. Mr Keeling was admitted to hospital on 9 September and received two units of blood. He was discharged on 11 September.

45. When he returned to Doncaster, Mr Keeling told a healthcare assistant that he wanted to sleep and to just slip away as he had had enough. The hospital discharge letter said that Mr Keeling's fentanyl dose could be increased. Prison healthcare staff actioned this and, after discussion with the Palliative Medicine Consultant, increased the morphine and pregabalin doses.

46. On 13 September, PPCS refused Mr Keeling's compassionate release application. The main reason for refusal was that there was no clear prognosis and PPCS were not satisfied that the evidence submitted demonstrated that Mr Keeling was in the last three months of his life.

47. On 16 September, Mr Keeling told staff that he had fallen six times but had not reported it. That night, a nurse noted that Mr Keeling was clearly distressed and frightened. She told him that she was available all night and she checked on him several times during the night. He said he did not want to go to hospital as he wanted to be around familiar people.

48. On 17 September, the Palliative Care Lead noted that Mr Keeling was struggling to settle due to nausea and build-up of fluid on the lungs. She gave him medication to reduce pain, nausea, secretions and agitation. Prison staff agreed that Mr Keeling's door could be left open so that healthcare staff had easy access.

49. At around 8.25am on 18 September, a nurse administered Mr Keeling's medication and noted that his extremities were cold, he was lethargic and visibly very poorly. She put some warm socks on his feet and ensured he had his duvet over him. She put some low music on at Mr Keeling's request and stayed with him until he died. He died at around 9.30am.

Contact with Mr Keeling's family

50. On 2 March, the prison appointed a family liaison officer (FLO). Mr Keeling had listed his sister as his next of kin. His sister told us that she had very limited contact from the FLO and queried the point of family liaison if communication was so limited.

51. The FLO log shows that the FLO contacted Mr Keeling's sister on 6 April, after she visited her brother and had expressed concerns about how he was being cared for. The FLO contacted healthcare staff, who said they would liaise with Mr Keeling's sister (with Mr Keeling's consent).

52. The FLO then met with the family when they visited Mr Keeling on 1 July. On 2 September, she noted that staff on Mr Keeling's wing told her that Mr Keeling had

been deteriorating and they might need to arrange a visit by his sister as his condition advanced. They told her that Mr Keeling was in regular phone contact with his sister. The level of FLO contact seems appropriate given that Mr Keeling was in regular contact with his sister.

53. On 13 September, another FLO took over in the first FLO's absence. She was asked to arrange for Mr Keeling's family to visit him as soon as possible due to his failing health. His sister visited him on 14 September and two friends visited him on 15 September.

54. At around 8.25am on 18 September, healthcare staff asked prison staff to contact Mr Keeling's family as it appeared that Mr Keeling was nearing the end of his life. At around 9.00am, the FLO called Mr Keeling's sister and asked her to attend the prison as quickly as possible. Mr Keeling's sister said she was around 40 minutes away. Mr Keeling's sister arrived at 9.50am, shortly after Mr Keeling died. Mr Keeling's sister told us that the FLO had shown compassion and been very helpful to her.

55. The prison contributed to the costs of Mr Keeling's funeral in line with national policy.

Post-mortem report

56. The post-mortem report concluded that Mr Keeling died from mixed drug (tramadol, morphine, fentanyl and midazolam) toxicity. Coronary artery disease (where blood supply to the heart is blocked by the build-up of fatty substances in the blood vessels supplying the heart) and advanced oesophageal adenocarcinoma (cancer) were listed as contributory factors.

57. Toxicological analysis showed that tramadol was at four times the lethal range. (Mr Keeling was not prescribed tramadol.) The pathologist noted that there was also appreciable morphine, liable to independently be fatal. The presence of fentanyl and midazolam would likely have added to the overall drug toxicity.

58. The pathologist noted that while there was evidence of natural disease in the form of oesophageal malignancy and coronary artery disease, the very high level of drugs had to be regarded as the prime pathology. The pathologist noted that the drug levels were very pronounced and more than might be expected. It could not be determined whether the drugs were prescribed at therapeutic level and then poorly excreted (potentially pointing to liver and kidney disease and general ill health), although the levels were outside those seen in similar cases.

Findings

Cause of death

59. The post-mortem report concluded that Mr Keeling died from mixed drug (tramadol, morphine, fentanyl and midazolam) toxicity. Mr Keeling was prescribed morphine, fentanyl and midazolam but was not prescribed tramadol.

60. We do not know how Mr Keeling was able to obtain tramadol. The pathologist noted that third party involvement could not be ruled out. The police investigated and are satisfied that no one else administered tramadol to Mr Keeling. Pharmacy checks confirm no missing medication. Only one person on Mr Keeling's unit was prescribed tramadol. The police obtained a statement from him, and he denied supplying drugs to Mr Keeling. We therefore do not know how Mr Keeling obtained tramadol, especially as he was very unwell in the lead up to his death.

61. With the absence of a note left by Mr Keeling it is not possible to be absolutely certain, but bearing in mind he had a very painful terminal illness, had made recent comments that indicated he was despairing of life and that he intentionally ingested four times the lethal dose of a drug that was not prescribed to him, that it is likely that in doing so he intended to end his life.

Clinical care

62. The clinical reviewer concluded that the care Mr Keeling received was of a generally good standard and was equivalent to that which he could have expected to receive in the community. However, she noted some areas of concern.

Medication

63. The clinical reviewer noted that there were delays with medication prescribing, getting it in stock and dispensing in a timely manner. The clinical reviewer raised this as a concern with the Acting Matron. She advised that the delays were due to having an external pharmacist, and that there was now a pharmacist on site which had resulted in medication being ordered and dispensed in a timelier manner. We recommend:

The Head of Healthcare should ensure that the new measures in place are audited at frequent intervals to ensure that pain relief and end of life medications are sourced and dispensed in a timely manner.

Diet

64. There were some challenges ensuring that Mr Keeling received his soft diet but also a varied diet. Mr Keeling made three complaints about the diet provided to him. We recommend:

The Head of Healthcare should ensure that when a specific diet is advocated, the healthcare team maintain contact with the kitchen to ensure appropriate food is available, which is varied and balanced.

Early release on compassionate grounds

65. Release on compassionate grounds is a means by which prisoners who are seriously ill, usually with a life expectancy of less than three months, can be permanently released from custody before their sentence has expired. A clear medical opinion of life expectancy is required. The criteria for early release are set out in the Early Release on Compassionate Grounds Policy Framework. Among the criteria is that the risk of reoffending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of HMPPS.

66. The application submitted on 25 April was incomplete as no specialist/consultant report had been included. The requirement for a specialist report is clear in the policy and should have been included at the outset. It took another four months before any further information was provided to PPCS, but again this did not meet the requirement as the hospital letters provided did not contain a prognosis. This meant that the application was refused on 13 September, on the basis that there was no evidence that Mr Keeling was in the last three months of his life. In fact, he had deteriorated significantly by then and was clearly in the final days of his life.

67. We consider that the compassionate release application was handled poorly. Staff responsible for submitting compassionate release applications should be aware of the requirements and ensure that all necessary information is included with the application at the outset. Prison healthcare staff should make every effort to obtain a specialist report, which includes a prognosis. If a prisoner deteriorates during this process, healthcare staff should seek an up-to-date prognosis.

68. We acknowledge that healthcare staff at Doncaster tried to get a report from the hospital's palliative care consultant, but he declined to provide one due to lack of recent face-to-face contact with Mr Keeling. However, there is no evidence that healthcare staff explored alternatives, such as approaching the consultant named in Mr Keeling's solicitor's letter who had prompted the compassionate release application, or another gastroenterology specialist involved in Mr Keeling's care. We recommend:

    The Director and Head of Healthcare should review the process in place for preparing applications for early release on compassionate grounds to ensure that the necessary evidence, including a specialist medical report, is obtained as quickly as possible.

Inquest

69. The inquest was held on 14 and 15 August 2024. The jury concluded that Mr Keeling died by suicide.

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