

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stephen Keogh a prisoner at HMP Manchester on 24 April 2016

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**



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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.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Stephen Keogh died of respiratory failure due to chronic obstructive pulmonary disease at HMP Manchester on 24 April 2016. He was 78 years old. I offer my condolences to those who knew him.

Mr Keogh had a lung removed in 1996, following treatment for lung cancer, and suffered from multiple health issues, but his primary health concern was chronic obstructive pulmonary disease (COPD). He suffered frequent breathlessness, was subject to acute deterioration and prone to infection.

On arrival at the prison, healthcare staff provided Mr Keogh with end of life care and, from June 2015, Mr Keogh's condition began to decline. In November, a hospital doctor told Mr Keogh that he only had a few months to live. Throughout his time in prison, healthcare staff delivered appropriate and responsive end of life care, which enabled him to be nursed in comfort and with dignity. I am satisfied that HMP Manchester followed established national guidance in caring for Mr Keogh's chronic health needs and that he received a good standard of care, which was equivalent to that he could have expected to receive in the community.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

November 2016

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Summary

Events

1. On 30 April 2015, Mr Stephen Keogh was remanded to HMP Manchester. He was later sentenced to 15 years in prison. On arrival, Mr Keogh had multiple physical health problems, though his primary health concern was chronic obstructive pulmonary disease (COPD – the name for a collection of lung diseases including chronic bronchitis and emphysema) and breathlessness.
2. On 10 May, healthcare staff placed Mr Keogh on the end of life register and created a care plan to treat his condition, which included ensuring that he received his prescribed medication at correct times and that his emotional needs were met.
3. In June, Mr Keogh's condition declined and hospital doctors diagnosed an infective exacerbation of his COPD.
4. Mr Keogh required a further six emergency hospital admissions between July and November as a result of increases in the severity of his COPD.
5. On 12 November, Mr Keogh's respiratory consultant told Mr Keogh that he had a short prognosis of a few months but he was not actively dying at that moment. The consultant considered that Mr Keogh required palliative care, and Mr Keogh confirmed that he did not want staff to resuscitate him if his heart or breathing stopped.
6. Two days later, the prison admitted Mr Keogh to the inpatient unit and created an end of life care plan for him. A Macmillan nurse visited Mr Keogh to provide specialist palliative care support and explained he would only go to a hospice for the last weeks of his life. Healthcare staff regularly assessed Mr Keogh to ensure that his care and medication was appropriate.
7. On 19 April, Mr Keogh moved to the enhanced care suite, as healthcare staff noted that he appeared to be deteriorating. The following day, a doctor told Mr Keogh that he was dying and that healthcare staff would give him regular analgesia to keep him comfortable. The prison attempted to transfer him to a hospice but no beds were available.
8. On 24 April, a nurse entered Mr Keogh's room to make sure that he was comfortable but noted that he was not to be breathing and had no pulse. She requested an emergency ambulance. Paramedics arrived and confirmed that Mr Keogh had died.

Findings

9. We agree with the clinical reviewer that when Mr Keogh's condition deteriorated, he received a good standard of care, which was appropriate, compassionate and responsive. There was evidence of effective and supportive communication throughout his time in prison, and the creation of an end of life care plan ensured that Mr Keogh died in comfort and with dignity. The clinical reviewer found that

Mr Keogh received a good standard of care, which was equivalent to that he could have expected to receive in the community.

10. We are also satisfied that Mr Keogh was not restrained during a hospital admission in 2016.
11. However, we are disappointed that the prison did not discuss compassionate release with Mr Keogh, despite him being terminally ill.

Recommendation

- The Governor should ensure that when a prisoner is diagnosed with a terminal illness with a short time left to live, the possibility of compassionate release is fully considered and documented.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Manchester informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
13. The investigator obtained copies of relevant extracts from Mr Keogh's prison and medical records.
14. NHS England commissioned a clinical reviewer to review Mr Keogh's clinical care at the prison.
15. We informed HM Coroner for City of Manchester District of the investigation who gave us the cause of death. We have given the coroner a copy of this report.
16. One of the Ombudsman's family liaison officers contacted Mr Keogh's solicitor, who he had listed as his next of kin, to explain the investigation and to ask if she had any matters they wanted the investigation to consider. She had no questions or concerns to raise and said that having visited Mr Keogh in prison, he had not complained to her about any aspect of his care.
17. The investigation has assessed the main issues involved in Mr Keogh's care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.
18. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.
19. Mr Keogh's solicitor received a copy of the initial report. They did not make any comments.

Background Information

HMP Manchester

20. HMP Manchester operates as both a high security prison and as a local prison serving the courts of the Greater Manchester area. It can hold more than 1,200 men. Manchester Mental Health and Social Care Trust provide 24 hour nursing care and the healthcare centre includes an inpatient unit

HM Inspectorate of Prisons

21. The most recent inspection of HMP Manchester was in May 2015. Inspectors reported that health services were reasonably good, and most prisoners were satisfied with the quality of healthcare. They further commented that staff on the inpatients unit provided compassionate care for patients with complex needs.

Independent Monitoring Board

22. 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 February 2016, the IMB reported that inpatient care was often hampered by lack of available staff but, that given the financial constraints, they believed healthcare staff offered the best possible level of care to their patients.

Previous deaths at HMP Manchester

23. Mr Keogh was the third person to die of natural causes at Manchester since January 2015. There has been one other natural cause death since Mr Keogh died. There were no similarities between the circumstances of Mr Keogh's death and previous deaths at the prison.

Findings

The diagnosis of Mr Keogh's terminal illness and informing him of his condition

24. On 30 April 2015, Mr Stephen Keogh was remanded into custody for sexual offences and sent to HMP Manchester. On 9 November, he was sentenced to 15 years imprisonment.
25. At a reception health screen, Mr Keogh confirmed his extensive medical conditions, which included chronic obstructive pulmonary disease (COPD), asthma, ischaemic heart disease and an abdominal aortic aneurysm (a swelling of the main blood vessel of the heart). Mr Keogh also said that he had had his left lung removed in 1996 after having suffered lung cancer. He used a walking stick, a Zimmer frame and a wheelchair for long distances.
26. Due to his multiple health issues, the nurse manager assessed Mr Keogh's nursing needs and created care plans for Mr Keogh's physical and mental health issues. These included instructions to ensure he received his prescribed medication and that any adverse reactions should be reported to a doctor.
27. On 10 May, following various assessments, the nurse manager noted that Mr Keogh's multiple health problems would cause deterioration in his general condition. As a result, she placed Mr Keogh on the end of life register and created an end of life care plan, to ensure Mr Keogh's progress was tracked, he was placed on appropriate waiting lists, he received his prescribed medication at the correct times and his emotional needs were met
28. On 1 June, Mr Keogh saw a physiotherapist. She noted he was breathless on arrival and took about five minutes to settle and regain his breath. Mr Keogh told her his only problem on the wing was his breathing but that officers and other prisoners looked after him.
29. On 26 June, a nurse saw Mr Keogh in his cell after he complained of severe chest pain. The nurse noted that Mr Keogh was pale with cyanosed lips and requested an ambulance. Mr Keogh was admitted to hospital and doctors diagnosed an infective exacerbation of his COPD. They prescribed steroids and discharged Mr Keogh on 29 June.
30. On 21 July, a nurse saw Mr Keogh in his cell when he complained of being short of breath. She noted Mr Keogh face looked congested with a purple tinge so called for an ambulance. While in hospital, doctors diagnosed a further exacerbation of his COPD and decided Mr Keogh needed to be put on constant oxygen. The hospital discharged Mr Keogh on 23 July.
31. On 27 August, a prison GP examined Mr Keogh, after he had difficulty breathing. The GP diagnosed a further exacerbation of COPD and sent him to hospital. Mr Keogh was discharged the following day and prescribed carbocysteine capsules (allows sufferer to bring up sputum more easily).
32. On 19 September, a prison GP saw Mr Keogh, who complained of hip pain. The GP noted Mr Keogh looked grey and struggled for breath. The GP administered oxygen, but Mr Keogh was still breathless at rest so he requested an ambulance.

After a series of tests, hospital doctors told the prison healthcare staff that Mr Keogh's breathing was normal for his condition.

33. On 21 October, a prison GP examined Mr Keogh due to concerns over his oxygen saturations. Mr Keogh said the left corner of his mouth had increased droop. The GP gave Mr Keogh some oxygen and noted he was unable to hold air in his left cheek when pressed. The GP suspected Mr Keogh may have had a stroke and sent him to hospital. Following a CT scan, hospital doctors diagnosed Mr Keogh with Bells Palsy (a one-sided facial nerve paralysis of unknown cause). He returned to Manchester on 23 October.
34. On 29 October, a nurse attended to Mr Keogh after he collapsed in his cell. Mr Keogh was very short of breath so she called for an ambulance and administered oxygen for five minutes. Mr Keogh went to hospital for further investigation and treatment of an exacerbation of his COPD. The hospital discharged Mr Keogh on 3 November.
35. On 9 November, a prison GP reviewed Mr Keogh, who had suffered increased shortness of breath overnight. The GP diagnosed a further exacerbation of COPD and sent him to hospital. The hospital admitted him and, on 12 November, Mr Keogh's respiratory consultant said that Mr Keogh had a short prognosis of a few months but he was not actively dying at that moment. The consultant confirmed that he required palliative care, which included high flowing oxygen, regular nebulisers and oramorph to relieve respiratory distress. While in hospital, Mr Keogh confirmed that he did not want to be resuscitated if his heart or breathing stopped.
36. We agree with the clinical reviewer that as Mr Keogh's condition deteriorated, healthcare staff appropriately assessed his condition and referred him for hospital care. The clinical reviewer also felt that prison healthcare staff had effectively supported Mr Keogh when it became clear that he required palliative care.

Mr Keogh's clinical care

37. On 14 November, after being discharged from hospital, the prison moved Mr Keogh to the inpatient unit. The nurse manager assessed Mr Keogh's nursing needs and completed an end of life care plan for him. Mr Keogh told her that he was ready to die as he knew how advanced his disease was and that he wished to be nursed at a hospice at the end of his life.
38. On 24 November, a Macmillan palliative care nurse visited Mr Keogh to provide specialist palliative care support. She also explained he would only go to a hospice for the last weeks of his life and he was not at that stage yet.
39. In light of the care plan, healthcare staff regularly assessed Mr Keogh's care and medication. During February 2016, healthcare staff noted that his condition had improved, as he had put on weight and there had been no increase in the severity of his COPD. Mr Keogh's mobility had improved and he spent less time using oxygen therapy.
40. However, on 3 March, Mr Keogh complained he felt unwell and a prison GP examined him. The GP found that Mr Keogh was very short of breath, unable to

speak in sentences and his blood pressure was dropping. The doctor sent Mr Keogh to hospital, who treated him for an exacerbation of his COPD. He returned to Manchester the same evening.

41. On 17 March, the Macmillan palliative care nurse reviewed Mr Keogh and noted that the oramorph controlled his pain. Nurses also regularly assessed Mr Keogh several times a day, noting any concerns.
42. On 19 April, Mr Keogh was moved to the enhanced care suite due to him being incontinent of faeces. Healthcare staff noted Mr Keogh appeared to be deteriorating and assisted him to shower and shave. On 20 April, a prison GP spoke to Mr Keogh. Mr Keogh said he did not feel unwell and he was not in pain, though he did not want any help and wanted to die soon. The GP diagnosed terminal care, advised Mr Keogh that he was dying and told him he would be given regular analgesia and kept comfortable.
43. As Mr Keogh was entering the terminal phase of his disease, the prison attempted to transfer him to a hospice for specialist palliative care. However, on 21 April, the prison was told that there were no beds available at two local hospices.
44. Mr Keogh's condition continued to deteriorate. At about 5.50pm on 24 April, a nurse entered Mr Keogh's room to make sure that he was comfortable but noted that he was not breathing and had no pulse. She requested an emergency ambulance at 5.54pm. Paramedics arrived at 6.13pm and confirmed that Mr Keogh had died.
45. We agree with the clinical reviewer that healthcare staff provided Mr. Keogh with appropriate and responsive end of life care, which allowed Mr Keogh to die in comfort and with dignity. There was evidence that that Mr Keogh's emotional, psychological, social, cultural and spiritual needs were also considered. As a result, we were satisfied that the care Mr Keogh received was equivalent to that he could have expected to receive in the community.

Mr Keogh's location

46. In his early days in prison, Mr Keogh was located in a ground floor cell that allowed him to mobilise. As his condition deteriorated, Mr Keogh moved, firstly, to the prison's inpatient unit and then to the enhanced care suite. This allowed healthcare staff to deliver appropriate and responsive end of life.
47. Additionally, the prison attempted to transfer Mr Keogh to two local hospices for specialist palliative care but no beds were available. Unfortunately, Mr Keogh died before a bed could be secured. We are satisfied that Manchester appropriately located Mr Keogh throughout his illness.

Restraints, security and escorts

48. When prisoners have to travel outside of the prison to a hospital or hospice, a risk assessment is conducted to determine the nature and level of any security arrangements, including any restraints.

49. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity and maintain their dignity. The level of restraints used should be necessary in the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes account of factors such as the prisoner's health and mobility.
50. Mr Keogh attended hospital once during 2016, on 3 March. During this emergency admission, two officers accompanied Mr Keogh and a prison manager authorised them not to use restraints. We consider that Manchester appropriately took into account Mr Keogh's health, age and mobility, when reaching this decision.

Liaison with Mr Keogh's family

51. Mr Keogh was estranged from his family and did not wish to be in contact with them. He asked his solicitor to arrange his will prior to his death and asked her to be his next of kin. In light of Mr Keogh's wishes, the prison did not appoint a family liaison officer. The solicitor asked the prison to inform her by phone when Mr Keogh died, which the prison did.
52. Mr Keogh's funeral was held on 7 June and the prison arranged and paid for it, in line with national instructions.

Compassionate release

53. 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 for determinate sentenced prisoners are set out in Prison Service Order (PSO) 6000. Among the criteria is that the risk of re-offending 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 the National Offender Management Service (NOMS).
54. From November 2015, Mr Keogh's condition had deteriorated significantly and a hospital consultant had given him a short prognosis. Following this, healthcare staff paid attention to his care needs but we could not find any evidence that anyone had discussed compassionate release with Mr Keogh. While he was only a year into his 15 year sentence and was estranged from his family, so may not have fulfilled all the criteria for compassionate release, we consider that it should have been discussed as part of his end of life care planning. We make the following recommendation:

The Governor should ensure that when a prisoner is diagnosed with a terminal illness with a short time left to live, the possibility of compassionate release is fully considered and documented.

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