Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mark Keegan, a resident at Lightfoot House Approved Premises, on 1 June 2023

A report by the Prisons and Probation Ombudsman

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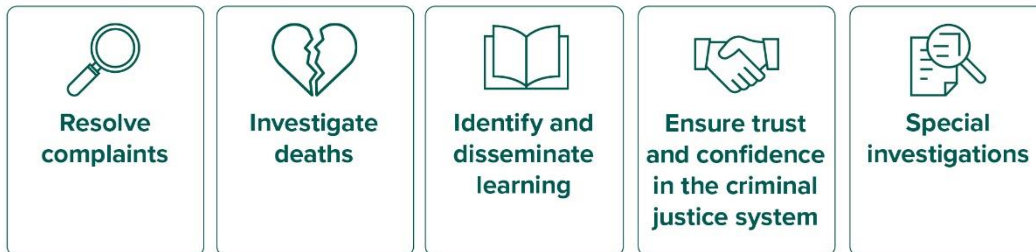
OUR VISION

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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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.

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.

Mr Mark Keegan died in hospital of multiorgan failure on 1 June 2023, while a resident at Lightfoot House Approved Premises. He was 54 years old. I offer my condolences to Mr Keegan's family and friends.

Mr Keegan had liver disease and advanced bladder cancer when he was released from HMP Highpoint to Lightfoot House on 26 April 2023.

We found that the healthcare team at Highpoint ensured Mr Keegan was able to access healthcare services in the community and continue receiving treatment for bladder cancer upon his release.

We make no recommendations.

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

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

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Summary

Events

1. On 2 September 2020, Mr Mark Keegan was recalled to prison for driving offences. On 22 October, he was moved to HMP Highpoint.

2. On 22 March 2022, a GP at Highpoint diagnosed Mr Keegan with chronic viral hepatitis B (an infection of the liver caused by the hepatitis B virus).

3. On 22 November, Mr Keegan was diagnosed with advanced bladder cancer. Three weeks later, he started radiotherapy treatment.

4. On 26 April 2023, Mr Keegan was released from Highpoint to Lightfoot House Approved Premises (AP). He registered with a community GP and attended his hospital appointments for his cancer treatment.

5. On 15 May, after an abnormal blood test result, Mr Keegan was admitted to hospital where his health rapidly deteriorated. He died in hospital on 1 June.

6. A hospital doctor gave Mr Keegan's cause of death as multiorgan failure caused by hepatorenal syndrome (impaired kidney function that occurs during end-stage liver disease) and metastatic bladder cancer.

Findings

7. We found that the healthcare team at Highpoint gave Mr Keegan the relevant information to ensure that he could access healthcare services in the community and continue receiving treatment for bladder cancer.

8. We consider that Mr Keegan was released to appropriate accommodation where AP staff monitored his condition daily. They then continued to make daily contact when he was admitted to hospital.

9. We make no recommendations.

The Investigation Process

10. HMPPS notified us of Mr Keegan’s death on 5 June 2023.

11. The investigator issued notices to staff and residents at Lightfoot House Approved Premises informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

12. We informed HM Coroner for Suffolk of the investigation. We have sent the Coroner a copy of this report.

13. The Ombudsman’s family liaison officer contacted Mr Keegan’s mother to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.

14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

Lightfoot House Approved Premises

15. Approved premises (APs, formerly known as probation and bail hostels) mostly accommodate offenders released from prison on licence and those directed there by the courts as a condition of bail. Their purpose is to provide a supportive and structured environment. Residents are responsible for their own healthcare and are expected to register with a GP.

16. Lightfoot House is situated near Ipswich city centre and has 26 single rooms. A key worker is allocated to each resident to discuss their progress and wellbeing. The key worker also ensures that residents adhere to their individual licence conditions and the AP rules.

Previous deaths at Lightfoot House AP

17. Mr Keegan was the second resident to die at Lightfoot House since June 2020. The previous death was from natural causes.

Key Events

18. On 30 July 1997, Mr Mark Keegan was convicted of murder and was sentenced to life in prison.

19. On 15 February 2013, Mr Keegan was released from prison on a life licence. He was subsequently recalled to prison and released again several times after being convicted of further offences.

20. On 2 September 2020, Mr Keegan was recalled to prison for driving offences. He was sent to HMP Norwich.

HMP Highpoint

21. On 22 October, Mr Keegan was moved to HMP Highpoint. Routine tests carried out as part of the initial health screening suggested that Mr Keegan might have hepatitis B. After further tests, Mr Keegan was formally diagnosed with chronic viral hepatitis B on 22 March 2021. Healthcare staff at Highpoint monitored his condition with regular blood tests and liver scans.

22. On 13 August 2022, Mr Keegan told a nurse at Highpoint that he had blood in his urine. She referred him to hospital where he was diagnosed with a urine infection and was prescribed antibiotics.

23. However, Mr Keegan continued to have blood in his urine and after further tests was diagnosed with advanced bladder cancer on 22 November. He started radiotherapy treatment in January 2023.

24. On 26 April, Mr Keegan was released from Highpoint to live at Lightfoot House AP. The discharge nurse told Mr Keegan that he needed to register with a GP in the community and gave him a supply of medication for the next two weeks. The nurse gave Mr Keegan copies of his upcoming hospital appointments and gave him the contact details of the hospital. She told him he would need to contact the hospital and give them his new address.

Release from HMP Highpoint

25. On the day of his release, Mr Keegan attended Lightfoot House AP. He completed the AP induction and signed to say he understood the rules. He remained in the AP for the next three weeks. In this time, he registered with a local GP and attended his scheduled hospital appointments.

26. On 15 May, Mr Keegan's GP rang him to say that he was concerned about the results of Mr Keegan's recent blood test. The GP told Mr Keegan to go to the local hospital for an assessment.

27. The same day, Mr Keegan attended hospital and was admitted to a ward. He remained in hospital for the next two weeks where his health rapidly deteriorated. AP staff kept in regular contact with Mr Keegan during this time.

28. On 1 June, at 3.15pm, Mr Keegan died in hospital.

Contact with Mr Keegan’s family

29. On 1 June, a member of staff from the bereavement office at Ipswich Hospital informed Mr Keegan’s mother that he had died.

30. The Probation Service contributed to the cost of Mr Keegan’s funeral in line with national policy.

Post-mortem report

31. The coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Keegan’s cause of death as multiorgan failure caused by hepatorenal syndrome (a life-threatening condition that affects kidney function in people with advanced liver disease) and metastatic bladder cancer (cancer which has spread to other areas of the body). Hepatitis B was a contributing factor.

32. The coroner accepted that Mr Keegan died from natural causes and did not hold an inquest.

Findings

33. We found that the healthcare team at Highpoint gave Mr Keegan the relevant information to ensure that he could access healthcare services in the community and continue receiving treatment for bladder cancer. As Mr Keegan was being released to an area in which he was not yet registered with a GP, they could not transfer the care over themselves. They did however make Mr Keegan aware that he would need to register with a GP upon his release from Highpoint and gave him details of his upcoming hospital appointments.

34. We found that Mr Keegan was released to appropriate accommodation, where AP staff made daily welfare checks and ensured that Mr Keegan attended his scheduled hospital appointments. When Mr Keegan was admitted to hospital in May, AP staff kept in regular communication with both him and the local hospital via daily phone calls to ensure they were regularly updated on his location and his condition.

35. We make no recommendations.

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