Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Keene, a prisoner at HMP Swaleside, on 6 August 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 His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit if appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. Mr David Keene died in hospital on 6 August 2022 of extensive metastatic carcinoma (cancer which has spread around the body) caused by renal cell carcinoma (kidney cancer) while a prisoner at HMP Swaleside. He was 64 years old. We offer our condolences to Mr Keene's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Keene received at Swaleside was equivalent to that which he could have expected to receive in the community. She made three recommendations which did not directly affect Mr Keene's death but will need to be addressed by the Head of Healthcare.

5. We were concerned that the risk assessment to consider the level of restraints for Mr Keene when he went to hospital on 20 July 2022 was not completed by healthcare staff. It was also not considered by an authorising manager. The decision to restrain Mr Keene was not justified given his terminal cancer diagnosis and deteriorating health.

6. Swaleside did not provide the investigator with all the documentation about the use of restraints when Mr Keene was in hospital, which meant that we could not determine whether the decision-making process on those occasions was appropriate.

Recommendations

- The Governor and the 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 in all cases:
    - healthcare staff complete the medical information section of the escort risk assessment to say whether the prisoner's current medical condition affects their mobility and risk of escape; and
    - authorising managers show that they have taken this information into account when assessing a prisoner's current level of risk.

The Investigation Process

7. NHS England and NHS Improvement (NHSE&I) commissioned an independent clinical reviewer, to review Mr Keene's clinical care at HMP Swaleside.

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

9. Mr Keene did not have any nominated next of kin.

Previous deaths at HMP Swaleside

10. Mr Keene was the 16th prisoner to die at Swaleside since August 2020. There have been six since. Of the previous deaths, eight were from natural causes, six were self-inflicted and one was a drugs death.

11. In two previous investigations, Swaleside did not provide the PPO with all of the evidence we had requested to progress our investigation and made recommendations to the Governor as a result. In December 2022, Swaleside said that relevant staff had received additional training to ensure that they fully understood which evidence needed to be collected for an investigation. Swaleside also said that a new member of staff would lead on actions following a death and ensure the PPO received all of the evidence required.

Key Events

12. On 22 August 2018, Mr David Keene was remanded in custody for sex offences. He was later sentenced to 21 years in prison. In June 2020, he was transferred to HMP Swaleside.

13. On 2 March 2021, Mr Keene received a diagnosis of metastatic melanoma (skin cancer which spreads around the body) and clear cell sarcoma of the right kidney (kidney cancer). Two days later, he refused any further investigations or treatment. He was deemed to have the mental capacity to make this decision and referred to the GP for review.

14. On 25 May, a nurse saw Mr Keene with a member of the mental health in-reach team to carry out a mental capacity assessment. The nurse noted that the in-reach worker determined that he had the capacity to refuse medical treatment.

15. On 15 June, Mr Keene said he did not with anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect.

16. On 17 July 2022, a nurse saw Mr Keene as part of the care plan for his illness. She noted that he was in pain all the time and seemed to have deteriorated. She completed his clinical observations however she did not record a National Early Warning Score (NEWS). (NEWS2 is a tool to detect and respond to clinical deterioration. A score above 7 indicates the need for an emergency response.) She discussed his disease progression with him, and he stated that he would like to die in a hospice. She agreed to refer him to a hospice, which she did the same day.

17. On 18 July 2022, a nurse saw Mr Keene to complete a welfare check. She noted that Mr Keene wanted to stay on the wing until he got accepted into a hospice and that he was still in pain despite medication. She did not record a NEWS.

18. On 20 July, a nurse reviewed Mr Keene with a hospice palliative specialist nurse and a hospital palliative nurse because his condition had deteriorated. They noted that he had a swollen stomach and swelling to his feet. They advised admission to the hospital. The nurse spoke to a GP at Swaleside and asked him to review Mr Keene that afternoon to make a decision about going to hospital.

19. Later that day, a nurse and a prison GP saw Mr Keene. They completed clinical observations but did not complete a NEWS. The GP requested that Mr Keene was sent to hospital for an abdominal scan. He was transferred to the inpatient healthcare unit at Swaleside whilst they awaited the escort to hospital.

20. Before Mr Keene went to hospital, prison staff completed an escort risk assessment. Healthcare staff did not complete the medical section (which provides information on the prisoner's existing health concerns, their mobility and whether there are any medical reasons why restraints should not be applied) which remained blank. A security intelligence collator completed the security risk assessment and noted that Mr Keene was low risk of hostage taking and escape and was a low risk to hospital staff and the victim of his offences. He recorded that he was medium risk to the public and to females. He advised that Mr Keene was to be escorted by two officers and restrained for the escort using double cuffs and an

escort chain. Double cuffing is when the prisoner's hands are handcuffed in front of them, and one wrist is attached to a prison officer by an additional set of handcuffs. 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. He advised that the restraints should not be removed for medical treatment and that the prison should be contacted in all circumstances that removal of the restraints might be considered. No authorising governor signed off the risk assessment to authorise the use of restraints.

21. At 2.20am, on 21 July, officers at Mr Keene's bedside removed his restraints to undergo a CT scan. The restraints were replaced after the scan. At this stage it was noted that Mr Keene was not double cuffed but that the escort chain was in use.

22. At 10.51pm, Officer A, who was with Mr Keene, called the prison to ask if he could get permission to remove the double cuff from Mr Keene. No one was available to answer the question and he did not receive a call back. He tried calling again at 11.11pm. It is not clear when the double cuff had been put back on before this call.

23. At 12.27am on 22 July, Officer A spoke to the duty manager in charge of the prison who refused the removal of the cuff stating that the risk assessment would be reviewed the next day.

24. At 2.30pm, a Custodial Manager (CM) spoke to the Head of Residence, who agreed that the restraints could be reduced to an escort chain until Mr Keene returned to Swaleside. There is no risk assessment documentation to support this decision.

25. On 22 July, hospital doctors gave Mr Keene a life expectancy of 2 weeks.

26. At 2.35am on 25 July, two officers were sitting by Mr Keene's bedside. Officer B reported that Mr Keene had abruptly woken up and pulled on the escort chain in a violent manner. He warned Mr Keene to 'behave well' and told him that if he did not, he would call the prison to get permission to reapply the double cuffs. He reported that Mr Keene calmed down.

27. At 5.00am, Officer B reported that Mr Keene had deliberately attempted escape by slipping his cuff halfway down his hand. He called the prison and spoke to a CM, who gave permission to put the double cuff restraint back on.

28. On 26 July, a CM competed a management check and noted that Mr Keene remained compliant and that, due to his illness and current condition he felt it was appropriate to remove the escort chain. It is not clear when the double cuffs had been removed prior to this and the escort chain reapplied. The CM authorised that Mr Keene was no longer restrained. He remained unrestrained until he died. There is no risk assessment documentation to support this decision.

29. On 6 August Mr Keene collapsed in the bathroom at the hospital and died.

Post-mortem report

30. The post-mortem report concluded that Mr Keene died of extensive metastatic carcinoma caused by renal cell carcinoma.

Clinical Findings

Clinical care

31. The clinical reviewer found that the care that Mr Keene received at Swaleside was of the standard he could reasonably have expected to receive in the community. She identified a number of points of good practice which included an assessment of Mr Keene's mental capacity in relation to his refusal of cancer treatment, good communication between the healthcare team and the hospital, consistent and regular support for Mr Keene alongside continuity of care, an understanding of his end of life wishes and good record keeping.

32. She made four recommendations, three of which were not related to Mr Keene's death and the Head of Healthcare will need to address separately.

33. The clinical reviewer was concerned about the lack of healthcare input into the escort risk assessment when Mr Keene went to hospital on 20 July. This is addressed below in this report.

34. She was also concerned that Swaleside did not consistently use the NEWS2 system to identify deteriorating patients at the time of Mr Keene's death. She identified that NEWS2 scoring was not a part of the standard clinical template that Swaleside were using at the time. However, she did not make a formal recommendation as the Head of Healthcare has confirmed that they are now using NEWS2 scoring templates regularly.

Non-Clinical Findings

Restraints, security, and escorts

35. 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.

36. Mr Keene was restrained during the escort to hospital on 20 July using a double cuff and an escort chain. He remained restrained until 26 July, however it was not always clear at which times the decision to change from one form of restraints to another was made, or at what time the restraints changed.

37. When he went to hospital on 20 July, the medical section of the risk assessment was not completed. The security section was completed advising the level of cuffing, however there was no authorising managers decision recorded on the

assessment. We are therefore unable to confirm whether the decision to restrain Mr Keene on 20 July was appropriately considered or not. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances.

38. On 25 July Officer B perceived Mr Keene's actions as an attempted escape and telephoned the prison for approval to apply double cuffs again. There is no record of this being considered as a serious risk of escape after this point as the following day a CM made the decision to remove the restraints altogether. Despite requests, Swaleside did not provide any risk assessments which supported a change in the level of restraints after 20 July. This meant that we were unable to fully consider whether decisions about the level of restraints used on Mr Keene were appropriate.

39. Mr Keene was a terminally ill patient who was told on 22 July that he had just two weeks to live. He was very unwell, and his condition was deteriorating. He had no next of kin, which reduced the risk of outside assistance to escape. He was escorted by two officers. We consider that the application of double cuffs and an escort chain from 20 to 26 July was disproportionate to the risks Mr Keene posed. We make the following recommendations:

The Governor and the 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, in all cases:

- **healthcare staff complete the medical information section of the escort risk assessment to say whether the prisoner's current medical condition affects their mobility and risk of escape; and**
- **authorising managers show that they have taken this information into account when assessing a prisoner's current level of risk.**

Governor to note

40. PSI 58/2010 requires prisons to provide evidence to the Ombudsman's office for the purpose of our investigation. Despite requests, Swaleside did not supply all the risk assessment documentation to the investigator which hampered our investigation.

41. In December 2022, following recommendations made by the PPO, Swaleside said that relevant staff had received additional training to ensure that they fully understood which evidence needed to be collected for an investigation. Swaleside also said that a new member of staff would lead on actions following a death and ensure the PPO received all of the evidence required. Given that these actions came after Mr Keene's death, and to allow time for them to embed, we make no recommendations, but the Governor will want to assure himself that processes to cooperate with PPO investigations are robust.

Inquest Verdict

42. The inquest into the death of Mr Keene was held on 11 October 2023. It confirmed that the medical cause of Mr Keene's death was extensive metastatic carcinoma

caused by renal cell carcinoma. It concluded that Mr Keene died from natural causes.

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

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