Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lee Sadler a prisoner at HMP Birmingham on 17 January 2017

A report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

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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.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Lee Sadler died on 17 January 2017 of lung cancer while a prisoner at HMP Birmingham. He was 50 years old. I offer my condolences to Mr Sadler's family and friends.

The investigation found that Mr Sadler generally received good care at Birmingham and that his clinical care was equivalent to that he could have expected to receive in the community. However, we note that there was scope to improve the quality of risk assessments for the use of restraints and to have considered compassionate release.

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 **October 2017**

Contents

Summary ....

The Investigation Process ....

Background Information ....

Findings ....

Summary

Events

1. On 29 July 2016, Mr Lee Sadler was convicted of robbery and sent to HMP Birmingham.

2. When he arrived, Mr Sadler told healthcare staff that he had chronic obstructive pulmonary disease (a condition of the lungs) and that a doctor diagnosed him with lung cancer three years earlier. He said that, after treatment, there were no signs of the disease, but he had not attended his oncology appointments over the next two years and a CT scan had subsequently confirmed that the cancer had spread. Mr Sadler's condition was not curable and he was treated palliatively.

3. A nurse put in place a care plan, and a doctor prescribed medication to manage all of his conditions. Multidisciplinary meetings were held so that healthcare and prison staff could manage Mr Sadler's varying needs effectively.

4. Over the following months, Mr Sadler underwent palliative radiotherapy and chemotherapy. There were occasions when he went to hospital appointments but was sent back to the prison because the hospital was not aware of them, or they had been cancelled.

5. In late December, a nurse recorded that Mr Sadler looked unwell and had a distended stomach. The swelling increased and he was sent to hospital for fluid to be drained on 6 January, but discharged himself before treatment. Mr Sadler's swelling worsened and, on 11 January, healthcare staff sent him back to hospital. Mr Sadler's health declined rapidly, and he died in hospital on 17 January 2017.

Findings

6. We are satisfied that Mr Sadler's care at Birmingham was equivalent to that which he could have expected to receive in the community, although the clinical reviewer noted problems with Mr Sadler attending unnecessary hospital appointments.

7. We found no evidence in Mr Sadler's clinical records to indicate that staff considered conditional release on compassionate grounds.

8. We found that the prison's escort risk assessments did not have the required medical input to consider the impact of his health on his ability to escape and, were therefore not based on the actual risk that he presented at the time.

Recommendations

- The Head of Healthcare should ensure that there is effective communication between the prison healthcare department and the hospital so that prisoners do not attend hospital unnecessarily.

- The Director and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on using restraints and that assessments fully take into

account a prisoner’s health and are based on the actual risk the prisoner presents at the time.

- The Director should ensure that when a prisoner is given a terminal diagnosis, any decisions about compassionate release are clearly documented.

The Investigation Process

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

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

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

12. We informed HM Coroner for Birmingham and Solihull of the investigation. A post mortem was not held, as the coroner accepted the opinion of the oncologist at the hospital that Mr Sadler died of lung cancer. We have sent the coroner a copy of this report.

13. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS found two factual inaccuracies.

14. The investigation has assessed the main issues involved in Mr Sadler'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.

Background Information

HM Prison Birmingham

15. HMP Birmingham is a local prison, and holds up to 1,450 men. It is managed by G4S Care and Justice Services. Birmingham and Solihull Mental Health Foundation Trust provides 24-hour health services at the prison and sub-contract Birmingham Community Healthcare NHS Trust to provide primary care services, which includes two 20 bed wards.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Birmingham was in March 2014. Inspectors noted that health services were generally very good and valued by most prisoners. Patients with complex, acute or chronic needs had access to well-organised inpatient units staffed by caring nurses and officers. External health appointments were rarely cancelled for security reasons. Inspectors noted that the healthcare centre had a new palliative care room and waiting times to see the doctor were less than 48 hours.

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 June 2016, the IMB reported that healthcare staff sickness levels had had a negative impact on the prison regime, particularly when multiple unlock (more than one officer is needed for safety reasons) was required. However, there continued to be a high level of prisoner satisfaction with the service provided by the healthcare department.

Previous deaths at HMP Birmingham

18. Mr Lee Sadler is the seventh prisoner to die of natural causes at Birmingham since January 2016. We have made previous recommendations about the need for appropriate risk assessments before the use of restraints.

Findings

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

19. On 29 July 2016, Mr Lee Sadler was convicted of robbery and was sent to HMP Birmingham that day.

20. On arrival, Mr Sadler told a nurse that he had COPD, that a doctor diagnosed him with lung cancer in 2013, and that he had a prognosis of six months. There is no evidence to suggest that anyone from the prison sought to confirm Mr Sadler's prognosis.

21. The nurse referred Mr Sadler to a doctor. A prison doctor saw him that day.

22. The prison doctor assessed Mr Sadler as suitable for in-possession medication. He was not prescribed cancer medication as it was incurable but was prescribed pain relief, and Fortisip (a disease-related malnutrition supplement). Staff reviewed and updated Mr Sadler's care plans throughout his sentence.

23. On 30 July, a nurse created a care plan, including a waterlow assessment (for bed sores/ulcers), a daily food log, regular blood tests to check for any nutritional deficiencies and he was to be weighed weekly. Mr Sadler agreed to attend smoking cessation appointments and she gave him a nicotine inhaler.

24. On 1 August, a nurse saw Mr Sadler. They discussed his diagnosis and prognosis and Mr Sadler told her that he was clear about his future.

25. Mr Sadler arrived in prison with an incurable form of cancer, and the clinical reviewer felt that healthcare staff provided him with appropriate medication and pain relief, when required. There is evidence in Mr Sadler's medical records that staff at the prison kept him informed at all times and involved him in decisions about his care.

Mr Sadler's clinical care

Background

26. From September 2013, Mr Sadler had chemotherapy. In January 2014, Mr Sadler received his fifth and final planned cycle of chemotherapy. Following further radiotherapy, a CT scan in August 2014 showed that there was no evidence of recurrent disease. Mr Sadler failed to attend later follow-up appointments but, in April 2016, Mr Sadler had a CT scan which showed that the cancer had spread to his back and abdomen.

27. On 21 July, an oncologist recommended palliative radiotherapy but he was admitted to Birmingham eight days later.

HMP Birmingham

28. As part of his initial health screen, Mr Sadler agreed to attend smoking cessation appointments but he did not stop smoking.

29. On 1 August, Mr Sadler signed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order, which meant that in the event of cardiac or respiratory arrest, no attempt at resuscitation would be made (but he would receive all other appropriate treatment and care). A nurse told Mr Sadler that staff could review this if he changed his mind; and there is evidence that this happened throughout his sentence. Mr Sadler took a copy of the DNACPR to his hospital appointments.

30. That day, a nurse referred Mr Sadler to the community Macmillan nurse and told her that Mr Sadler was due to start chemotherapy and radiotherapy on 11 August. She asked the hospital to give Birmingham's healthcare department all Mr Sadler's treatment dates.

31. On 10 August, Mr Sadler had his first round of radiotherapy. Afterwards, Mr Sadler complained of increased pain, and a prison doctor prescribed him diazepam (pain relief). On 12 August, Mr Sadler attended an appointment with a cancer specialist at a hospice. She explained that his radiotherapy might increase his pain, and suggested that his oramorph (pain relief) was increased

32. Throughout August, staff made sure that Mr Sadler was adequately supported. A nurse referred him to the dietician and, after he fell over on 27 August, she implemented a prevention plan.

33. Over the following months, there was confusion about Mr Sadler attending hospital appointments for treatment. On four separate occasions he attended hospital, only to be returned to Birmingham having not been seen. After attending hospital for an appointment on 20 November which was then cancelled, an administration assistant contacted the hospital to clarify what had happened. The hospital gave further dates up to February 2017 for Mr Sadler's treatment.

34. On 21 December, a nurse reviewed Mr Sadler's DNACPR. He decided that he wanted to be resuscitated and the document was amended to reflect this.

35. On 27 December, a nurse reviewed Mr Sadler. He recorded that he looked unwell, that his abdomen was distended and that he was not able to lie in his bed. He arranged for him to see a doctor. A prison GP saw Mr Sadler the next day, and observed increased swelling to his abdomen and ankles and that he was coughing up sputum. He prescribed Mr Sadler with antibiotics for his chest.

36. Mr Sadler had increased swelling to his body and, on 5 January, a prison doctor arranged for him to go to hospital the next day to drain his swelling. He was not restrained on transfer, or while in hospital. Mr Sadler discharged himself and when he returned to the prison, a nurse discussed whether he would like to go back to hospital. Mr Sadler said that he would if his condition deteriorated.

37. On 9 January, a nurse saw Mr Sadler. She recorded that he had difficulty breathing and that he used his nebuliser, but continued to smoke. She referred him to a prison doctor as he had developed swelling to his scrotum. The doctor referred him to hospital for drainage. A bed became available on 11 January, and he was admitted that day. He was not restrained on transfer or during treatment.

38. Mr Sadler remained in hospital as his condition was worsening. On 14 January, doctors at the hospital felt that he was nearing the end of his life and asked the prison to contact his next of kin. The hospital facilitated end of life care, with open visitation so that his family could be with him. On 16 January, all medication was stopped, and at 2.15pm on 17 January, a doctor confirmed Mr Sadler's death.

39. We agree with the clinical reviewer that Mr Sadler's condition was well managed at Birmingham and equivalent to the care that he could have expected to receive in the community. Despite this, there was some confusion about the times and dates of his outpatient appointments, and while the clinical reviewer did not think that this would have impacted on Mr Sadler's care, it would not have been in his best interests to attend hospital appointments unnecessarily.

The Head of Healthcare should ensure that there is effective communication between the prison healthcare department and the relevant hospital so that prisoners do not attend hospital unnecessarily.

Mr Sadler's location

40. When Mr Lee Sadler arrived at Birmingham on 29 July 2016, he lived on D wing but after his healthcare induction, he was appropriately moved to ward one in the healthcare department.

41. On 1 August, Mr Sadler asked a nurse if he could return to D wing as he wanted to smoke. She explained that the move would mean him not having the appropriate bed and access to 24 hour healthcare. She recorded that he had full capacity, understood the consequences and yet still wanted to move.

42. On 2 August, again contrary to advice from the healthcare team, Mr Sadler discharged himself from the healthcare wing. He signed a disclaimer and it was recorded that his DNACPR was now held by the wing.

43. After he had pain overnight due to not having access to specific pain relief, Mr Sadler asked to return to the healthcare department. Prison staff moved him that day.

44. Mr Sadler had difficulties when bathing and was at risk of falling. On 28 August, a clinical team manager arranged for him to have a personal alarm. As Mr Sadler was becoming frailer, she referred him to the local hospice. On 27 August, a nurse from the hospice contacted the clinical team manager and advised her that they could not accept him, as he planned to have further treatment.

45. When Mr Sadler's health deteriorated, he was taken to hospital. On 11 January, a nurse spoke to Mr Sadler's mother, who said that it was likely her son would not want to be taken to a hospice should a bed become available. She advised Mr Sadler's mother that as long as her son was able to make his own care choices, they would consider his wishes.

46. On 12 January, a nurse recorded in Mr Sadler's medical record that he wanted to be nursed in a hospice setting as his health declined, allowing him access to his dog and family. His health declined rapidly and, on 15 January, even though a

hospice bed had not become available, he was assessed as too unwell for transfer, and the hospital facilitated end of life care and open visitation.

47. We agree with the clinical reviewer that Mr Sadler's location was appropriate and did not affect his clinical care. There are several examples of good practice where prison and healthcare staff worked well together to take Mr Sadler's wishes into account and maintain his comfort as much as possible.

Restraints, security and escorts

48. The Prison and Probation 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. The judgment indicated 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.

49. On 10 August 2016, Mr Sadler attended hospital for his first round of therapy. Mr Sadler was assessed as at a standard risk of escape, hostage taking and a standard risk to the public and to hospital staff. A security manager authorised that Mr Sadler should be restrained by a single cuff and escort chain, with two escorting officers. (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 said that Mr Sadler's restraints should not be removed for medical treatment without the duty director's approval. It is not clear from the risk assessment whether staff restrained him during treatment, though a prison manager told the investigator that he would not have been

50. The prison manager told the investigator that they used a generic risk assessment for all Mr Sadler's other admissions for treatment. The risk assessment contained conflicting information, which said in one place that only an escort chain should be used, and separately that an escort chain and a single cuff should be used. The document had no input from medical staff, but the assessment said that there were no medical objections to Mr Sadler being restrained, and that restraints should not be removed for treatment without the approval of the duty director.

51. While we do not criticise the decisions themselves, (and we note that on 11 January, Mr Sadler was not restrained in transit or in hospital) we are concerned that staff used a generic risk assessment throughout his treatment, without input from medical. Staff completing risk assessments should always consider the risk a prisoner poses at that time, taking into account any current and relevant information, in particular medical opinion as to the prisoner's ability to escape. We make the following recommendation:

    The Director and 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 assessments fully take into account a prisoner's health and are based on the actual risk a prisoner presents at the time.

Liaison with Mr Sadler's family

52. On 1 August 2016, an officer was appointed as the family liaison officer. She met Mr Sadler to discuss his wishes. He wanted his mother to be recorded as his next of kin. She remained in weekly contact with Mr Sadler's mother and assisted with arranging regular visits.

53. Mr Sadler's mother was with him when he died. The officer visited Mr Sadler's mother the day after he died to offer her condolences and support. She remained in contact with Mr Sadler's family, offering practical and emotional support. Mr Sadler's funeral took place on 10 February 2017, and the prison contributed towards funeral costs in line with national policy.

Compassionate release

54. Release on compassionate grounds is a means by which prisoners, who are seriously ill, usually with a life expectancy of less than three months, can be permanently released from custody before their sentence has expired. A clear medical opinion of life expectancy is required. The criteria for early release for determinate sentenced prisoners are set out in Prison Service Order (PSO) 6000. Among the criteria is that the risk of re-offending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of the National Offender Management Service (NOMS).

55. When Mr Sadler arrived at Birmingham, he advised healthcare staff that he had six months to live. A letter from Mr Sadler's GP to the sentencing court outlined that Mr Sadler was on the palliative register at the surgery, which meant that death might occur within the next six months. Despite this, as Mr Sadler had not attended previous appointments with his oncologist, his GP was unable to give a definitive prognosis.

56. There is no evidence in Mr Sadler's clinical records to indicate that the healthcare team tried to confirm a prognosis. Even without this information, as Mr Sadler's condition was terminal, we would expect to see a documented discussion in his medical records about whether he wanted to be considered for early release on compassionate grounds when he was given a prognosis of three months or less. We make the following recommendation

The Director should ensure that when a prisoner is given a terminal diagnosis, any decisions about compassionate release are clearly documented.

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