Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr James Hall a prisoner at HMP Leyhill on 21 May 2016

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*

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 Hall died from lung cancer, at HMP Leyhill, on 21 May 2016. He was 70 years old. I offer my condolences to Mr Hall's family and friends.

Mr Hall died only two weeks after the diagnosis of his terminal cancer. The investigation found that healthcare and prison staff gave caring and compassionate palliative treatment and support. There was a short delay in moving Mr Hall to the palliative care suite due to uncertainty among healthcare staff about the criteria for determining the end of life stage, but this did not affect his medical care.

Overall, Mr Hall's care was of a high standard, equivalent to that he could have expected in the community.

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 **November 2016**

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Summary

Events

1. Mr James Hall was a life-sentenced prisoner. He had been at HMP Leyhill since 17 November 2015. Mr Hall had several chronic health problems, including diabetes, high blood pressure, peripheral vascular disease (narrowing of the arteries outside the heart and brain), chronic obstructive pulmonary disease (COPD - the name for a collection of progressive lung diseases, including chronic bronchitis and emphysema) and mental health problems.

2. At the end of December 2015, blood tests showed that Mr Hall had anaemia. A prison doctor suspected that he might have bowel cancer and referred him urgently to a specialist. No cancer was found, but healthcare staff continued to monitor him and referred him to a gastroenterologist when his iron deficiency did not improve. On 27 April, a prison doctor sent Mr Hall to hospital as an emergency, with symptoms of breathlessness, wheezing, a productive cough, loose bowels, and low oxygen levels. Hospital doctors diagnosed advanced, inoperable lung cancer and advised that he could only receive palliative treatment to ease his symptoms. Mr Hall said that he did not want to be resuscitated if his heart or breathing stopped.

3. Mr Hall chose to return to the prison for palliative care and he left hospital on 12 May. A multidisciplinary team oversaw his management. Nurses created care plans, in consultation with community practitioners, and reviewed him daily. A social care assistant attended the prison twice a day to help with his personal care. A prison doctor prescribed end of life medication on 13 May, and his other medication was reviewed. Mr Hall's health declined rapidly. On 20 May, he moved into the prison's palliative care suite and he died the following day.

Findings

4. We are satisfied that prison doctors and nurses promptly investigated and monitored Mr Hall's symptoms, and sent him to hospital without delay when his condition deteriorated. After his diagnosis, he had supportive medical and social care.

5. We are concerned that there was a lack of clarity and consensus between healthcare staff as to whether Mr Hall had reached the end of life stage, and that the clinical judgement of a prison GP to move him to the palliative care suite was initially overruled. Although the issue was quickly resolved, Mr Hall might have benefitted from moving to the palliative care unit sooner for assistance with his medication, and enhanced social care. We are satisfied that the short delay did not significantly impair his medical care, and agree with the clinical reviewer that his care was equivalent to that he would have expected to receive in the community.

Recommendation

- The Head of Healthcare should review the criteria to determine end of life and issue guidance to all medical staff.

The Investigation Process

6. 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.

7. The investigator obtained copies of relevant extracts from Mr Hall's prison and medical records.

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

9. We informed HM Coroner for Avon of the investigation who gave us Mr Hall's cause of death. We have sent the coroner a copy of this report.

10. One of the Ombudsman's family liaison officers contacted Mr Hall's brother to explain the investigation. He raised no questions or concerns for the investigation to consider.

11. The investigation has assessed the main issues involved in Mr Hall's 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.

12. Mr Hall's brother received a copy of the initial report. He did not make any comments.

13. The initial report was shared with the Prison Service. The Prison Service pointed out two factual inaccuracies, which have been amended.

Background Information

HM Leyhill

14. HMP Leyhill is an open prison in South Gloucestershire, holding 515 prisoners who require minimum security. Some are life-sentenced prisoners preparing for release.

15. 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

16. The most recent inspection of HMP Leyhill was in April 2012. The Inspectorate considered 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

17. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to January 2016, the IMB reported that there was a high standard of healthcare, with access to GPs every weekday. Prisoners with chronic illnesses received a care plan booklet explaining their condition, medication and test results, with sections to record their own comments. Personal care assistants provided daily assistance to those who needed help with social care. The Board said that the palliative care suite was appreciated by those who used it.

Previous deaths at HMP Leyhill

18. Mr Hall was the seventh prisoner to die from natural causes at Leyhill since the beginning of 2014. There were no significant similarities with the circumstances of the deaths we have already investigated. In each case, we found that the prison provided a good standard of care.

Findings

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

19. Mr James Hall was serving a life sentence for sexual offences. He had been at HMP Leyhill since 17 November 2015. Mr Hall had several chronic health conditions, including diabetes, high blood pressure, peripheral vascular disease, COPD and mental health problems. He had stopped smoking in 2013.

20. On 29 December, a prison GP reviewed Mr Hall as blood tests had revealed anaemia. She asked him about symptoms, and Mr Hall said he had not lost weight, or noticed any changes in his bowel movements. In spite of this, she suspected that he might have bowel cancer and referred him urgently to a colorectal specialist, under the NHS pathway, which requires patients with suspected cancer to be seen by a specialist within two weeks. A prison administrator processed the referral the same day and Mr Hall received an appointment for 6 January. The hospital consultant found no abnormalities and advised a repeat blood test in two months, with a referral to a gastroenterologist if there was no improvement in his anaemia.

21. On 30 March, a prison GP referred Mr Hall to a gastroenterology consultant, as medication had not improved his iron deficiency. While waiting for an appointment, Mr Hall became unwell. On 27 April, he told a nurse that over the previous 10-12 days, he had felt ill, with a wheezy chest, shortness of breath, a productive cough, and loose bowels. She found that his oxygen levels were low. A prison GP sent him to hospital, where he was admitted for further tests.

22. During an update on 5 May, hospital staff informed the prison that Mr Hall had advanced, incurable lung cancer. They expected him to remain in hospital for some time and he would need palliative care as soon as he was discharged.

23. While in hospital, Mr Hall said that he did not want to be resuscitated if his heart or breathing stopped. Medical staff signed an order to this effect and agreed with staff at Leyhill that it would remain in place when he returned to the prison.

24. On 11 May, a multidisciplinary team, comprising hospital and prison healthcare staff discussed a care plan to allow Mr Hall to return to Leyhill. It was agreed that he would receive social care twice a day; he would be prescribed oramorph for symptom control and continuous oxygen; a hospital bed and commode would be provided; and the hospital's palliative care team would refer him to a hospice.

25. Healthcare staff appropriately monitored and treated Mr Hall's medical conditions and a prison GP referred Mr Hall to a specialist promptly to further investigate his symptoms when she was concerned that he might have cancer. Although nothing abnormal was detected at that time, routine monitoring of his symptoms continued. When Mr Hall's health worsened, another GP sent him to hospital immediately and doctors diagnosed his cancer just over a week later. We are satisfied that there were no missed opportunities to diagnose Mr Hall's cancer sooner.

Mr Hall's clinical care

26. Mr Hall was discharged from hospital during the afternoon of 12 May and returned to Leyhill. Wing staff noted that he had been prescribed Oramorph (liquid morphine), but had not starting using it.

27. The next morning, a prison GP discussed the diagnosis with Mr Hall. The GP noted that he was only suitable for palliative care, that there was a new diagnosis of cirrhosis of the liver, but no further assessment would take place due to his lung cancer. Mr Hall had respiratory failure, but was not particularly short of breath. Although very frail, he was in no pain and the doctor noted he was likely to deteriorate quickly. The GP considered Mr Hall had no specific nursing needs, but would need to go to hospital if he became unwell over the weekend. He prescribed end of life medication, and planned to discuss his future care with the healthcare managers.

28. Nurses reviewed Mr Hall every day. They checked his oxygen and pain levels, and his bowel actions. A social care assistant helped with his personal care twice a day. Mr Hall signed a consent form to allow appropriate information about his condition to be shared with discipline staff. Wing staff spoke to him several times a day and completed a very detailed record of their visits. Chaplaincy staff also visited him.

29. The prison held a multidisciplinary team meeting, comprising healthcare and discipline staff and managers, on 16 May, to discuss Mr Hall's palliative and social care. They planned to move him to the palliative care unit and increase his nursing support when his condition deteriorated. They also created contingency plans to support staff if they needed out of hours advice or assistance.

30. On 17 May, a palliative care nurse from a hospice visited Mr Hall. The next day a prison GP examined him and completed a prescription for medication through a syringe driver (a pump to deliver a continuous flow of medication, injected under the skin). As Mr Hall's condition worsened, healthcare staff consulted the hospice and the community district nurses about his palliative care needs and adjusted his medication.

31. Several times on 19 May and 20 May, wing staff reported that Mr Hall had been incontinent in his cell. In the early hours of 20 May, they called a prison GP, who said he should have a carer. She agreed to contact the Head of Healthcare to arrange for a carer from HMP Eastwood Park to wash and change Mr Hall.

32. Later that morning, a prison GP examined Mr Hall, and found a significant deterioration in his condition. He was breathless, in pain, nauseous, confused and had diarrhoea. The GP noted that he was likely to be entering his final stage of life, he could not manage his medication and his symptoms were not well controlled. A multidisciplinary meeting was held to discuss Mr Hall's location and care and healthcare staff later reviewed his care plan.

33. At 8.40am on 21 May, healthcare staff asked a GP to go to the prison, due to a rapid deterioration in Mr Hall's condition overnight. After examining Mr Hall, she increased his oxygen intake and stopped all oral medication. She felt he did not

need the syringe driver yet, as his symptoms were not causing distress. She also rewrote the order not to resuscitate Mr Hall, as she considered a faxed photocopy of the original document from the hospital was invalid.

34. At around 1.40pm on 21 May, Mr Hall's carer and the officer on duty noted that Mr Hall had stopped breathing. At 2.20pm, a prison GP confirmed his death.

35. The Coroner confirmed that the cause of Mr Hall's death was lung cancer. Mr Hall also had congestive cardiac failure and COPD.

36. We agree with the clinical reviewer that Mr Hall received appropriate and compassionate palliative care at Leyhill, equivalent to that he could have expected in the community.

Mr Hall's location

37. After his admission to hospital on 27 April, Mr Hall's condition deteriorated rapidly. However, he did not want to stay in hospital and asked to return to Leyhill. When he returned to the prison on 12 May, staff moved him to a double cell with a medication safe.

38. On 20 May, after noting a significant deterioration in his condition, a prison GP recommended to healthcare staff that Mr Hall transfer to the palliative care unit, as his medical and care needs had increased and the doctor was concerned about the lack of dignity on an open wing. A multidisciplinary meeting was convened to discuss how to address this. It was noted that Mr Hall was unable to manage his medication and that, in the last few days, disability liaison orderlies had inappropriately assisted with this and aspects of his personal care.

39. A nurse noted in the medical records that it had been agreed Mr Hall should move to the palliative care unit and, between them, healthcare staff had arranged 24-hour cover. However, after discussing the proposed move with the prison GP, the Head of Healthcare refused to authorise it and said that healthcare could not cover nights until Mr Hall was at the end of life stage. He considered he had not yet reached the end of life, as he was not yet using a syringe driver. Several discussions then took place between the doctor, healthcare staff, the social care manager and the community end of life assessment team about Mr Hall's needs and the definition of end of life. The community team suggested that this would be around the final six weeks and especially once end of life medication had been prescribed. (The GP had prescribed such medication a week before.)

40. A nurse noted that the Governor then approved the move, to ensure Mr Hall's dignity and privacy, and the Head of Healthcare subsequently agreed. At around 4.00pm, Mr Hall moved into the palliative care suite, where he was supported by staff overnight.

41. We are satisfied that the prison considered and discussed Mr Hall's location with him and complied with his wishes to go back to Leyhill, rather than remaining in hospital. On his return, they provided a larger cell and appropriate furniture. However, we are concerned that the GP's clinical opinion and advice about moving Mr Hall to the palliative care suite was initially disregarded, due to uncertainty and a lack of consensus among healthcare staff about the criteria for

deciding when a patient has reached the end of life stage. This led to a delay in transferring him to the suite. We make the following recommendation:

The Head of Healthcare should review the criteria to determine end of life and issue guidance to all medical staff.

Restraints, security and escorts

42. When prisoners have to travel outside of the prison, a risk assessment determines the nature and level of 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. Any restraints used should be necessary and decisions should be based on the security risk taking into account factors such as the prisoner's health and mobility.

43. As a category D prisoner in an open prison, Mr Hall was released on temporary licence for hospital appointments, accompanied by an officer for support. No restraints were used.

Liaison with Mr Hall's family

44. After Mr Hall returned from hospital on 12 May, the prison immediately appointed an officer as his family liaison officer. The same day, the officer spoke to Mr Hall about his illness and contacting his family. Mr Hall told him he had two brothers, but he was estranged from them. He said he was content for the officer to tell them about his illness, but did not want them to visit. Later that day, the officer informed one of Mr Hall's brothers of his condition. He spoke to his other (elder) brother on 16 May.

45. At 2.40pm, as agreed during their conversations, the officer telephoned Mr Hall's elder brother, to notify him of Mr Hall's death. In line with national policy, the prison arranged and paid for Mr Hall's funeral, held on 22 June 2016.

46. We are satisfied that the prison appointed a family liaison officer promptly after Mr Hall's diagnosis and complied with his wishes about contacting his family.

Compassionate release

47. Prisoners can be released from custody 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.

48. During a discussion with an officer on 16 May, Mr Hall said that, after visiting the prison's palliative care suite, he had firmly decided that he did not want to be considered for early release.

49. We are satisfied that the prison discussed the possibility of compassionate release with Mr Hall and respected his preference to remain at Leyhill.

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