Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Key a prisoner at HMP Exeter on 10 November 2016

A report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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 John Key died of lung cancer, which had spread to other parts of his body, at HMP Exeter on 10 November 2016. He was 65 years old. I offer my condolences to his family and friends.

I agree with the clinical reviewer that the care Mr Key received at Exeter was not equivalent to that he would have had in the community, although I recognise that healthcare staff could not have prevented his death. In particular, I am concerned that blood tests were not performed and care plans were not recorded in Mr Key's medical record.

The prison decided, wrongly, that restraints were appropriate when Mr Kay went to hospital on two occasions, despite his terminal medical condition and limited mobility. I have raised concerns about inappropriate use of restraints at Exeter on several occasions and have been assured by NOMS that steps have been taken to address those concerns. I am disappointed to find that those steps have not been adequate.

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 **May 2017**

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Summary

Events

1. On 15 September 2016, Mr John Key was sentenced to 17 years in prison for sexual offences. He was sent to HMP Exeter the following day. He already had an established diagnosis of chronic obstructive pulmonary disease (COPD – the name for a collection of lung diseases including chronic bronchitis and emphysema) and he used walking sticks.

2. One week before going to prison, Mr Key had also been diagnosed with lung cancer, which was neither operable nor curable. He was fully aware of his diagnosis and did not want to be resuscitated in the event that his heart or breathing stopped. The hospital completed an order to that effect. He also declined chemotherapy.

3. On 19 September, at Mr Key's request, a prison GP recorded that Mr Key did not want to be resuscitated. She also requested a GP appointment for Mr Key. A nurse also made a referral to a specialist palliative care nurse from a local hospice charity as part of care planning.

4. The GP, on 30 September, realised that the care plans had not been progressed and the GP appointment had not been arranged. She met Mr Key for a comprehensive review on 3 October and he was fully involved in deciding how his care should be delivered.

5. Following this, healthcare staff scheduled fortnightly GP reviews and made a referral to oncology for Mr Key to re-consider whether to have chemotherapy. Care plans were agreed and a hospice nurse visited but little detail on these appear in Mr Key's medical record.

6. On 17 October, the GP ordered blood tests to check Mr Key for anaemia but there was no record that the tests were completed.

7. Mr Key attended a series of hospital appointments between 21 October and 2 November. He agreed with his clinical oncologist, on 21 October, to palliative radiotherapy to improve his symptoms but continued to decline chemotherapy.

8. Mr Key's condition deteriorated over time and, on 3 November he moved to a wing for men with social care needs, where he remained until his death.

9. In the early hours of 10 November, Mr Key's respiratory rate gradually decreased and stopped. An out of hours' doctor confirmed his death at 3.05am.

Findings

10. When Mr Key went to prison he had already been diagnosed with terminal lung cancer but with no firm prognosis. The clinical reviewer considered that there was no evidence that Mr Key suffered with uncontrolled pain or respiratory distress, and he was satisfied that a prison GP involved Mr Key in decisions about his care.

11. While there was some evidence of good care, we note that a GP appointment was not arranged, blood tests were not performed and information about care plans and hospice referrals were not recorded on Mr Key's clinical records. We agree with the clinical reviewer that the care Mr Key received was not equivalent to the care he would have had in the community.

12. Due to Mr Key's limited mobility and his medical condition, we do not believe that the prison's use of restraints during his first two hospital appointments was appropriate.

Recommendations

- The Head of Healthcare should review the current arrangements for GP appointments to ensure that referrals for appointments are not missed.
- The Head of Healthcare should ensure that blood tests are carried out in accordance with GP instructions and the results are made available to clinicians in a timely manner.
- The Head of Healthcare should ensure that healthcare staff complete medical records in line with the General Medical Council and Nursing and Midwifery Council's guidance, recording full details of care plans and referrals. .
- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Exeter 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 Key's prison and medical records.

15. NHS England commissioned a clinical reviewer to review Mr Key's clinical care at the prison.

16. We informed HM Coroner for Exeter of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

17. The investigator wrote to Mr Key's brother to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not respond to our letter.

18. The investigation has assessed the main issues involved in Mr Key'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.

19. The initial report was shared with the Prison Service. The Prison Service pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Exeter

20. HMP Exeter is a local prison holding a maximum of 560 men either on remand, convicted or sentenced. The prison serves the courts of the South West. Dorset NHS University Foundation Trust provides health services, including mental health services. The prison has 24 hours healthcare cover. The prison also has a palliative care suite for terminally ill prisoners.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Exeter was in August 2016. Inspectors reported that when a prisoner needed a cell with special adjustments, they had to wait for a cell on the social care unit. They also reported that the palliative care service was inconsistent, as prisoners did not always receive care and medication in a timely way owing to the lack of staff. They also noted that there were not enough social care staff to meet prisoners' 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 most recently published annual report, for the year to December 2015, the IMB reported that it believed that Exeter was a well-run and generally safe establishment and staff made a genuine effort to treat prisoners with dignity and respect. The IMB made special mention of the work of healthcare staff but considered that healthcare resources were inadequate and did not reflect community provision.

Previous deaths at HMP Exeter

23. Mr Key was the ninth prisoner to die from natural causes at HMP Exeter since January 2016. There have been two subsequent deaths. We have made previous recommendations about the need to complete blood tests promptly. We have also raised concerns over the unjustified use of restraints on five separate occasions.

Findings

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

24. On 15 September 2016, Mr John Key was sentenced to 17 years in prison for sexual offences. He had failed to appear at court and was arrested on warrant the following day. He was sent to HMP Exeter.

25. A week before being sentenced, Mr Key had been diagnosed with inoperable lung cancer. He was fully aware of the diagnosis and did not want to be resuscitated in the event that his heart or breathing stopped. The hospital had completed a form detailing his resuscitation wishes.

26. On reception into prison, Mr Key also confirmed that he had had a diagnosis of chronic obstructive pulmonary disease (COPD – the name for a collection of lung diseases including chronic bronchitis and emphysema). He also confirmed that a back problem meant that he used walking sticks and a disability scooter for longer distances.

27. On Mr Key's arrival at Exeter, healthcare staff requested his medical records from his community GP and they indicated that Mr Key's treatment plan was to receive palliative chemotherapy.

28. We are satisfied that Mr Key had been diagnosed with inoperable lung cancer before he arrived at Exeter. Upon his arrival at the prison, healthcare staff obtained full information on his condition and immediately began to treat it.

Mr Key's clinical care

29. On 19 September, a healthcare administrator spoke to a member of the hospital lung cancer team at the hospital, who told her that Mr Key had been offered and declined chemotherapy.

30. Later that day, a nurse saw Mr Key to discuss his clinical needs. He asked to see the prison GP and reiterated that he did not want to be resuscitated. She arranged a GP appointment and contacted a specialist palliative care nurse from Hospiscare (a local hospice charity), to start care planning. Meanwhile, a prison GP created a new form to document his resuscitation wishes.

31. On 30 September, the prison GP noticed that the GP appointment had not been arranged and no care plans were in place for Mr Key. She saw him on 3 October and Mr Key was involved in decisions about his care. They decided that GPs should review Mr Key fortnightly and that Mr Key should be referred to oncology so that he could reconsider whether to have palliative chemotherapy. She also arranged for a Hospiscare review and created care plans, though details of these were not recorded in Mr Key's medical record.

32. On 12 October, a Hospiscare nurse visited Mr Key and discussed his ongoing care but again there was little detail in his medical notes about the visit, with the exception of a plan to transfer Mr Key to the social care unit.

33. Mr Key was eating and drinking well and continued to self-care in his cell, but because of his mobility issues and increasing shortness of breath, he found it increasingly difficult whenever he moved.

34. On 17 October, a prison GP ordered blood tests to exclude the possibility of anaemia. The following day, due of a shortage of escort officers, Mr Key missed the test. The appointment was rebooked for 19 October but there was no record that it took place.

35. Four days later, Mr Key attended the first of six outpatient appointments with a consultant clinical oncologist at the hospital. He agreed to palliative radiotherapy to improve his symptoms but not to chemotherapy, which he believed would prolong his life and he did not want this. Mr Key received radiotherapy until 2 November.

36. A nurse noted, on 7 November, that Mr Key was becoming more breathless. She spoke to a prison GP to ensure oxygen was available to him if required. The doctor noted on the treatment escalation plan in the carers' folder that, if necessary, oxygen could be administered.

37. At 9.30am on 9 November, a nurse noted that Mr Key was bright, chatty and had raised no issues.

38. In the early hours of 10 November, Mr Key became increasingly breathless and his skin appeared blue. A nurse reviewed him and noted that his respiratory rate gradually decreased and then stopped. She noted that he died at 1.41am and did not attempt resuscitation in line with Mr Key's wishes. An out of hours GP confirmed that Mr Key had died at 3.05am.

39. The clinical reviewer considered that Mr Key's death was not preventable and that he did not suffer from uncontrolled pain or respiratory distress other than in the last hour of his life. The clinical reviewer also felt that the prison GP fully involved Mr Key in decisions about his care.

40. While there was some evidence of good care, we agree with the clinical reviewer that some areas could have been improved and that delays in arranging a GP appointment and completing blood tests hindered Mr Key's care. We also note that Mr Key's medical record did not contain sufficient information about his care plans and the Hospiscare referral. Overall, we agree with the clinical reviewer that the care Mr Key received was not equivalent to that he could have expected to receive in the community. We make the following recommendations:

    The Head of Healthcare should review the current arrangements for GP appointments to ensure that referrals for appointments are not missed.

    The Head of Healthcare should ensure that blood tests are carried out in accordance with GP instructions and the results are made available to clinicians in a timely manner.

    The Head of Healthcare should ensure that healthcare staff complete medical records in line with the General Medical Council and Nursing and Midwifery Council's guidance, recording full details of care plans and referrals.

Mr Key's location

41. On 17 September, shortly after arriving in Exeter, Mr Key moved to a ground floor cell where his mobility and medical issues could be better supported. Mr Key also received help from Exeter's 'Buddy Scheme' (prisoner trained to support the needs of less able men).

42. A month later, a prison GP requested that Mr Key be moved to the social care unit when a bed became available. He moved on 3 November to a wing that caters for men with social care needs and includes a palliative care unit. He settled well over the next few days.

43. We are satisfied that Mr Key's accommodation at Exeter was appropriate for his needs and in line with his wishes.

Restraints, security and escorts

44. 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 takes into account the prisoner's health and mobility. 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. The judgment indicated 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.

45. Mr Key was scheduled for six appointments at the hospital between 21 October and 2 November for palliative radiotherapy treatment. On all of his escort risk assessments, prison security staff considered that Mr Key presented a "normal" risk except to females, members of the public, hospital staff and children for which he was categorised as "medium to high risk".

46. The prison GP made no note on the first risk assessment about Mr Key's medical condition but on later risk assessments identified that he was suffering from a terminal illness, was short of breath and struggled to walk any distance.

47. During the first two hospital visits on 21 and 27 October, a prison manager recommended that two officers accompany Mr Key and restrain him with double handcuffs (double cuffing is when the prisoner's hands are handcuffed in front of him and one wrist is attached to a prison officer by an additional set of handcuffs). Hand written notes on both risk assessments decided that officers should restrain Mr Key with an escort chain (an escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer).

48. We note that for his final four appointments, Mr Key was not restrained despite nothing of significance having changed in the risk that he presented, his health or his mobility.

49. We consider that, given Mr Key's health problems and restricted mobility, it was inappropriate for officers to restrain Mr Key for his first two hospital appointments.

We are also concerned with the limited information on Mr Key's health that appeared in the first risk assessment, although a prison GP corrected this for future risk assessments. The risk assessments for his first two hospital appointments appear to have been based primarily on Mr Key's risks when well, with little consideration of how his health and mobility affected this risk, as the 2007 High Court judgment requires. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

Liaison with Mr Key's family

50. During his short stay at Exeter, Mr Key had no contact with his family or friends and had not named a next of kin or emergency contact. On 7 November, the prison appointed an officer as his family liaison officer and another officer as her deputy.

51. When Mr Key died, the family liaison officers contacted the police to obtain contact details for his family. The police provided family details on the afternoon of 10 November so the Governor and a chaplain travelled to the family home and broke the news of his death to his family members.

52. Both officers remained in contact with Mr Key's family and offered their support up to and after the funeral.

53. Mr Key's funeral was held on 29 November, which the prison contributed towards in line with national instructions.

54. We are satisfied that the prison appropriately supported Mr Key's family following his death.

Compassionate release

55. Prisoners can be released before their sentence has finished on compassionate grounds. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months.

56. Doctors diagnosed Mr Key's terminal cancer just before he went to prison and decided that he had less than a year to live. This information had been disclosed when he was sentenced.

57. As Mr Key prognosis did not change during his time at Exeter, we consider that it was acceptable for the prison to not start a compassionate release application as the information on his terminal condition had already been provided to the sentencing court.

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