

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Neil McKenna, a prisoner at HMP Littlehey, on 19 July 2022

A report by the Prisons and Probation Ombudsman

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OUR VISION

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

WHAT WE DO



WHAT WE VALUE



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Summary

1. 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.
2. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr Neil McKenna died of pneumonia caused by malignant mesothelioma (an aggressive form of cancer) in hospital on 19 July 2022, while a prisoner at HMP Littlehey. He was 77 years old. We offer our condolences to Mr McKenna's family and friends.
4. The clinical reviewer concluded that the clinical care Mr McKenna received at Littlehey was of a good standard and equivalent to that which he could have expected to receive in the community. The clinical reviewer made no recommendations but highlighted concerns about the decision to use restraints on Mr McKenna during his escorts to hospital.
5. We are concerned about the issues we have identified in the escort risk assessment process at Littlehey and the impact on Mr McKenna in the weeks before his death. We found that healthcare staff did not record clear information on Mr McKenna's ill-health and the reasons for their objection to restraints when they first provided advice for prison management. Handcuffs were approved. On 20 June, handcuffs were applied again, despite a medical objection with a clear rationale. The result was that Mr McKenna was inappropriately restrained for most of his time in hospital and developed sores on his wrists. This is unacceptable and must be prevented in future. We note the steps that Littlehey have already taken to address the learning and we make recommendations to support this ongoing work. We hope that prison and healthcare managers will work together to ensure lasting change.

Recommendations

- The Head of Healthcare should ensure that healthcare input into escort risk assessments is based on up-to-date medical information and is clear and sufficiently detailed.
- The Governor and Head of Healthcare should ensure that healthcare and security teams share appropriate information and work collaboratively to complete escort risk assessments, to ensure restraints decisions are appropriate.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr McKenna's clinical care at Littlehey.
7. The PPO investigator investigated the non-clinical issues relating to Mr McKenna's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered. The investigator had a discussion with the Consultant in Palliative Medicine and a palliative care nurse at Littlehey.
8. The PPO family liaison officer wrote to Mr McKenna's next of kin, his son, to explain the investigation and to ask if he had any matters he wanted us to consider. He had no questions but requested a copy of our reports. We shared the initial report with him, and he did not raise any further issues, or comment on the factual accuracy of the report.
9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at HMP Littlehey

10. There were 30 deaths at Littlehey in the two years before Mr McKenna's death. 29 of the previous deaths were from natural causes (five of which were related to COVID-19). One of these is suspected to have been drug related but this has not been confirmed at the time of writing. Since Mr McKenna died, there have been three further deaths from suspected natural causes.
11. There are no similarities between our findings in the investigation into Mr McKenna's death and our investigation findings for the previous deaths.

Key Events

12. On 27 November 2015, Mr McKenna was sentenced to 26 years in custody and sent to HMP Elmley. On 2 January 2018, he was transferred to HMP Littlehey
13. Mr McKenna had long term health conditions including hearing difficulties, dermatitis, a hernia, and cataracts.
14. On 23 November 2021, Mr McKenna was transferred to ambulatory care at Hinchinbrook hospital because he had been having palpitations (irregular heartbeats). He had a scan the same day and was referred on the 'two week wait' rule for suspected cancer.
15. On 9 December, Mr McKenna was admitted to Hinchinbrook hospital for shortness of breath. He was diagnosed with severe heart failure and referred to Papworth Hospital Lung Team to investigate suspected mesothelioma (an aggressive form of cancer that covers the majority organs in the body).
16. On 12 December 2021, a prison officer was allocated as family liaison officer (FLO) in light of Mr McKenna's deteriorating health. Mr McKenna gave consent for an officer to contact his son.
17. Mr McKenna was discharged from hospital back to Littlehey on 16 December. A clinical nurse specialist in palliative care met with him to discuss his ongoing care and treatment.
18. On 25 January 2022, a consultant in palliative medicine told Mr McKenna that tests confirmed he had cancer. She advised Mr McKenna that he had a prognosis of between six months and six years. They discussed early release on compassionate grounds and Mr McKenna agreed for an application to be made. Mr McKenna told her that he did not want anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect.
19. Mr McKenna attended hospital on 3 February to discuss his treatment with a consultant oncologist. He agreed to try some short courses of chemotherapy to try and prolong his life.
20. On 25 May, Mr McKenna was escorted to Hinchinbrook hospital for a chemotherapy session. A nurse in the healthcare team at Littlehey made no recommendation about handcuffing Mr McKenna in his escort risk assessment but did record medical objections to the use of restraints. The risk assessment stated that there was no Do Not Resuscitate Order (DNR) in place for Mr McKenna. A prison manager authorised a two officer escort with a single handcuff.
21. On 20 June, Mr McKenna was due to be escorted to Hinchingbrooke hospital for a CT scan. Mr McKenna was considered a low risk of absconding and medium harm to public and there were no recorded intelligence concerns. In the escort risk assessment, a nurse stated that there were medical objections to the use of handcuffs. She assessed that these were not appropriate because Mr McKenna was frail and unwell, and his physical disability would affect the use of handcuffs. A prison manager authorised a two officer escort with a single cuff.

22. On 20 June 2022, a consultant reported concerns to the Governor of Littlehey that restraints had been used on Mr McKenna despite medical objections. She also recorded that Mr McKenna had developed red marks and the beginning of a pressure sore due to the handcuffs applied at his previous hospital visit.
23. On 28 June, a nurse completed an escort risk assessment for Mr McKenna's hospital appointment on 29 June. She added a medical objection to restraints being used on Mr McKenna but did not give a reason for the objection. The Head of Security authorised a single handcuff and two officers to escort Mr McKenna.
24. On 29 June, a prison manager authorised Mr McKenna's restraints to be changed from a single handcuff to an escort chain, because of his deteriorating health.
25. Mr McKenna's health and response to treatment reduced significantly and on 1 July a doctor confirmed that his cancer had progressed.
26. On 4 July, the clinical nurse specialist told Mr McKenna that his chemotherapy would stop because it was no longer working. Mr McKenna was given a prognosis of a matter of weeks, and he asked a consultant to share the news with his family. His cell door was left open at all times so that healthcare staff could provide immediate care when it was needed.
27. On 12 July, the clinical nurse specialist assessed that Mr McKenna's needs could no longer be managed within a prison environment and that he should be cared for in hospital. Mr McKenna was transferred by ambulance and admitted to Addenbrookes Hospital.
28. Mr McKenna's end-of-life care began on 14 July and the clinical nurse specialist informed Mr McKenna's son. A hospital visit was facilitated for Mr McKenna's family.
29. On 18 July a consultant met with the Governor of Littlehey to discuss the reason for restraints being used on Mr McKenna on 20 June, and the wider escort risk assessment processes at Littlehey. They found that healthcare staff had not always been aware of Mr McKenna's conduct in hospital.
30. On 18 July, Mr McKenna's health deteriorated and Littlehey held an emergency release on temporary licence (ROTL) board to support a transfer to a hospice. Mr McKenna was granted a temporary licence but by then had become too unwell to be transferred. Mr McKenna remained at Addenbrookes Hospital, escorted by one prison officer in plain clothes.
31. On 19 July at 9.35pm, Mr McKenna died. An officer was with him.
32. On 25 July, a consultant and the clinical nurse specialist met with the Head of Security to discuss joint concerns about the escort risk assessment process for Mr McKenna. They said that medical objections did not appear to have been taken into account when restraints were approved by prison management.

Post-mortem report

33. The coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor recorded Mr McKenna's cause of death as pneumonia caused by malignant mesothelioma.

Non-Clinical Findings

Escort risk assessments

34. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and considers the prisoner's health and mobility.
35. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. It said that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.
36. We are concerned that despite medical objections, prison management approved the use of restraints on Mr McKenna on three occasions. We are particularly concerned about the use of restraints on 20 June, when Mr McKenna was very frail and unwell. The consultant told us that Mr McKenna's body was emaciated at this time. She said that it was inevitable that any use of restraint would cause soft tissue damage to Mr McKenna's wrists, which it did.
37. It is also concerning that the healthcare contribution to the escort risk assessment completed on 25 May wrongly recorded that a Do Not Resuscitate Order (DNR) was not in place and did not make it clear that Mr McKenna had a terminal diagnosis. The only reference that healthcare made to Mr McKenna's health circumstances was 'known ca patient', which was a shorthand that prison management was unlikely to understand, and meant they were unaware of the nature of Mr McKenna's ill-health when considering use of restraints.
38. We are aware that the consultant has since met with two prison managers to address the issues found in the escort risk assessment process at the prison. In response to the learning from Mr McKenna's assessment, Littlehey has changed local procedures to build in contact between the Head of Security and healthcare where there are intelligence concerns that conflict with a recommendation not to use restraints or when the reason for medical objection is not clear. The new local procedure also contains guidance on medical objections, which includes consideration of skin quality on wrists. In addition, healthcare staff have been briefed on the importance of accurate medical explanations when objecting to restraints. It has also been agreed that a list of prisoners who should not be handcuffed for medical reasons is shared proactively with the security team, and regularly reviewed.
39. We consider the decision to use restraints on Mr McKenna to have been inappropriate, particularly on 20 June when he was seriously unwell and clearly nearing the end of his life. We note that Littlehey have made changes to processes to improve the quality of medical assessments and communication between the security and healthcare teams. We consider that more joined up, collaborative

working is key to improving practice. To support this work, we make the following recommendations:

The Head of Healthcare should ensure that healthcare input into escort risk assessments is based on up-to-date medical information and is clear and sufficiently detailed.

The Governor and Head of Healthcare should ensure that healthcare and security teams share appropriate information and work collaboratively to complete escort risk assessments, to ensure restraints decisions are appropriate.

**Tallulah Frankland
Assistant Ombudsman**

March 2023

Inquest

At the inquest, held on 16 July 2024, the jury concluded that Mr McKenna died from industrial disease due to the asbestos dust he had been exposed to during his employment from the 1960s onwards.

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