Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Kinnear, a prisoner at HMP Wymott, on 11 May 2023

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100

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

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 Michael Kinnear died in a hospice of kidney cancer on 11 May 2023, while a prisoner at HMP Wymott. He was 54 years old. We offer our condolences to Mr Kinnear's family and friends.

4. The clinical reviewer concluded that, with the exception of one element of care, the clinical care Mr Kinnear received at Wymott was equivalent to that which he could have expected to receive in the community. She found many examples of good care but found that national guidance on caring for people at risk of malnutrition was not followed. She made one recommendation which can be found in the clinical review report.

5. When the prison submitted an early release on compassionate grounds (ERCG) application for Mr Kinnear on 29 March, they did not include a consultant's report as required. This delayed the application and Mr Kinnear died before it could be considered.

Recommendations

- The Governor and Head of Healthcare should ensure that Healthcare provide the correct consultant report immediately after prognosis and the Governor ensures that this is sent off with the ERCG application.

The Investigation Process

6. HMPPS notified us of Mr Kinnear's death on 11 May 2023.

7. NHS England commissioned an independent clinical reviewer to review Mr Kinnear's clinical care at Wymott.

8. The PPO investigator investigated the non-clinical issues relating to Mr Kinnear's care.

9. The PPO family liaison officer wrote to Mr Kinnear's next of kin, his daughter, to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond to our letter.

10. The initial report was shared with HMPPS. HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Previous deaths at HMP Wymott

11. Mr Kinnear was the twenty-third prisoner to die at Wymott since May 2020. Of the previous deaths, 20 were from natural causes, one was self-inflicted, and one was drug related. There are no similarities between our findings in the investigation into Mr Kinnear's death and our investigation findings for the previous deaths.

Key Events

12. On 16 October 2015, Mr Michael Kinnear was sentenced to nine years imprisonment for sexual offences. On 23 April 2021, he was moved to HMP Wymott.

13. On 3 January 2023, a nurse and a GP saw Mr Kinnear as he had stomach pain, a loss of appetite, vomiting and constipation. The nurse took blood samples and the GP referred Mr Kinnear under the urgent two-week referral route for suspected cancer.

14. On 5 January, a GP reviewed Mr Kinnear's blood test results. They showed he had severe hypercalcemia (very high levels of calcium in the blood). The GP arranged for Mr Kinnear to be urgently transferred to hospital.

15. The following morning, Mr Kinnear discharged himself from hospital. A nurse at Wymott spoke to Mr Kinnear about the risk of refusing treatment, but he did not want to return to hospital. He told the nurse that while in hospital he had further blood tests done and was told by a doctor he might have cancer. Later that day, the GP asked for Mr Kinnear to be urgently transferred to hospital as his blood test results were very abnormal, however, he refused to go.

16. On 7 January, staff started suicide and self-harm monitoring (known as ACCT) for Mr Kinnear as they were concerned about his refusal to attend hospital for treatment. The healthcare team spoke to Mr Kinnear about the risks of not having treatment, but he continued to refuse to go to hospital.

17. On 9 January, a GP saw Mr Kinnear and told him that his liver function was very abnormal and that his blood tests suggested he had kidney failure. Mr Kinnear agreed to go to hospital and was admitted.

18. On 11 January, Mr Kinnear discharged himself from hospital. A nurse at Wymott saw him on his return as he looked very unwell. Mr Kinnear told the nurse he was struggling with his thoughts and mood at the hospital and was distrusting of the hospital staff. He returned to hospital on 20 January for a CT scan. Staff stopped ACCT monitoring the same day.

19. On 8 February, a GP saw Mr Kinnear. She told him the results of his CT scan and that he had a diagnosis of renal cell cancer (kidney cancer) that had spread to his liver and adrenal glands (glands at the top of each kidney). She told him that his cancer was terminal.

20. On 2 March, Mr Kinnear saw an oncologist (cancer specialist) who advised that his prognosis would likely be three months without treatment, or 12 months with treatment. Mr Kinnear agreed to start treatment and was prescribed medication to help treat his cancer.

21. On 22 March, staff started ACCT monitoring again as Mr Kinnear was refusing to attend hospital for treatment.

22. On 24 March, Mr Kinnear said he did not want anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect.

23. On 29 March, staff submitted an application for Mr Kinnear's early release on compassionate grounds (ERCG) to the Public Protection Casework Section (PPCS) of HMPPS. PPCS asked for a report from Mr Kinnear's oncologist. This was still outstanding when Mr Kinnear died.

24. On 8 April, an officer found Mr Kinnear on the floor in his cell and radioed a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties that alerts staff to attend and the control room to call an ambulance). The healthcare team responded to the code and helped Mr Kinnear back to his bed. They were concerned that his breathing was rapid and blood pressure was low. The ambulance crew arrived and took him to hospital.

25. On 11 April, Mr Kinnear was seen by the palliative care team in hospital. They explained that he would not receive any further active treatment for his cancer and would be kept comfortable.

26. On 13 April, a palliative care doctor at the hospital told the healthcare team at Wymott that Mr Kinnear was approaching the end of his life and he had a prognosis of days to weeks. Staff stopped ACCT monitoring on 19 April.

27. On 24 April, Mr Kinnear was moved to a hospice for palliative care. He had told staff that he wanted to return to Wymott, however as Wymott were unable to meet his 24-hour care needs, the doctors agreed it was in his best interests to be moved to a hospice.

28. On 11 May, at approximately 12.52am, Mr Kinnear died.

Cause of death

29. The coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Kinnear's cause of death as metastatic renal cell carcinoma (kidney cancer).

Findings

Compassionate release application

30. 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 (ERCG) 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.

31. Paragraph 4.25 of the ERCG Policy Framework says, 'The application must include a multidisciplinary report completed by all roles currently caring for the prisoner. This must include, but is not limited to, a report from the prison GP/locum and an additional report from the medical specialist(s) – this is usually a consultant – involved in the care of the prisoner. The reports should provide a diagnosis, assessment of incapacity/frailty, prognosis, treatment pathway/plan and, where applicable, a clear indication of life expectancy'.

32. The prison submitted an ERCG application to PPCS on 29 March 2023, without a report from a consultant as required. This meant that PPCS were unable to progress the application. A caseworker from PPCS responded the same day to request a consultant report.

33. On 28 April, the healthcare team sent a list of questions to Mr Kinnear's consultant at St Catherine's Hospice and asked him to complete them for his ERCG application. The consultant asked for a multi-disciplinary team (MDT) meeting before completing the questions as he had only been responsible for Mr Kinnear for four days. An MDT meeting took place on 3 May. The healthcare team asked for an update on the questions on 10 May, following a meeting at the hospice. On 11 May, Mr Kinnear died.

34. The PPO investigator was told by the lead GP at Wymott that they do not routinely request consultant reports when completing ERCG applications.

35. Mr Kinnear's oncologist gave him his prognosis on 2 March. We consider that the prison should have asked for a report at that stage, with a view to submitting the ERCG application as soon as possible. The fact that they did not, unnecessarily delayed the ERCG process. We recommend:

    The Governor and Head of Healthcare should ensure that Healthcare provide the correct consultant report immediately after prognosis and the Governor ensures that this is sent off with the ERCG application.

Good Practice

36. On 3 March 2023, following his terminal diagnosis, Mr Kinnear was added to the palliative care register at Wymott. From this point onwards he was no longer cuffed or restrained when attending hospital or on an escort.

37. The Governor at Wymott told the PPO investigator that their general policy, based on the dying well in custody charter, is to not apply restraints once a prisoner has been added to the palliative care register unless the risk requires. This is to provide comfort to prisoners and their families during a difficult time. This is reflective of a compassionate approach to applying restraints and is considered good practice.

Adrian Usher
Prisons and Probation Ombudsman **November 2023**

Inquest

The inquest, held on 5 July 2024, concluded that Mr Kinnear died from natural causes.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100