

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Thompson a prisoner at HMP Leyhill on 22 February 2016

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

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*



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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.

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 Michael Thompson died on 22 February 2016, at HMP Leyhill, from pancreatic cancer, which had spread to his liver and lungs. He was 69 years old. I offer my condolences to Mr Thompson's friends.

Mr Thompson was diagnosed with cancer just a few weeks before his death. Staff at Leyhill actively planned how best to manage his condition and met his medical and social care needs during the rapid decline in his health. I am satisfied that Mr Thompson received a high standard of end of life care at Leyhill.

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

August 2016

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Summary

Events

1. On 29 October 2008, Mr Michael Thompson received an indeterminate sentence for public protection, with a minimum term to serve of two years. The Parole Board had never considered he was suitable for release.
2. Mr Thompson had no significant health problems until 3 December 2015, at HMP Bullingdon, when he said he had difficulty swallowing, had abdominal pain, vomiting and had lost weight. A prison GP planned to refer him to a specialist, but asked for blood tests first. On 10 December, after receiving the results, the GP referred Mr Thompson urgently to a consultant with suspected cancer. Mr Thompson received a hospital appointment for 23 December.
3. Mr Thompson decided to cancel the appointment, as he preferred to transfer to HMP Leyhill, an open prison, on 22 December, the day before it was due. On 23 December, the day after he arrived at Leyhill, a GP made a further referral.
4. On 5 January 2016, a hospital consultant found a tumour in Mr Thompson's abdomen. After further investigations, doctors diagnosed incurable pancreatic cancer, which had spread to Mr Thompson's liver and lungs. Doctors told him he had only a short time to live.
5. On 20 February, Mr Thompson was admitted to the prison's palliative care unit for 24-hour end of life care. He died on 22 February.

Findings

6. The clinical reviewer considered that there was no need for the GP to wait for blood tests in December before referring Mr Thompson urgently to a specialist. However, he concluded that this, and the further delay in diagnosis when Mr Thompson decided to defer a specialist appointment in favour of a transfer to Leyhill, did not affect the outcome, as his cancer was already advanced.
7. Healthcare staff at Leyhill implemented appropriate care plans to manage Mr Thompson's condition and held weekly multidisciplinary planning meetings. He received daily medical and social care but only palliative care was possible.
8. We are satisfied that Mr Thompson received very good care at Leyhill, at least equivalent to that he could have expected to receive in the community.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Leyhill, informing them of the investigation and inviting anyone with relevant information to contact her. No one responded.
10. NHS England commissioned a clinical reviewer to review Mr Thompson's clinical care in prison.
11. The investigator obtained and reviewed copies of Mr Thompson's medical records and relevant extracts from his prison record.
12. We informed HM Coroner for Avon of the investigation, who gave us the initial cause of death. We have sent the coroner a copy of this investigation report.
13. Mr Thompson had no recorded next of kin and did not want the prison to inform anyone of his terminal illness or death.
14. The investigation has assessed the main issues involved in Mr Thompson's care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, and whether compassionate release was considered.
15. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Background Information

HMP Leyhill

16. Leyhill is an open prison in South Gloucestershire, holding 527 prisoners who require only minimum security. Some are life-sentenced prisoners preparing for release.
17. Bristol Community Health provides primary care services at Leyhill from 7.30am to 4.30pm, Monday to Friday. A local NHS centre, Hanham Health, provides GP and out of hours services. The prison has a palliative care unit, comprising two en-suite patient rooms, a family room for visiting relatives, and a nurses' office. The unit is staffed 24-hours a day when occupied.

HM Inspectorate of Prisons

18. The most recent inspection of Leyhill was in April 2012. Inspectors found a high standard of care at the prison, although there was some concern about the healthcare staffing mix and the disproportionate responsibility carried by healthcare support workers. Inspectors also found good provision of chronic disease management for older prisoners and commended the palliative care service.

Independent Monitoring Board

19. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure prisoners are treated fairly and decently. In its most recently published annual report for the year to January 2015, the IMB commented that problems with providing 24-hour medical and social care for terminally ill prisoners had been resolved and the care and treatment of such prisoners was exemplary.

Previous deaths at HMP Leyhill

20. Mr Thompson was the seventh person to die of natural causes at Leyhill since January 2014. We have consistently found that terminally ill prisoners receive a good standard of care at Leyhill.

Findings

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

21. On 29 October 2008, Mr Michael Thompson received an indeterminate sentence for public protection, with a minimum term to serve of two years, for sexual offences. The Parole Board had never directed his release.
22. Mr Thompson reported no significant health problems. His medical notes showed that he had an aversion to doctors and hospitals but healthcare staff reviewed his health periodically and offered him help to give up smoking, which he declined.
23. On 3 December 2015, at HMP Bullingdon, Mr Thompson told a prison GP that he had problems swallowing food, had abdominal pain, vomiting and had lost weight. The GP advised Mr Thompson that he might have a serious illness but Mr Thompson said he was due to transfer to an open prison and he did not want to delay the move for medical investigations.
24. The GP planned to refer Mr Thompson under the NHS pathway, which requires patients with suspected cancer to be seen by a specialist within two weeks, but requested blood tests first. On 10 December, the results of the blood tests indicated abnormalities and the GP made an urgent specialist referral. Mr Thompson received an appointment for 23 December, but transferred to HMP Leyhill on 22 December and chose to cancel his appointment, rather than stay at Bullingdon.
25. At Mr Thompson's initial health screen at Leyhill, a nurse noted the need for an urgent referral to hospital and referred Mr Thompson to the prison GP. On 23 December, a prison GP discussed the possibility of cancer with Mr Thompson and made another urgent referral. On 5 January 2016, a consultant at hospital examined Mr Thompson and requested an urgent CT scan.
26. On 8 January, a prison GP told Mr Thompson that there was a strong possibility he had a malignant tumour and offered support. The prison's mental health team assessed Mr Thompson and offered support if he needed help to cope with a diagnosis of cancer. On 15 January, the GP informed Mr Thompson that the results of the scan, taken the previous day, showed that he had a tumour in his pancreas and that the cancer had spread to his lungs and the liver.
27. The clinical reviewer considered that Mr Thompson's symptoms in December, would have justified an urgent specialist referral without blood tests. Mr Thompson's decision to move to Leyhill caused a further two weeks delay in diagnosis. However, this was Mr Thompson's choice. The clinical reviewer was satisfied that these delays did not affect the outcome for Mr Thompson, as the cancer was already very advanced. Mr Thompson's decision to postpone his appointment was equivalent to a decision by someone in the community who chose to move and postpone treatment.

Mr Thompson's clinical care

28. On 18 January, a prison GP discussed Mr Thompson's diagnosis and treatment plan with him and arranged for a nurse to support him. Healthcare staff implemented care plans to manage Mr Thompson's condition and pain and held weekly multidisciplinary meetings, to which he was invited.
29. On 3 February, the prison received a letter from the hospital consultant, who advised that Mr Thompson had a short life expectancy and that palliative chemotherapy was not appropriate. The next day, a GP discussed this with Mr Thompson who decided that he did not want to be resuscitated if his heart or breathing stopped. The GP completed and signed a form to confirm this and circulated it to all those involved in Mr Thompson's care.
30. On 7 February, healthcare staff arranged additional nursing and social care. Healthcare staff reviewed him once or twice daily and he received social care support twice a day.
31. On 10 February, staff noted that Mr Thompson's condition was deteriorating. A doctor prescribed opiate pain relief, which was initially taken orally or by skin patches. As his pain increased, top ups were given by injection. On 21 February, a syringe driver was fitted, to give a continuous combination of opiates and anti-anxiety medication.
32. Mr Thompson died in the prison's palliative care unit at 3.51am on 22 February. An officer and a nurse were with him at the time.
33. The clinical reviewer considered that Mr Thompson's care was at least equivalent to that he could have expected to receive in the community. Mr Thompson's treatment was well managed at Leyhill, he had comprehensive care plans, and appropriate pain relief. We are satisfied that he received good end of life care.

Mr Thompson's location

34. Healthcare staff initially cared for Mr Thompson in his cell. He moved to a larger room with a hospital bed. A trained prisoner carer helped Mr Thompson with day-to-day living, collected meals for him and kept his room clean.
35. As his condition worsened, healthcare staff prepared for Mr Thompson's admission to the prison's palliative care unit and took him to see the accommodation. They frequently reviewed his location. On 20 February, Mr Thompson moved to the unit, when he needed 24-hour healthcare.
36. We are satisfied that Mr Thompson was appropriately located throughout his terminal illness.

Restraints, security and escorts

37. As a category D prisoner in an open prison, Mr Thompson was released on temporary licence for his medical appointments. A prison officer accompanied him for support and to help effective communication about his care, but no restraints were used.

Liaison with Mr Thompson's family

38. On 3 February, the prison appointed an officer as a family liaison officer. He visited Mr Thompson frequently and offered additional support. Mr Thompson had not named anyone as his next of kin and said he did not want anyone outside the prison to be informed of his illness or death. He declined to give details of any family, but asked the officer to tell a particular friend on his wing when he died.
39. At 10.30am on 22 February, the officer went to see Mr Thompson's friend and informed him of Mr Thompson's death. As the prison had no information about any family, he was unable to inform anyone else.
40. In line with national policy, the prison arranged and paid for Mr Thompson's funeral, which was held on 7 March. A memorial service was held in the prison chapel.

Compassionate release

41. Prisoners can be released before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months.
42. During their meeting on 3 February, a GP and Mr Thompson discussed compassionate release and prison staff started an application the next day. They began to explore accommodation options, but Mr Thompson died before suitable care was found. In any event, just before he died, Mr Thompson told nurses that he preferred to remain at Leyhill.
43. We are satisfied that the prison appropriately considered compassionate release.

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