Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Godfrey Reeves a prisoner at HMP Leyhill on 8 December 2015

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*

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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 Godfrey Reeves died on 8 December 2015 of pneumonia and a lung infection, while a prisoner at HMP Leyhill. He was 71 years old. I offer my condolences to Mr Reeves' family and friends.

I visited Leyhill in November 2015 and met Mr Reeves shortly before his death. Mr Reeves told me that staff were caring for him well and this has been confirmed by the investigation. I am satisfied that Mr Reeves received a good standard of care in prison and there was nothing that staff at the prison could have done to prevent his death.

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

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Nigel Newcomen CBE
Prisons and Probation Ombudsman **June 2016**

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Summary

Events

1. On 11 August 2008, Mr Godfrey Reeves was sentenced to 18 years in prison for sexual offences. On 20 August 2013, he was transferred to HMP Ashfield. Mr Reeves had a number of health problems including heart disease, shortness of breath, arthritis, deep vein thrombosis in his leg and hypertension (high blood pressure). His mobility was poor.

2. In February 2015, Mr Reeves was diagnosed with chronic obstructive pulmonary disease (COPD – the name for a collection of progressive lung diseases, including emphysema and chronic bronchitis). His condition was incurable and it was recognised that he was entering the final, palliative phase of his life.

3. In July 2015, Mr Reeves told a hospital doctor that he did not want anyone to resuscitate him if his heart or breathing stopped. In August, a doctor at Ashfield reviewed the decision with Mr Reeves and noted that he was a little uncomfortable about the discussion but agreed he did not want to be resuscitated. Two weeks later, another doctor formally recorded the decision.

4. On 1October, Mr Reeves was admitted to hospital and treated for a chest infection. As he now needed continuous oxygen therapy, which was not available at Ashfield, he was discharged to HMP Leyhill on 8 October. On 14 October, he told a prison GP that he was not aware that he had agreed to a 'do not resuscitate order' and the GP reversed the decision to allow him more time to think about it.

5. Mr Reeves' health continued to deteriorate and he was prone to chest infections. On 7 December, Mr Reeves decided again that he did not want to be resuscitated if his heart or breathing stopped. On 8 December, he was admitted to hospital with a suspected chest infection and died in hospital that evening.

Findings

6. Mr Reeves' condition was appropriately investigated and diagnosed in February 2015. From that point, his death was foreseeable but no one knew how long he would live. At times, Mr Reeves appeared unsure about his wishes about resuscitation and records could have reflected this better, but overall we are satisfied that Mr Reeves received a good standard of care. The clinical reviewer noted that during the last two years of his respiratory illness, prison healthcare staff reviewed and monitored him appropriately, particularly after he was diagnosed with incurable lung disease and his subsequent move to Leyhill. In the final stage of his life, healthcare staff at Leyhill looked after him with care and compassion.

The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Leyhill informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

8. NHS England commissioned a clinical reviewer to review Mr Reeves' clinical care at the prison.

9. The investigator obtained copies of relevant extracts from Mr Reeves' prison and medical records. She and the clinical reviewer interviewed four members of staff at Leyhill on 4 February 2016.

10. We informed HM Coroner for Avon of the investigation, who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

11. One of the Ombudsman's family liaison officers contacted Mr Reeves' family to explain the investigation. They had no specific matters for the investigation to consider.

12. The investigation has assessed the main issues involved in Mr Reeves' care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.

13. Mr Reeves' family received a copy of the report. They made comments regarding the factual accuracy of the report. Changes were made to the report.

14. The prison considered our initial report and made seven suggestions regarding changes to the report. Five were accepted and changed; two were not as they were not considered to be factual inaccuracies.

Background Information

HMP Leyhill

15. HMP Leyhill is an open prison in South Gloucestershire, holding 515 prisoners, who require only minimum security.

16. 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.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Leyhill was in April 2012. The Inspectorate noted there was a high standard of healthcare at the prison, although there was some concern about the staffing mix and the disproportionate responsibility carried by healthcare support workers. Inspectors found good chronic disease management and an excellent palliative care service.

Independent Monitoring Board

18. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure prisoners are treated fairly and decently. In its annual report for the year to January 2015, the IMB noted that terminally ill prisoners received excellent care and treatment.

Previous deaths at HMP Leyhill

19. Mr Reeves was the fifth prisoner to die from natural causes at Leyhill since the start of 2014. There were no significant similarities with the circumstances of the previous deaths. In each case, we found that the prison provided a good standard of care.

Findings

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

20. On 11 August 2008, Mr Godfrey Reeves was sentenced to 18 years in prison for sexual offences. He began his sentence at HMP Cardiff and transferred to HMP Ashfield on 20 August 2013.

21. Mr Reeves had a number of health problems including heart disease, shortness of breath, arthritis, deep vein thrombosis in his leg and high blood pressure. Despite his health problems Mr Reeves smoked. His mobility was poor. Prison healthcare staff frequently monitored and reviewed Mr Reeves' conditions.

22. On 12 February 2015, a prison GP examined Mr Reeves, who was breathless and coughing green sputum. The GP arranged for him to be admitted to hospital. In hospital, Mr Reeves was treated with antibiotics for a chest infection and doctors diagnosed chronic obstructive pulmonary disease (COPD). Doctors informed Mr Reeves of the diagnosis and told him he needed oxygen therapy to ease his breathlessness.

23. On 20 February 2015, the hospital discharged Mr Reeves back to Ashfield. Nurses and GPs continued to monitor and review Mr Reeves frequently. From the time of his diagnosis with COPD, it was recognised that his condition was incurable and only palliative treatment to alleviate symptoms would be possible.

24. We are satisfied that the prison GP appropriately referred Mr Reeves to hospital to investigate his symptoms and that he was appropriately informed of his diagnosis of COPD.

Mr Reeves' medical treatment

25. On 30 July 2015, Mr Reeves was admitted to hospital and treated with antibiotics for pneumonia. On 5 August, the hospital discharged him back to Ashfield. In hospital, a doctor had discussed Mr Reeves' wishes about resuscitation with him. Mr Reeves had said he did not want to be resuscitated if his heart or breathing stopped. This decision was formally recorded and noted in the hospital discharge letter.

26. On 7 August, a prison GP discussed the decision about resuscitation with Reeves. He noted that Mr Reeves was "a little fazed" but confirmed that he did not anyone to resuscitate him if his heart or breathing stopped. On 20 August, the GP signed a formal Do Not Attempt Cardiopulmonary Resuscitation notice. He said he had not discussed this with Mr Reeves but it had appeared as a task to be completed on SystmOne, the computerised medical record system. The prison GP presumed this was the result of the GP's earlier discussion with Mr Reeves.

27. Throughout September, healthcare staff reviewed and monitored Mr Reeves regularly. Records show that his need for oxygen was increasing and staff reviewed and adjusted his medication.

28. On 1 October, Mr Reeves reported feeling breathless and coughing up phlegm. He was admitted to hospital and doctors treated him with intravenous antibiotics. Doctors noted that Mr Reeves now required continuous oxygen therapy. Ashfield could not provide this, so prison staff arranged for him to transfer to HMP Leyhill, which could facilitate the continuous oxygen therapy he needed. On 8 October, the hospital discharged Mr Reeves directly to Leyhill.

29. When he arrived at Leyhill, a healthcare support worker assessed Mr Reeves and noted that he knew how to use the oxygen concentrators and cylinders. She also checked his medication.

30. On 9 October, a healthcare assistant discussed Mr Reeves' social care needs with him. A prison GP reviewed him and noted the COPD diagnosis. The doctor told the healthcare assistant that if Mr Reeves' condition deteriorated, arrangements should be made to give him antibiotics or for him to be readmitted to hospital. Later that day, the healthcare assistant and a Bristol Community Health manager went to check Mr Reeves in his cell. The healthcare assistant noted that he was using more oxygen than anticipated, and arranged for more oxygen cylinders to be delivered.

31. On 13 October, a nurse rang the Respiratory Clinic at the hospital for more detail about Mr Reeves' condition, prognosis, and care plan. Hospital staff told her that his condition was incurable and his treatment was palliative, to alleviate symptoms, but he was not yet at the end of life stage. The hospital confirmed he was prescribed oramorph (liquid morphine) for pain relief. She arranged for Mr Reeves to have a social care assessment and referred him to a prison GP.

32. On 14 October, a prison GP spoke to Mr Reeves about his diagnosis, his oxygen, pain relief prescription and his wishes about resuscitation. She noted that Mr Reeves said he was not aware of the formal do not resuscitate order. After a long discussion, the doctor and Mr Reeves agreed to rescind the order. She told Mr Reeves they should talk about resuscitation again and she would speak to his relatives about this, if he wanted.

33. During the night of 17 October, Mr Reeves was having breathing difficulties and asked for a nebuliser (a machine which administers medication in the form of a mist.) The wing log shows that officers contacted the out of hours GP, who gave permission for Mr Reeves to use another prisoner's nebuliser and suggested staff call an ambulance if he did not improve.

34. On 30 October, the healthcare support worker reviewed Mr Reeves and noted he was exhausted, pale, and too tired to do anything. She did not record any action to follow this up.

35. On 4 November, Mr Reeves told a prison GP that had decided that he wanted to be resuscitated. The GP told him he had a severe, irreversible lung condition and should his heart stop, it would be traumatic and almost certainly futile to attempt resuscitation. The GP said that they did not want to cause him suffering and Mr Reeves said he would think about this further.

36. On 7 November, Mr Reeves told the healthcare support worker that he was having difficulty breathing. She noted his respiratory rate and blood pressure

were low and rang the on call GP, who told her to call an ambulance. When paramedics arrived, they adjusted Mr Reeves' oxygen cannula (which provides oxygen through the nostrils) and decided that he did not need to go to hospital. She referred Mr Reeves to the practice nurse, who reviewed him the next day.

37. On 24 November, a prison GP prescribed antibiotics as Mr Reeves had a chest infection. On 26 November, another prison GP noted that Mr Reeves was exhausted and arranged blood tests. On 3 December, the results showed Mr Reeves was anaemic and a GP arranged his admission to hospital for a blood transfusion, which he had on 7 December, and told staff he felt better for it. That day, Mr Reeves told the GP that he had decided that he did not want to be resuscitated if his heart or breathing stopped, and the GP formally recorded his decision.

38. On 8 December, Mr Reeves collapsed in his cell when his nasal cannula became dislodged and he was gasping for breath. A nurse noted he looked grey, his respiration and oxygen were both low; he was very chesty and coughed up a yellow/green phlegm. Mr Reeves was admitted to hospital and died there that evening.

39. A post-mortem examination found that Mr Reeves had died from pneumonia and empyema (lung infection) with a background of dilated cardiomyopathy (enlarged heart that cannot pump blood effectively) and COPD.

40. The clinical reviewer noted that it was that an earlier blood transfusion when Mr Reeves appeared pale and exhausted on 30 October might provided some symptomatic relief, but would not have affected the outcome for Mr Reeves. The Head of Healthcare was also concerned that the out of hours GP had advised using another prisoner's medication on 17 October. We are satisfied that she has taken action to address these matters. The clinical reviewer noted that a decision about resuscitation was not discussed with Mr Reeves at Ashfield at the time it was recorded and in his review has made a recommendation, which the Head of Healthcare at Ashfield will need to address.

41. Overall, we are satisfied that Mr Reeves received an appropriate standard of care at both prisons. The clinical reviewer noted that in the final months of his life, healthcare staff at Leyhill treated Mr Reeves with care and compassion.

Mr Reeves' location

42. When Mr Reeve was admitted to hospital in October 2015, his condition had deteriorated significantly and he needed continuous oxygen therapy, which could not be provided at Ashfield. On 2 October, a prison nurse contacted Leyhill to arrange for Mr Reeves to go there. Nurses from both prisons attended a multidisciplinary meeting to arrange his effective transfer. At Leyhill, nurses arranged continuous oxygen therapy and saw him daily. We are satisfied that Mr Reeves was appropriately located throughout his illness.

Restraints, security, and escorts

43. When prisoners have to travel outside prison, a risk assessment determines the nature and level of any security arrangements, including restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. The level of restraints used should be necessary in the circumstances and the risk assessment should consider the risk of escape, the risk to the public and take into account factors such as the prisoner's health and mobility.

44. We are pleased to note that Ashfield did not use restraints when Mr Reeves was admitted to hospital in October. After his transfer to Leyhill, as a category D prisoner in an open prison, no restraints were used. On 8 December, Mr Reeves was released on temporary licence when he was admitted to hospital, with one officer to accompany him for support. We are satisfied this was appropriate.

Liaison with Mr Reeves' family

45. Mr Reeves phoned his wife often and she was fully aware of his condition and declining health. On 8 December, the prison appointed an officer as their family liaison officer. A custodial manager rang Mr Reeves' wife to tell her he had been admitted to hospital. Mr Reeves' wife and daughter went to the hospital and hospital staff told them that Mr Reeves had died. The family liaison officer spoke to Mr Reeves' wife at the hospital and offered her condolences and support.

46. Mr Reeves' funeral was held on 6 January 2016.

47. We are satisfied that the prison properly informed Mr Reeves' family of his admission to hospital on 8 December and that his family was appropriately supported, after his death.

Compassionate release and release on temporary licence

48. 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.

49. Although Mr Reeves' COPD was deteriorating and his condition was incurable, he had no clear prognosis for end of life and no application for compassionate release was made. We are satisfied this was appropriate.

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