Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Kenneth Lewis, a prisoner at HMP Littlehey, on 27 July 2022

A report by the Prisons and Probation Ombudsman

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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

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 Kenneth Lewis died in hospital from cancer on 27 July 2022, while a prisoner at HMP Littlehey. He was 75 years old. We offer our condolences to Mr Lewis's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Lewis received at Littlehey was of a very good standard and was equivalent to that which he could have expected to receive in the community. The clinical reviewer made no recommendations.

5. We found that the decisions to restrain Mr Lewis when he was taken to hospital on 15 and 28 June 2022, were not justified given his advanced age and frailty.

Recommendations

- The Governor and Head of Healthcare should ensure that staff understand the legal position on the use of restraints and that:
    - Healthcare staff complete the medical section of the escort risk assessment fully and accurately so that it is clear whether the prisoner's health and/or mobility affect their ability to escape;
    - Authorising managers consider the healthcare input to the escort risk assessment and record that they have done so; and
    - Authorising managers note whether the prisoner is on the 'no cuffing list' and if restraints are authorised, record the full reasoning.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Lewis's clinical care at Littlehey.

7. The PPO investigator investigated the non-clinical issues relating to Mr Lewis's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

8. The PPO family liaison officer wrote to Mr Lewis's next of kin, his 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 found no factual inaccuracies.

Previous deaths at HMP Littlehey

10. Mr Lewis was the thirty-third prisoner to die at Littlehey since July 2020. Of the previous deaths, one was self-inflicted, one was from a suspected drug overdose and all the others were from natural causes. There are no similarities between our findings in the investigation into Mr Lewis's death and our investigation findings into the previous deaths.

Key Events

11. On 11 October 2018, Mr Kenneth Lewis was sentenced to ten years imprisonment for sex offences.

12. Mr Lewis had several long-term health conditions including heart disease, hypertension (high blood pressure) and sleep apnoea (a condition which causes breathing to stop and start during sleep) for which he used a CPAP machine (a machine that uses air pressure to prevent breathing from stopping). He had been a smoker for 50 years.

13. On 22 January 2020, Mr Lewis was sent to HMP Littlehey.

14. Mr Lewis was in good health for the majority of his time at Littlehey. In the spring of 2022, he was still a wheelchair pusher for another prisoner as well as a wing painter.

15. On 6 April, Mr Lewis tested positive for COVID-19. He did not become very unwell from the virus but said that he continued to suffer from breathlessness following his recovery. He also said that he was having trouble sleeping.

16. On 5 May, Littlehey consulted with the hospital specialist who monitored Mr Lewis's CPAP machine remotely. The specialist said that the breathlessness was not related to his sleep apnoea.

17. On 19 May, Mr Lewis saw a prison GP as he was experiencing some abdominal pains and he wanted some pain relief. The doctor did not find anything of immediate concern but made an adjustment to Mr Lewis's blood pressure medication. Mr Lewis declined to accept this and asked to see another doctor.

18. On 23 May, Mr Lewis had a fall in his cell. Although he was not injured from the fall, healthcare staff found that he was very confused, had breathing problems, an elevated heart rate and temperature, along with a reduced blood oxygen level. They called an ambulance, and Mr Lewis was taken to hospital.

19. Mr Lewis remained in hospital for two days. While there, hospital staff discovered that Mr Lewis had lung cancer, which had probably spread to other parts of his body, and that it was likely that it was not curable.

20. When he returned to Littlehey, Mr Lewis and his wife were well supported by the prison's palliative care team, and the prison's family liaison team.

21. On 15 June, Mr Lewis had an X-ray at hospital which showed that his cancer had spread in the past three weeks. The consultant discussed the poor outlook with Mr Lewis but said that he would need to take biopsies (a procedure to remove a tissue sample from the body so that it can be tested in a laboratory), to confirm the nature and probable progress of Mr Lewis's cancer.

22. On 28 June, Mr Lewis returned to hospital for the biopsy procedure. The results were available on 4 July, and they showed that the cancer had developed rapidly and that it was likely that Mr Lewis would die within a few weeks or months.

23. The palliative care team at Littlehey met with Mr Lewis on 4 and 5 July, to discuss his end of life wishes with him. He said that he did not want to be resuscitated if his heart or breathing stopped and signed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order to that effect. Mr Lewis also participated in drawing up an Advance Care Plan, which details other preferences around dying, such as treatment and place of death.

24. Mr Lewis was regularly reviewed and supported by healthcare staff and moved to a more suitable larger cell with a hospital bed on 7 July.

25. Over the next two weeks, Mr Lewis's breathing difficulties increased, and, on 25 July, he was taken to hospital when his condition deteriorated further.

26. On 27 July, Mr Lewis died in hospital.

Post-mortem report

27. The coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Lewis's cause of death as right lung mesothelioma, a cancer commonly but not exclusively associated with asbestos.

Non-Clinical Findings

Restraints

28. 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. 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.

29. On his visit to hospital on 15 June, Mr Lewis was restrained 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). On the escort risk assessment form, healthcare staff did not raise any objection to the use of restraints but said that Mr Lewis was a frail cancer patient only able to walk short distances. The restraint level was authorised by the Head of Security, and she indicated on the form that she had taken account of the input from healthcare staff.

30. On his follow up trip on 28 June, Mr Lewis was again restrained with an escort chain. This time healthcare staff said that they objected to the use of restraints and that Mr Lewis was frail and unwell. The authoriser of the restraints was also the Head of Security. On this occasion, she made no indication of the health factors she had taken into account.

31. On 25 July, Mr Lewis was very ill, and he was taken to hospital without any restraints.

32. The investigator asked Littlehey for some information about the restraint arrangements for Mr Lewis in June following his cancer diagnosis. The palliative care consultant said that on 20 June, healthcare staff had added Mr Lewis to a 'no cuffing list' that they maintain for prisoners at Littlehey. On 4 July, she discovered that Mr Lewis had been restrained on 28 June. She raised the matter in meetings with the Governor on 18 July and with the Head of Security on 25 July.

33. We understand that as a result of these discussions, Littlehey has been taking a closer look at its use of restraints. We are aware that the Head of Security has said that there will also be occasions when there are security considerations that would outweigh medical considerations.

34. We consider that the use of restraints on Mr Lewis when he was taken to hospital on 15 and 28 June was inappropriate, given his age and poor mobility. We are concerned that Mr Lewis's health and poor mobility was not taken into account by the authorising manager and that on 28 June, the fact that Mr Lewis was on the 'no cuffing list' was apparently ignored (there is no evidence that security considerations outweighed the medical objections to restraints). We recommend:

The Governor and Head of Healthcare should ensure that staff understand the legal position on the use of restraints and that:

- **Healthcare staff complete the medical section of the escort risk assessment fully and accurately so that it is clear whether the prisoner's health and/or mobility affect their ability to escape;**
- **Authorising managers consider the healthcare input to the escort risk assessment and record that they have done so; and**
- **Authorising managers note whether the prisoner is on the 'no cuffing list' and if restraints are authorised, record the full reasoning.**

Louise Richards **March 2023**
Assistant Ombudsman

Inquest

35. The inquest into Mr Lewis's death was held on 24 May 2023. The conclusion was that Mr Lewis's death was from natural causes.

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