

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Kenneth Light, a prisoner at HMP Stafford, on 20 April 2023

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. 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.
3. Mr Kenneth Light died in hospital on 20 April 2023 of pneumonia, caused by lung cancer, while a prisoner at HMP Stafford. He was 79 years old. We offer our condolences to Mr Light's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Light received at Stafford was of a good standard and equivalent to what he could have expected to receive in the community. She made recommendations about clinical observations, assessments, and training, which we do not repeat here, but which the Head of Healthcare will wish to address.
5. Stafford did not provide us with the escort risk assessment for the 11 April 2023. As a result, we were unable to assess whether the restraints used on Mr Light for his final admission to hospital were appropriate.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Kenneth Light's clinical care at Stafford.
7. The PPO investigator investigated the non-clinical issues relating to Mr Light's care.
8. The PPO family liaison officer wrote to Mr Light's wife to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond to our letter.
9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at HMP Stafford

10. Mr Light was the twenty-sixth prisoner to die at Stafford since April 2020. Of the previous deaths, 24 were from natural causes and two were self-inflicted. There are no similarities between our findings in the investigation into Mr Light's death and our investigation findings for the previous deaths.

Key Events

11. On 23 September 2019, Mr Kenneth Light was sentenced to eight years and eight months in prison for indecent assault on a child. He was transferred to HMP Birmingham. A year later, Mr Light received an additional sentence of nine years in prison for rape of a female aged 16 or over.
12. Mr Light had several pre-existing medical conditions, including chronic obstructive pulmonary disease (COPD – a collection of lung diseases that cause respiratory symptoms), ischemic heart disease and type 2 diabetes.
13. On 26 January 2021, Mr Light was transferred to HMP Stafford.
14. On his arrival, a nurse completed Mr Light's initial health screen and identified his long-term medical conditions. The next day, a nurse completed Mr Light's secondary health screen and created care plans for his long-term medical conditions. He received appropriate medications for his conditions and was provided with a rescue pack to help manage his COPD. (A rescue pack is an emergency medical pack for COPD patients at risk of an exacerbation of the condition.)
15. On 16 August 2022, Mr Light reported to a nurse that he was coughing up discoloured phlegm and had lost some weight. The nurse completed a chest examination, arranged for him to have a chest X-ray, and created a care plan. Mr Light said that he was reluctant to use his rescue pack as he felt it was a different kind of cough. Healthcare staff completed daily observations on Mr Light for the next ten days.
16. Mr Light had an X-ray on 5 September. A couple of days later, a nurse reviewed the X-ray results and recorded that an ill-defined mass had been identified in Mr Light's right lung. The nurse arranged for Mr Light to have an urgent CT scan. The CT scan results indicated that Mr Light did have a mass on his right lung. On 27 October, Mr Light had a phone call with a respiratory consultant, who told him that it was highly likely he had lung cancer but would need a PET scan to confirm diagnosis. Mr Light had a PET scan on 23 November.
17. On 8 December, a senior hospital registrar saw Mr Light and informed him that although the results of the PET scan strongly suggested lung cancer, he would like Mr Light to have a CT scan of his head and a lung biopsy to confirm the diagnosis and check for possible secondary disease. On 13 December, Mr Light had a CT scan and the results did not show any signs of brain cancer. However, the biopsy results confirmed that Mr Light had cancer.
18. In light of his diagnosis, the healthcare team at the prison held weekly multi-disciplinary team (MDT) meetings to discuss Mr Light's care needs. On 6 January, the MDT noted that Mr Light was struggling with increased pain and moved him to the prison's specialist care unit for symptom management and support. Healthcare staff created a cancer care plan and reviewed him daily.
19. On 19 January 2023, an oncology specialist discussed treatment options with Mr Light and he signed a consent form to start radiotherapy treatment. He received five radiotherapy treatments between 1 and 7 February.

20. On 23 January, an Advanced Nurse Practitioner from a local hospice visited Mr Light, along with a nurse from the prison, and asked him if he wanted to be resuscitated in the event his heart or breathing stopped. Mr Light said that he did not and signed an order to that effect.
21. On 2 March, a consultant oncologist informed Mr Light that he would not receive further treatment and indicated that his future treatment plan would now involve symptom management and supportive care.
22. On 5 April, a nurse recorded that Mr Light had fallen and that he had hurt his right hip and elbow. Healthcare staff assessed him and monitored him during the night. Healthcare staff said that Mr Light was walking around his cell and had normal range of movement in all limbs.
23. The next day, a nurse asked a GP at the prison to review Mr Light after his fall the previous day. The GP noted that Mr Light had restricted movement in his right leg and was in pain when he rotated it. He discussed a possible fractured hip with Mr Light, but Mr Light declined to go to hospital because he had a visit already arranged in the afternoon. The GP recorded that Mr Light had the mental capacity to make this decision and, if he deteriorated, he needed to be referred to hospital urgently. Healthcare staff did not ask him to sign a disclaimer form for refusing to attend A&E as they should have done.
24. On 10 April, a nurse recorded that Mr Light had fallen in his cell while going to the toilet. She did not record his NEWS2 score. (National Early Warning Score is a tool which improves the detection and response to clinical deterioration in adult patients.) Mr Light injured his left hip and was in considerable pain. Later that day, a Healthcare Assistant recorded Mr Light's NEWS2 score as six. He did not escalate this to a senior clinician as he should have done. However, at 9.47pm, a nurse recorded his NEWS2 score as one. Healthcare staff observed Mr Light throughout the night and no concerns were raised.
25. On 11 April, a GP at the prison saw Mr Light after his fall the previous day. Mr Light had pain in his hip and his left foot was rotated outwards. The GP advised him that he needed to go to hospital to assess whether he had fractured his hip and Mr Light agreed. Mr Light was sent to hospital and was escorted by two officers. We do not know if Mr Light was restrained.
26. Later that day, the hospital informed healthcare staff at the prison that Mr Light had fractured his left hip and needed surgery.
27. On 18 April, Mr Light was placed on end-of-life care and, on 20 April, it was confirmed that Mr Light had died.

Cause of death

28. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Light's cause of death as pneumonia caused by advanced squamous cell carcinoma of the lungs (lung cancer). He also had diabetes, ischaemic heart disease, neck of femur fragility fracture due to cancer and osteoporosis which did not cause but contributed to his death.

Governor to note

Retention of evidence

29. PSI 58/2010 on the Prisons and Probation Ombudsman requires prisons to ensure that all evidence relevant to a death in custody is retained and that evidence is made available to the PPO.
30. Stafford did not provide us with the escort risk assessment for the 11 April 2023 and told us that they could not locate it. The bedwatch log paperwork indicated that no restraints were used on Mr Light for the duration of the bedwatch, but we are unable to verify this and are not able to assess whether the restraints used during the escort were appropriate for Mr Light. We bring this matter to the Governor's attention.

Adrian Usher
Prisons and Probation Ombudsman

August 2023

At the inquest held on 29 August 2024, the coroner concluded that Mr Light died of natural causes.

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