Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr James Farndale a prisoner at HMP Parc on 10 November 2018

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 Ombudsman's 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 James Farndale died on 10 November 2018 from lung cancer and secondary liver cancer at HMP Parc. He was 64 years old. I offer my condolences to Mr Farndale's family and friends.

Mr Farndale received a good standard of care at Parc. The day to day management of his conditions was of a good standard and prison healthcare staff worked closely with both hospital staff and specialist secondary care providers to ensure his health needs were met. The end of life care provided by the prison was also of a good standard.

I am satisfied that the care Mr Farndale received at Parc was at least equivalent to that which he could have expected to receive 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.

Sue McAllister CB
Prisons and Probation Ombudsman **June 2019**

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Summary

Events

1. On 15 March 2011, Mr James Farndale was sentenced to seventeen years imprisonment for multiple sexual offences. On 3 May 2015, he was transferred to HMP Parc.

2. On 19 August 2017, Mr Farndale was noted as being unusually lethargic and unable to get out of bed. He told healthcare staff he had felt unwell for the previous twelve days. He was sent to hospital for review. Hospital staff carried out a number of tests, including a CT scan. The results showed he had lung and liver cancer.

3. Following his diagnosis, both healthcare staff and secondary care providers monitored and reviewed Mr Farndale regularly. Comprehensive care plans were implemented by the healthcare team who also sought advice from specialist cancer care providers.

4. On 5 October, following a series of further tests, hospital staff told Mr Farndale his condition was terminal. He agreed to undergo palliative chemotherapy.

5. Both healthcare staff and hospital staff reviewed Mr Farndale regularly in line with his care plans over the months that followed. He completed three cycles of palliative chemotherapy and began both radiotherapy and immunotherapy. Appropriate adaptations were made to his cell and he was well supported by both staff and prisoners. However, his condition continued to deteriorate.

6. On 11 September 2018, Mr Farndale was admitted to hospital. Hospital staff considered there were no further active treatment options available to him. On 14 September, Mr Farndale was discharged to the palliative care suite at Parc and 24-hour nursing care was put in place at the prison to cater for his increasing health needs.

7. At 1.59pm on 10 November, it was confirmed that Mr Farndale had died.

8. The coroner gave the cause of death as lung cancer with secondary liver cancer.

Findings

9. The clinical reviewer found that Mr Farndale received a good standard of clinical care at Parc. Healthcare staff appropriately assessed his clinical needs and sought advice from secondary care providers.

10. We are satisfied that Mr Farndale's care was at least equivalent to that which he could have expected to receive in the community.

Recommendations

11. We make no recommendations.

The Investigation Process

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

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

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

15. We informed HM Coroner for Bridgend and Glamorgan Valleys of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

16. The investigator wrote to Mr Farndale's family to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They did not respond to our letter.

17. The investigation has assessed the main issues involved in Mr Farndale'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.

18. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP & YOI Parc

19. HMP Parc is a medium security prison run by G4S, which holds around 1,600 convicted men and young adults on remand or convicted. It also has a unit for around 60 young people under 18.

20. G4S Medical Services provide primary physical and mental health care services. There is 24-hour general healthcare and palliative care facilities. A local GP practice provides GP services including a daily clinic and out of hours cover. Three healthcare staff are on duty in the prison at night.

HM Inspectorate of Prisons

21. The most recent inspection of Parc was in January 2016. Inspectors found that significant chronic recruitment and retention problems affected secondary health screening. In their survey of prisoners, significantly fewer prisoners than in comparator prisons said the quality of health provision was good. Inspectors noted that support for prisoners with complex health needs, including life-long conditions, was generally good.

Independent Monitoring Board

22. 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 February 2018, the IMB reported that the introduction of paramedics had increased the efficiency of the healthcare department and freed up the availability of GP appointments. In addition, improvement to the recruitment process had enabled the re-establishment of chronic disease management clinics. The Board was also pleased to note new initiatives in mental health care at the prison.

Previous deaths at HMP Parc

23. Mr Farndale was the 19th prisoner to die at Parc since July 2015. Of the previous deaths, twelve were from natural causes, three were self-inflicted, two were drug-related and one is awaiting classification. There have been three deaths since Mr Farndale's death, one self-inflicted, one natural causes and one awaiting classification. There are no similarities with those deaths.

Findings

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

24. On 15 March 2011, Mr James Farndale was sentenced to seventeen years in prison for multiple sexual offences and was sent to HMP Leeds. On 13 May 2015, Mr Farndale was transferred to HMP Parc.

25. An officer carried out Mr Farndale's initial health screen. He noted he had mobility issues caused by a stroke, which meant he needed a crutch and a leg brace on his right leg to get around. Due to his mobility issues, he was allocated a ground floor cell. It was also noted he was a heavy smoker. The officer offered Mr Farndale smoking cessation advice, which he declined. Mr Farndale declined help to stop smoking on a number of occasions while at Parc.

26. On 26 May, Mr Farndale was reviewed by a GP. He noted the Officer's review and adjusted Mr Farndale's medication. He noted Mr Farndale had been previously diagnosed with supraventricular tachycardia (SVT, which causes migraines and an abnormally fast heart rate and can cause shortness of breath). He also offered Mr Farndale smoking cessation advice, which he again refused. Mr Farndale was treated for migraines while at Parc.

27. Mr Farndale had no further contact of significance with healthcare staff until 12 August 2017. He was reviewed by a healthcare assistant (HCA), after experiencing flu like symptoms and shortness of breath. HCA Scott used the National Early Warning Score (NEWS, a tool developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in adult patients) to review Mr Farndale. He scored six (a score of five or more indicates the need for a review by hospital staff). HCA Scott administered oxygen therapy and monitored the level of oxygen in his blood. Mr Farndale recovered sufficiently enough that an admission to hospital was not necessary.

28. On 19 August, a nurse, reviewed Mr Farndale. She noted he had been unwell for the previous twelve days and he had been unable to get out of bed. She raised her concerns with a GP. The GP agreed Mr Farndale should be reviewed by hospital staff.

29. Mr Farndale was taken to the hospital the same day. Blood tests showed a probable infection. Mr Farndale had a chest X-ray and was initially diagnosed with pneumonia. He was given intravenous antibiotics and was discharged back to the prison. Mr Farndale was prescribed a course of antibiotics and was regularly reviewed by healthcare staff at Parc.

30. On 31 August, a GP spoke with a hospital consultant to discuss the results of Mr Farndale's chest X-ray. The results indicated a mass in the upper part of his right lung. While the findings of the chest X-ray were consistent with a diagnosis of pneumonia, the mass indicated he had lung cancer.

31. The GP reviewed Mr Farndale the same day. She had a frank conversation with him about the results of the chest X-ray and told him that he had suspected lung cancer. She said he would need an urgent referral to hospital to confirm the

diagnosis and decide on a treatment plan under the two-week pathway for suspected cancer (which requires patients with suspected cancer to be reviewed by hospital staff within two weeks). Following her review, the GP also referred Mr Farndale to the Mental Health In-Reach Team (MHIRT) for support.

32. Mr Farndale's two-week wait referral took place on 8 September at hospital. Hospital staff informed him he had lung cancer. They also told him the cancer had spread to his liver and left-sided lymph nodes.

33. Following his diagnosis, good care plans were put in place by healthcare staff at Parc and advice was sought from the hospital to ensure Mr Farndale's care needs were met.

34. We are satisfied that healthcare staff appropriately investigated Mr Farndale's symptoms, made timely referrals to secondary care providers and discussed his diagnosis with him.

Mr Farndale's clinical care

35. When he returned to Parc, Mr Farndale was seen by a nurse. She created a cancer care plan which consisted of daily contact by healthcare staff, regular reviews by GPs and input from Macmillan nurses for specialist advice and care. The nurse offered Mr Farndale smoking cessation advice, which he accepted.

36. A cancer care nurse, regularly reviewed Mr Farndale following his diagnosis.

37. On 13 September, a GP discussed Mr Farndale's diagnosis and his care plans with him. She noted his cell was already well equipped with handrails and a raised toilet seat, and she was aware healthcare staff had ordered an airflow mattress to make him more comfortable. Mr Farndale told her he felt well supported by both healthcare and prison staff and that he had prisoners helping him with daily tasks. The GP prescribed oramorph for pain relief (a morphine based pain killer) and arranged for him to have a soft diet from the prison kitchen.

38. On 19 September, healthcare and prison staff held a Complex and Vulnerable Older Prisoners (CVOP) meeting to discuss Mr Farndale's care needs. They discussed whether they should apply to release Mr Farndale on compassionate grounds. However, at that time he did not meet the criteria for early release.

39. On 20 September, Mr Farndale attended hospital for further tests and biopsies. On 5 October, he returned to the hospital to discuss the results with hospital staff. They told him his condition was terminal and that, without treatment, it was unlikely he would live longer than three months. Mr Farndale agreed to have palliative treatment at a cancer centre, consisting of repeated courses of chemotherapy.

40. On 19 October, a GP reviewed Mr Farndale. He discussed the issue of resuscitation with him and asked if he would like to consider signing a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order (which means that, in the event of cardiac or respiratory arrest, no attempt at resuscitation will be made). Mr Farndale made it clear that in the event of a heart attack he wanted to be resuscitated.

41. Healthcare staff continued to review Mr Farndale daily over the months that followed. He continued to attend the cancer centre for his chemotherapy treatment. In addition, the MHIRT reviewed Mr Farndale regularly, offering him support whenever he needed it.

42. On 31 January 2018, a GP reviewed Mr Farndale. They discussed his condition and if he had any particular needs or adaptations that could make him more comfortable. Mr Farndale told her he had everything he needed and felt well supported by staff and prisoners. She discussed his prognosis with him and noted he fully understood that only 16% of patients with his condition lived for more than five years after diagnosis. She considered Mr Farndale was pragmatic about his condition and fully understood both his diagnosis and prognosis.

43. The GP discussed the issue of compassionate release with Mr Farndale again. Mr Farndale said that he did not want to be considered for compassionate release as he felt he would be better cared for in prison than in the community.

44. On 21 March, a Macmillan nurse met with Mr Farndale to discuss his care and treatment. She considered Mr Farndale fully understood his condition and prognosis.

45. On 26 April, a GP carried out a cancer care review with Mr Farndale. She considered that he continued to have a positive outlook about his condition and was keen to accept any treatment that could be offered to him. She noted he had completed three cycles of palliative chemotherapy and that the most recent CT scan of his lungs and liver showed a reduction in the size of the tumour in his lungs. However, the CT scan also showed the tumour in his liver had increased in size. She noted hospital staff were considering immunotherapy treatment (which uses the body's own immune system to fight the cancerous cells by assisting the immune system to recognise and attack cancer cells).

46. On 21 June, following a further review by hospital staff, Mr Farndale was told the cancer in his lung had grown. Hospital staff considered he would benefit from a course of radiotherapy. The treatment started on 9 July.

47. On the same day, Mr Farndale was reviewed at the prison by a GP and a palliative care nurse from the hospital's oncology unit. They discussed how Mr Farndale was coping with radiotherapy and if he had any concerns. The GP asked that Mr Farndale be given a nebulizer to aid his breathing at night. Healthcare staff obtained a nebulizer the same day.

48. Over the months that followed, healthcare staff continued to review Mr Farndale daily in line with his care plan. He was regularly reviewed by GPs at the prison who remained in contact with hospital staff to ensure his health care needs were met. He continued to attend the cancer centre for radiotherapy treatment and the MHIRT continued to support him.

49. On 4 September, a healthcare support worker was washing Mr Farndale and giving him lunch. She noted he appeared to be generally unwell, extremely lethargic and that his eyes were rolling in his head. She asked a prison paramedic to review Mr Farndale. He took his observations (the measurement of

temperature, respiratory rate, pulse, blood pressure and blood oxygen saturation, an indicator of a patient's state of health) and noted Mr Farndale's blood pressure was low. He repeated the observations and his blood pressure improved. He referred Mr Farndale to a nurse for a further review.

50. Later the same day, the nurse reviewed Mr Farndale. She noted he was alert, answered her questions fully and that his observations were at an acceptable level. She asked if he would like a hospital bed, which he refused and said that his mattress was sufficient. When she discussed the matter of DNACPR, Mr Farndale said he would still like to be resuscitated if he had a heart attack.

51. On 9 September, a nurse reviewed Mr Farndale. She noted he was drowsy and unresponsive and had also been vomiting. His observations were normal but she noted he could not keep himself awake.

52. A nurse discussed Mr Farndale's condition with a GP. She advised he should be taken to hospital for review as he could be suffering from dehydration. However, Mr Farndale refused to go to hospital and told healthcare staff he did not want to be taken to hospital unless he was unconscious. Healthcare staff considered he had the mental capacity to make choices about his care.

53. The following day, Mr Farndale's health had deteriorated further. A GP reviewed him and considered a change to his prescription medications would be beneficial. He also considered it would be beneficial to carry out blood tests. He spoke with another GP who agreed.

54. A GP revised Mr Farndale's prescription medications in line with the advice given to him by the other GP. In addition, he sent an email to the Macmillan nurses requesting that a syringe driver be made available to Parc (a syringe driver is a small, portable, battery powered device used to administer a continuous infusion of prescription drugs). The syringe driver was delivered to Parc later that day.

55. The results of the blood tests indicated a high calcium level, which a GP considered could have been the cause of Mr Farndale symptoms. He told Mr Farndale that his symptoms could be reversed with an admission to hospital for a course of intravenous fluids. However, Mr Farndale refused.

56. On 11 September, Mr Farndale agreed to be admitted to hospital. He received a course of intravenous fluids. His condition stabilised and his calcium level improved. However, while in hospital, hospital staff considered Mr Farndale had had all the treatment available to him and they discussed the issue of DNACPR with him. He agreed that he no longer wished to be resuscitated in the event of a heart attack and signed an order to that effect. He was discharged to the palliative care suite at the prison on 14 September.

57. On his return to prison, 24-hour nursing care was put in place to cater for his increasing health needs. There are many entries in his medical records documenting the care he was given and the discussions healthcare staff had had with him about his condition.

58. On 12 October, a GP reviewed Mr Farndale, along with another GP and a nurse. She made some more changes to his prescription medication in line with advice from a GP and asked if he wished to have his calcium levels checked. He

declined, and said that if they were high, it would require a further admission to hospital, something he was adamant he wanted to avoid.

59. On 30 October, a GP again reviewed Mr Farndale after healthcare staff had informed her his condition had deteriorated significantly in the past 24 hours. She noted that although he was experiencing pain, he was still comfortable and able to hold a brief conversation with her. She also noted he was only eating small amounts of food but continued to drink fluids.

60. On 6 November, a GP held a follow up review. She noted Mr Farndale told her he had had not eaten for the past 7 days and that he looked frail. She considered he had entered into the last stages of his life.

61. Mr Farndale's condition continued to deteriorate and at 1.59pm on 10 November, a HCA noted he had stopped breathing.

62. At 4.15pm, a GP confirmed Mr Farndale had died.

63. The clinical reviewer concluded that the standard of clinical care Mr Farndale received at Parc was equivalent to that which he could have expected to receive in the community. We agree.

64. The clinical reviewer also noted that the frequency and quality of the reviews completed by healthcare staff was higher than what could be expected in the community and equivalent to that of a hospice setting.

65. Mr Farndale's symptoms were investigated in a timely manner and appropriate referrals were made to secondary care providers. Once his condition had been diagnosed, he was reviewed by healthcare staff several times a day. There is also evidence of a good level of contact between healthcare staff and specialist secondary care providers to ensure Mr Farndale's care needs were fully met. There is also evidence of input from hospital staff who visited Mr Farndale in prison as his condition deteriorated. The reviews were well documented in Mr Farndale's medical records.

66. We are satisfied that there is good evidence that Mr Farndale's health needs were reviewed, managed and evaluated in line with best practice and NICE guidelines.

Mr Farndale's location

67. When Mr Farndale arrived at HMP Parc, his mobility issues were quickly identified and he was allocated a ground floor cell on X-3 unit, a unit that caters for vulnerable prisoners and prisoners with special care needs.

68. Following his diagnosis in August 2017, and as his condition deteriorated, adaptations were made to the cell to enable him to stay among his friends where he felt supported.

69. During his final hospital admission on 11 September, healthcare staff liaised with hospital staff to ensure all the equipment and care plans needed to care for Mr Farndale were in place for his return. When he returned to the prison, he was moved to the prison's palliative care suite on X-3 unit.

70. We are satisfied that Mr Farndale was appropriately located throughout his illness and was quickly taken to hospital on the occasions his condition deteriorated. Appropriate adaptations were made to his cell to enable him to receive a good standard of end of life care.

71. We are also satisfied that Mr Farndale's wish to die in prison, rather than in hospital, was respected.

Restraints, security and escorts

72. When prisoners must travel outside 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 must 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 considering factors such as the prisoner's health and mobility.

73. Staff carried out thorough risk assessments and following Mr Farndale's diagnosis, they did not restrain him. We are satisfied that this was the appropriate decision.

Liaison with Mr Farndale's family

74. On 9 September 2017, the day after Mr Farndale was diagnosed with cancer, the prison appointed a chaplain to act as family liaison officer (FLO). The chaplain visited Mr Farndale and asked if he had a next of kin he would like informed of his condition. He told her he had an ex-wife but would only like her to be contacted in the event of his death.

75. The chaplain spoke with Mr Farndale again on 13 September. He told her he had a son who he had not seen for many years, but he believed he lived in the same area as his ex-wife. She advised him to write to the last known address he had for his son to see if he would like to make contact. However, despite the chaplain encouraging him to write to his son on a number of occasions, he told her he could not do so.

76. On 8 May 2018, Mr Farndale told the chaplain he was finding it difficult to write the letter to his son, and he asked if she would write to him on his behalf. She agreed to write to the address asking for information on his son's whereabouts but not giving any information about his condition.

77. On 13 May, after receiving her letter, Mr Farndale's ex-wife contacted the chaplain and told her she and her son would like to visit him. The chaplain told Mr Farndale's ex-wife that he had been diagnosed with terminal cancer but was receiving treatment. Mr Farndale's family visited him on 17 May.

78. Following their visit, Mr Farndale's family regularly visited him at the prison. The chaplain kept in regular contact with his family both by email and telephone,

updating them as his condition deteriorated. Due to the frequency of the family visits, the prison paid for the travel and hotel costs on a total of five occasions.

79. On 10 November, the chaplain telephoned Mr Farndale's son to tell him that his father had died. She followed up her telephone conversation with an email explaining what would happen next and offering support.

80. Mr Farndale's funeral was held on 30 November. The prison contributed towards the funeral costs in line with national policy.

Compassionate release

81. 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.

82. Healthcare staff discussed the issue of compassionate release with Mr Farndale on 31 January 2018. Mr Farndale said he did not have a suitable release address or support network in the community. He said that he felt he would be better cared for by the staff at the prison.

83. We are satisfied the issue of compassionate release was appropriately discussed with Mr Farndale and that his wishes and choices were considered.

84. We make no recommendations.

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