Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Barry Keay, a prisoner at HMP Wakefield, on 13 September 2022

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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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 HM 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 Barry Keay died in hospital on 13 September 2022 of a cerebrovascular accident (a stroke) while a prisoner at HMP Wakefield. He was 64 years old. We offer our condolences to Mr Keay's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Keay received at Wakefield was equivalent to that which he could have expected to receive in the community.

5. On 2 August, the medical objection to restraints was not considered as part of the decision-making process and the use of restraints was not justified in the circumstances. The subsequent decision to restrain Mr Keay during and after an operation to remove his foot on 26 August was wholly inappropriate.

6. The prison did not tell attending paramedics that Mr Keay had an order in place not to be resuscitated if his heart and breathing stopped, and they therefore resuscitated him.

Recommendations

- The Head of Healthcare should ensure that all healthcare staff, including agency workers know how to process non-resuscitation orders.

- The Head of Healthcare should ensure that all healthcare staff complete the medical risk assessment in full so that the authorising manager has sufficient information to make an informed decision about restraints.

- The Governor should ensure that prison staff understand that medical information about a prisoner must be properly considered when deciding whether to use restraints and in cases where a medical objection is disregarded, the reason is documented.

- The Governor should satisfy himself that:

  - decisions to apply restraints are justifiable at all times in line with the Graham judgment and the rationale for those decisions is correctly documented; and

  - relevant staff are regularly trained on the Graham judgement in order to challenge the culture of risk aversion that exists at the institution and so as to be empowered to raise any concerns.

The Investigation Process

7. NHS England commissioned an independent clinical reviewer to review Mr Keay’s clinical care at Wakefield.

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

9. The PPO family liaison officer wrote to Mr Keay’s brother to explain the investigation and to ask if he had any matters he wanted us to consider. He asked why the prison had contacted him by letter and not email or telephone. We have addressed this in this report.

10. Mr Keay’s brother received a copy of the draft report. He did not make any comments.

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

Previous deaths at HMP Wakefield

12. Mr Keay was the twenty-fifth prisoner to die at Wakefield since September 2019. Of the previous deaths, twenty-two were from natural causes and three were self-inflicted. There have been seven deaths since, all from natural causes.

13. There are no similarities between our findings in the investigation into Mr Keay’s death and our investigation findings for the previous deaths. However, we issued two investigation reports into deaths which have occurred since September 2019 and there are ongoing investigations, where we identified concerns about the use of restraints.

Key Events

14. On 26 April 2019, Mr Barry Keay was convicted of sexual offences and sent to prison for 22 years.

15. On 2 August 2019, Mr Keay was transferred to Wakefield. Before he arrived, he had been diagnosed with type 1 diabetes and hypertension (high blood pressure).

16. On 5 August, Mr Keay told a Supervising Officer (SO) that he had no next of kin, but he wanted his sister to be notified if something happened to him.

17. On 16 December 2021, a nurse saw Mr Keay for muscular-skeletal pain. An ultrasound scan showed that he had rotator cuff syndrome (a degenerative condition). He was referred to a surgeon.

18. On 6 May 2022, a consultant physician in respiratory medicine saw Mr Keay as a scan had identified an issue with his lungs. He was referred for a chest X-ray and a CT scan, which took place on 20 May. The CT results suggested Mr Keay had lung cancer.

19. On 8 June, a consultant in respiratory medicine saw Mr Keay and confirmed that he had incurable cancer. She noted that Mr Keay had very few symptoms.

20. Later that month, healthcare staff noted that the toes on Mr Keay's left foot were painful, purple and cool to touch. He was sent to hospital for further assessment. On 30 June, Mr Keay was diagnosed with peripheral vascular disease (a blood circulation disorder).

21. On 12 July, Mr Keay complained of severe pain in his left foot. A nurse saw him and increased his pain relief. Two weeks later, the pain relief medication dose was increased again but there was a delay in providing the higher dose to Mr Keay.

22. On 15 July, a hospital consultant told Mr Keay that he had stage four lung cancer.

23. On 20 July, a consultant saw Mr Keay and told him that the lung cancer was inoperable. Mr Keay said he did not want to be resuscitated if his heart or breathing stopped and signed an order to that effect.

24. At approximately 8.20pm on 1 August, a nurse saw Mr Keay after he complained of chest pain. She completed his physical observations and concluded that his symptoms were likely due to anxiety.

25. At 1.49pm on 2 August, a nurse visited Mr Keay, took his physical observations, which did not indicate clinical deterioration.

26. At approximately 10.00pm that evening, Mr Keay pressed his emergency call bell and complained of chest pain. A nurse attended but told us a medical emergency code blue was not used.

27. The nurse took Mr Keay's physical observations and calculated a National Early Warning Score (NEWS2, which indicates clinical deterioration in a patient) of 7

which indicated an emergency response was needed. He administered aspirin and asked for an ambulance to be called, which arrived at 10.57pm.

28. The nurse completed the medical section of the escort risk assessment. He objected to the use of restraints and noted that Mr Keay's medical condition restricted his ability to escape unaided.

29. The Head of Security and duty governor on 2 August told us that he told a Custodial Manager (CM) that Mr Keay should be restrained using an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer). He said that he also gave a verbal instruction (known as a Part 11 at Wakefield) that should the chain need to be removed to allow for treatment, no further permissions were needed. This instruction is normally recorded on the security risk assessment document.

30. The Head of Security told us that he was not told that healthcare staff had objected to restraints. He stated that even if he had been aware, it would not have changed his decision. He said that the escort chain was appropriate given Mr Keay's offence and allowed for medical staff to treat him.

31. At 11.00pm, the CM, the night orderly officer, recorded on the prisoner escort record that two escort officers would accompany Mr Keay to hospital and restrain him using an escort chain. It was also noted that "*where there are no restraints applied HQ and Gov must be informed immediately".*

32. At 11.40pm, the ambulance left the prison. On route to the hospital, Mr Keay had a cardiac arrest and was resuscitated.

33. At 11.50pm, hospital doctors asked an officer for the restraints to be removed so that they could attend to Mr Keay. The CM authorised this but, at 12.15am on 3 August, the escort chain was reapplied as Mr Keay was stable.

34. At 4.25am, Mr Keay was admitted to intensive care and treated for diabetic ketoacidosis (a serious complication of diabetes).

35. On 3 August, an officer reviewed the security risk assessment. He concluded that Mr Keay should continue to be escorted by two officers and restrained. He determined that Mr Keay posed a high risk to the public, a medium risk to hospital staff and a medium risk of escape.

36. The officer told the investigator that all prisoners at Wakefield posed a high risk to the public as it was a high security prison and due to the nature of their offences. He said that the security risk assessment had no bearing on restraints arrangements.

37. At 3.20pm on 3 August, following a visit to the hospital, The Head of Security authorised the removal of Mr Keay's restraints because he was in the intensive care unit, he was attached to several machines and The Head of Security did not want the restraints to hinder medical interventions.

38. On 3 August, a nurse noted that she was unable to find the order not to resuscitate which Mr Keay and the consultant had completed.

39. At 9.40am on 4 August, the hospital doctor advised a Supervising Officer (SO) that Mr Keay was going to be moved from the intensive care unit to a hospital ward. An officer told the duty governor, who assessed information about Mr Keay's current health and mobility and instructed officers to reapply the escort chain.

40. Hospital staff advised the prison that Mr Keay would need to have his foot amputated because of the problems caused by peripheral vascular disease. On 22 August, an officer updated the risk assessment document to enable the restraints to be removed once he was unconscious in the surgical theatre and reapplied once the operation had been completed and before he regained consciousness. The Deputy Governor authorised this. On 24 August, Mr Keay was transferred to Leeds General Hospital.

41. At 2.30pm on 26 August, an escort officer at the hospital with Mr Keay phoned the duty governor to explain that Mr Keay was having an amputation without a general anaesthetic. The duty governor concluded that he could not send the Part 11 to the hospital in time for Mr Keay's operation and so he should remain restrained using the escort chain during his foot amputation.

42. An entry in the occurrence log noted that at 2.36pm on 27 August, an officer told the duty governor that the restraint had to be changed from Mr Keay's right wrist to the left wrist due to severe swelling. A CM authorised the change of restraints to Mr Keay's left wrist.

43. Over the next 24 hours, Mr Keay underwent two CT scans. Restraints were removed during the scans but reapplied after.

44. At approximately 10.00am on 28 August, a CM completed a management check and noted that the restraints should be removed, in line with the Graham judgment, due to the constant swelling of Mr Keay's arms and ongoing medical treatment. Restraints were removed a short while later.

45. The CM asked Mr Keay if there was anyone he wanted the prison to notify about his situation. He said that he wanted his brother who lived abroad to be notified of his cancer diagnosis and his amputation. The CM subsequently contacted the prison's family liaison officer (FLO) and asked him to write to Mr Keay's brother.

46. On 30 August, the Governor updated the risk assessment document to confirm that two escort officers should escort Mr Keay but restraints should not be used.

47. On 9 September, the FLO went to Mr Keay's cell to find contact details for his brother but could not locate any. (In interview, he could not recall why he did not do this or begin the family liaison log on 28 August.)

48. At 11.50am on 12 September, the control room contacted the FLO and told him that Mr Keay's condition had declined and his next of kin should be informed.

49. At 2.15pm, the FLO and a CM searched Mr Keay's cell again for next of kin details and found a letter with his brother's address. The FLO sent a letter to Mr Keay's brother to tell him that Mr Keay had terminal cancer and treatment had been withdrawn due to a decline in his condition. He asked Mr Keay's brother to contact him by email or telephone.

50. At approximately 3.40pm on 12 September, the healthcare team was notified that Mr Keay had had a major stroke. He died the next day.

51. On 14 September, the FLO contacted the prison’s police liaison officer to ask him to help contact Mr Keay’s brother.

52. On 23 September, the FLO received an email from Mr Keay’s brother, which included a telephone number for him. At 6.20pm, he phoned him and told him that Mr Keay had died on 13 September.

Post-mortem report

53. A hospital doctor established that Mr Keay had died from a cerebrovascular accident (a stroke). He also had lung cancer and peripheral arterial disease (a blood circulation disorder that causes the blood vessels outside of the heart and brain to narrow, block or spasm) which contributed to but did not cause his death. The Coroner accepted the cause of death, and no post-mortem examination was carried out.

Inquest into Mr Keay’s death

54. The inquest into Mr Keay’s death was held on 27 December 2023 and a verdict of natural causes was recorded. The coroner concluded that Mr Keay’s death was due to a cerebrovascular accident and that lung cancer and peripheral arterial disease contributed to the death but did not cause it.

Clinical Findings

55. The clinical reviewer found that the care Mr Keay received at Wakefield was equivalent to that which he could have expected to receive in the community. The clinical reviewer made five recommendations to Wakefield, none of which directly related to Mr Keay's death but which the Head of Healthcare will need to address.

Resuscitating Mr Keay

56. Although Mr Keay signed an order not to be resuscitated on 20 July, paramedics resuscitated him when he had a cardiac arrest on his way to hospital on 2 August.

57. After Mr Keay's death, the Head of Healthcare carried out an internal clinical case review which identified that the order had not accompanied Mr Keay in the ambulance to hospital on 2 August and consequently, the paramedics were not aware of it.

58. The Head of Healthcare established that an agency nurse had not followed the correct procedure for logging DNACPR orders. She recommended that all healthcare staff should be made aware of the recording process for orders not to resuscitate. The told us that an email about this had been sent to staff but we have not seen evidence as a copy could not be found. Given the seriousness of this issue, we make the following recommendation:

The Head of Healthcare should ensure that all healthcare staff, including agency workers know how to process non-resuscitation orders.

Non-Clinical Findings

Restraints, security and escorts

59. 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.

60. 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. We have identified a number of significant concerns about the use of restraints on Mr Keay.

Emergency escort on 2 August

61. Mr Keay needed to be admitted to hospital on 2 August because he was short of breath and had an abnormally fast heart rate. A nurse completed the medical risk

assessment and concluded that restraints should not be used but did not record the basis for this decision. Prison managers told us that they did not know that there was a medical objection to the use of restraints. A CM said that he had consulted the nurse and paramedic before restraining Mr Keay.

62. The Head of Security told us that even had he known about the medical objections to the use of restraints, he would still have directed that Mr Keay be restrained. He said that due to Mr Keay's offence and that the default position for a category B prisoner was to use a double cuff, the use of the escort chain was a sufficient reduction which enabled medical staff to provide treatment. He also said that he believed that the nurse who completed the assessment was risk-averse.

63. Mr Keay had a cardiac arrest on his way to hospital and the escort chain was removed at the request of a hospital doctor. The escort chain should not have been reapplied once Mr Keay had stabilised because he remained very unwell and was admitted to the intensive care unit.

64. Given the medical objection, the seriousness of his condition and that Mr Keay was escorted by two prison officers, restraints were inappropriate. The Head of Security's comments that he would have ignored the medical objection if he had been made aware of it were concerning.

65. The escort risk assessment was completed the following day. An officer concluded that Mr Keay posed a high risk to the public and a medium risk of escape due to his offences. He told us that the risk assessment had no real bearing on the restraints arrangements and a prisoner at Wakefield would always be deemed high risk because they were in a high security prison.

66. The investigator discussed the issue with the Governor. He explained that while the starting point for determining the level of risk for a prisoner at Wakefield was as the officer described, a prisoner's individual circumstances such as his age, frailty and presenting health were also considered when making a restraints decision. Given the issues identified I make the following recommendations:

The Head of Healthcare should ensure that all healthcare staff complete medical risk assessment in full so that the authorising manager has sufficient information to make an informed decision about restraints.

The Governor should ensure that prison staff understand that medical information about a prisoner must be properly considered when deciding whether to use restraints and in cases where a medical objection is disregarded, the reason for this decision is documented.

Restraints during and post-surgery

67. On 26 August, the medical team advised the escort officer that Mr Keay's foot would be amputated under local anaesthetic. Mr Keay was restrained with an escort chain throughout the operation because the decision making manager concluded that he could not get a revised Part 11 to the hospital before the surgery.

68. The decision that Mr Keay should be subject to restraints during an operation to have his foot amputated is wholly unjustified. Mr Keay's surgery should have triggered a review of the risk assessment and a decision to remove his restraints

should have been made promptly. It was not until 28 August that a new Part 11 was put in place to remove the restraints.

69. The Governor agreed that the decision to restrain Mr Keay during surgery was incorrect.

70. Despite a management check the day after Mr Keay's surgery and two occasions when restraints were removed to facilitate scans, there was no reassessment of whether restrains were still justified given the significant change in circumstances.

71. During our interviews with prison staff, some officers appeared to lack confidence or did not feel it was appropriate for them to query the appropriateness of restraints, especially when there was a Part 11 in place. It was also apparent that on occasions, the escort staff assumed that the decision-makers were fully aware of all of the circumstances, when in fact, this was not the case. This combination of factors resulted in poor and delayed decisions, and there are a number of deaths under investigation or recently investigated at Wakefield where we have identified an issue with the use of restraints. I make the following recommendations:

The Governor should satisfy himself that:

- **decisions to apply restraints are justifiable at all times in line with the Graham judgment and the rationale for those decisions is correctly documented; and**
- **relevant staff are regularly trained on the Graham judgement in order to challenge the culture of risk aversion that exists at the institution and so as to be empowered to raise any concerns.**

Governor to note

Medical emergency response

72. On 1 and 2 August, an entry in the wing observation book noted that Mr Keay reported having chest pain. While we recognise that on this occasion, it made no difference to the outcome for Mr Keay, there was no evidence that a medical emergency code blue was called.

Liaison with Mr Keay's family

73. When Mr Keay arrived at Wakefield, he advised that he did not have a next of kin. He was admitted to the hospital's intensive care unit on 3 August. However, the prison did not appoint a family liaison officer until 28 August. It then took until 12 September for Mr Keay's brother's address to be located. We consider there was an unnecessary delay in beginning the family liaison process which the Governor will wish to consider.

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Ombudsman **February 2024**

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