Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Darren Jeffries, a prisoner at HMP Long Lartin, on 20 February 2019

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 I oversee can improve their work in the future.

Mr Darren Jeffries died on 20 February 2019 of cancer of the bile duct while a prisoner at HMP Long Lartin. Mr Jeffries was 53 years old. I offer my condolences to Mr Jeffries family and friends.

The clinical reviewer is satisfied that Mr Jeffries received a good standard of clinical care at Long Lartin, equivalent to that which he could have expected in the community. Prison healthcare staff responded appropriately to his changing care needs, involved Mr Jeffries in all decision-making and helped him to remain independent for as long as possible.

I am concerned, however, that Long Lartin restrained Mr Jeffries on several hospital visits in the last few months of his life. I am not convinced that that these decisions were justified by a fully-considered risk assessment when Mr Jeffries' condition deteriorated.

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 **November 2019**

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Summary

Events

1. Mr Darren Jeffries was remanded into custody in March 2013, charged with sexual offences. In February 2014, he received a 36-year sentence of imprisonment. He spent time at HMP High Down before moving to HMP Long Lartin in 2014.

2. In December 2017, Mr Jeffries reported to the prison doctor that he had loose stools. A stool sample was requested for tests and this came back as normal.

3. In April 2018, Mr Jeffries reported nausea and retching. He was reviewed by the prison doctor and the results of his stool sample were discussed. Mr Jeffries was offered a colonoscopy which he declined.

4. At the end of May 2018, routine blood tests showed an abnormal liver function. On examination, no abnormalities of the liver were discovered and a non-urgent abdominal scan was requested.

5. At the beginning of August, Mr Jeffries went to hospital for his abdominal scan which showed liver cancer with secondary growths on the spine. In September, a liver biopsy confirmed cancer of the bile duct. Treatment options were restricted to palliative care.

6. Mr Jeffries refused palliative chemotherapy and, in November, signed a DNACPR (Do Not Attempt Cardio-Pulmonary Resuscitation) notice. In December, he was admitted to hospital for pain management. An MRI scan confirmed a spinal cord compression. He received radiotherapy and was discharged back to the prison on 27 December.

7. Mr Jeffries received palliative care in the end of life suite at Long Lartin. His health continued to deteriorate and he died on 20 February 2019.

Findings

8. Prison healthcare staff provided timely, responsive care and ensured Mr Jeffries' care needs were met. Staff informed Mr Jeffries of his diagnosis appropriately and he received a good level of clinical care while at Long Lartin. This was equivalent, if not better, to that he could have expected to receive in the community.

9. We are concerned, however, that there were occasions when a shortage of prison staff meant that nursing staff were not able to access Mr Jeffries in his cell as freely as they would have liked to treat him and administer pain relief.

10. Mr Jeffries was restrained for all his hospital appointments and admissions. We are not satisfied that that this was justified by properly completed risk assessments that took account of the significant deterioration in Mr Jeffries' health in the last few months of his life.

Recommendations

- The Governor 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 the health of a prisoner and are based on the actual risk the prisoner presents at the time.
- The Governor should revise the prison's escort risk assessment form to ensure that it requires:
    - healthcare staff to say whether the prisoner's current state of health has an impact on his mobility; and
    - prison staff to show that they have taken this information into account in assessing the prisoner's current level of risk;

  and should send the Ombudsman a copy of the revised form.

The Investigation Process

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

12. The investigator obtained copies of relevant extracts from Mr Jeffries' prison and medical records.

13. NHS England commissioned an independent clinical reviewer to review Mr Jeffries' clinical care at the prison.

14. We informed HM Coroner for Worcestershire of the investigation. He gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.

15. A PPO family liaison officer wrote to Mr Jeffries' daughter to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. She asked why there had been a delay in making the results of clinical tests available. We have answered her question in this report.

16. Mr Jeffries' family received a copy of the draft report. They pointed out some factual inaccuracies. This report has been amended accordingly. Mr Jeffries' family also raised a number of questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

17. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out no factual inaccuracies. The action plan has been annexed to this report.

Background Information

HMP Long Lartin

18. HMP Long Lartin is a high security prison in the Vale of Evesham, Worcestershire. It holds up to 609 men across five main wings and two support wings. All prisoners are accommodated in single cells. The healthcare contract is held by Care UK, with mental healthcare subcontracted to South Staffordshire and Shropshire NHS Foundation Trust Mental Health Team.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Long Lartin was carried out in January 2018. Inspectors reported that although the inpatient unit now had constant nursing input and routine mental health support, it did not provide an effective therapeutic regime. Pharmacy staffing was stretched but medicine management arrangements delivered timely and appropriate treatments. There had been good support for the few prisoners with social care needs, and prisoners with long-term conditions were managed well.

Independent Monitoring Board

20. 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 31 January 2018, the IMB reported that the prison was catering for an increasing number of elderly and disabled men, with very limited facilities. Work with the safer prisons team has led to an improved understanding of the men and the involvement of local social services in assessments and support.

Previous deaths at HMP Long Lartin

21. Mr Jeffries' was the ninth death at Long Lartin since June 2017. Of the previous deaths, six were self-inflicted, one was drug-related, and one was a homicide. There are no similarities between the other deaths and that of Mr Jeffries.

Findings

Diagnosis of Mr Jeffries' terminal illness and informing him of his condition

22. Mr Darren Jeffries was remanded into custody on 2 March 2013 charged with multiple sexual offences against children. On 11 February 2014, he received a 36-year sentence of imprisonment. He transferred from HMP High Down to HMP Long Lartin on 5 August 2014.

23. On 11 December 2017, Mr Jeffries reported to a prison GP that he had loose stools. Upon examination, his stomach was found to be soft. A stool sample was requested for further tests. The GP chased the results on 10 January but there is no evidence that this was successful. A further sample was sent off for testing on 17 January. On 1 March, the results returned normal.

24. On 5 April 2018, Mr Jeffries saw a nurse and told him he had had nausea and retching for around five weeks. The nurse made an appointment for Mr Jeffries to see a GP. On 19 April, Mr Jeffries was reviewed by a prison GP who discussed the results of the recent stool sample. Mr Jeffries declined a colonoscopy (in which a camera is passed through the anus to examine the bowel) which was intended to rule out cancer, but agreed to blood tests.

25. On 14 May, Mr Jeffries' blood test results showed liver abnormalities. On 23 May, a prison GP discussed the results with Mr Jeffries and requested repeat blood tests and an ultrasound. The following day, Mr Jeffries was reviewed by a GP. Upon examination, his stomach was found to be soft but she did not detect any enlargement to the liver.

26. On 7 June, a prison GP discussed the blood test results with Mr Jeffries and told him she would speak to the biochemist at the hospital for advice. The GP spoke to a biochemist, who said that the results were probably due to a fatty liver. The GP requested an auto-antibody screen and an ultrasound for completeness.

27. On 29 June, Mr Jeffries told the GP that his symptoms had improved. She requested that the further blood test results and ultrasound appointment be chased. She also requested that blood tests be repeated in a further four weeks.

28. On 2 August, Mr Jeffries attended a hospital outpatient appointment for the ultrasound. The following day, Mr Jeffries, saw a prison GP to discuss the results. The ultrasound suggested there were metastatic lesions (secondary cancers) in the liver and further tests were advised. Mr Jeffries complained of pain in his right side and lower back. The GP referred Mr Jeffries for an urgent CT scan.

29. On 15 August, Mr Jeffries reported an increase in pain around his back and hips, and vomiting. He attended hospital for a CT scan, which showed that the primary tumour was in his liver with metastases (secondary growths) in his spine.

30. On 18 August, a nurse visited Mr Jeffries in his cell to explain the results of the CT scan. Mr Jeffries was offered a bed in the prison's inpatient healthcare unit, which he declined.

31. On 22 August, the Clinical Team Manager visited Mr Jeffries on the wing. She told him that a multi-disciplinary team meeting would be held later in the day to discuss his results and treatment options. She explained to Mr Jeffries that he would need further tests, including a liver biopsy.

32. On 5 September, a nurse emailed the hospital to chase the biopsy appointment and to request a treatment plan.

33. On 13 September, Mr Jeffries attended the hospital for a liver biopsy. The results, which the prison received on 27 September, confirmed a cholangiocarcinoma (cancer of the bile duct) which was untreatable. A referral to the hospital's oncology team was made for further treatment options.

34. We are satisfied that healthcare staff referred Mr Jeffries for appropriate tests, when routine blood results showed liver abnormalities and informed him of his condition. It took several weeks to get a definitive diagnosis and prognosis but this was due to delays at the hospital, not prison healthcare.

Mr Jeffries' clinical care

35. On 4 October**,** Mr Jeffries attended the oncology (cancer) clinic to discuss his treatment options. He told hospital staff he wanted to meet with his daughters before making a decision.

36. On 29 October, Mr Jeffries was reviewed by a nurse. Mr Jeffries reported increased back pain during the night and requested a review of his pain medication. The nurse advised Mr Jeffries to consider a move to the healthcare unit for better pain management but he told her he wanted to stay on the wing. Mr Jeffries was reviewed by a prison GP later that day and his pain medication was increased.

37. On 1 November, Mr Jeffries attended a meeting with prison staff and his family. A nurse explained that Mr Jeffries would receive care in the end of life suite in the prison's healthcare unit. Visiting arrangements were also discussed. The following day, Mr Jeffries told a nurse that he did not want palliative chemotherapy but would consider radiotherapy to manage his back pain.

38. On 4 November, Mr Jeffries moved to the healthcare unit for respite care. The following day, Mr Jeffries was seen by a prison GP who noted that Mr Jeffries was in considerable pain and that his prognosis was very poor. He noted that Mr Jeffries should be housed in the end of life suite as he was likely to have only two to eight weeks to live. A DNACPR was put in place.

39. On 6 November, Mr Jeffries moved to the palliative care suite. An hourly unlock during the night was agreed with prison managers and an open-door policy was requested to enable healthcare staff to attend to Mr Jeffries as needed. Mr Jeffries was given supplement drinks and was supported to enable him to call his daughter.

40. On 8 November, Mr Jeffries was found on the floor of his cell. He told staff that he had fallen. He had been incontinent and had vomited. Cot sides were put on his bed to prevent further falls. Later that day the open-door policy was refused by prison managers due to staffing issues.

41. On 15 November, Mr Jeffries told a prison GP that he wanted radiotherapy but was concerned about transferring to hospital. Mr Jeffries was unable to sit and would need to be transported lying flat. On 19 November, Mr Jeffries was transferred to hospital. He was given a CT scan and received radiotherapy. He returned to the end of life suite on the same day. On 23 November, Mr Jeffries was reviewed by a GP. Mr Jeffries said that the radiotherapy had helped his pain and he was more mobile.

42. On 6 December, a nurse noted that Mr Jeffries had deteriorated over the past week, he was in more pain and had pressure sores. She administered treatment and his specialist air flow mattress was adjusted.

43. On 11 December, Mr Jeffries was discussed at a healthcare multi-disciplinary meeting. His pain was not under control despite the medication he had been given and he was confused during the night. He was incontinent, passing blood, had redness to his hip and was sore in his perineal region. Healthcare staff were concerned about whether they could meet Mr Jeffries' needs. His skin was becoming sore, and healthcare staff were having difficulties accessing him at night due to prison staffing issues. A prison GP was asked to enquire whether admission to hospital for pain management or a transfer to a hospice were options. The hospital's oncology ward confirmed that it had a bed and Mr Jeffries was admitted to hospital later that day.

44. Mr Jeffries received further treatment in hospital. On 13 December, an MRI scan showed that he had spinal cord compression with complete collapse of the lower spine. Mr Jeffries was nursed flat due to a significant risk of paralysis. A five-day course of radiotherapy was agreed.

45. On 27 December, Mr Jeffries returned to the end of life suite at the prison. A nurse noted that the hospital discharge information was poor and she was concerned that there was no social care plan. She requested an hourly unlock so that healthcare staff could access Mr Jeffries in his cell overnight.

46. On 2 January 2019, a palliative care plan was created to support Mr Jeffries during the day and night. On 3 January, a nurse saw Mr Jeffries to conduct a welfare check at 4.30am, as prison staff would not able to open the cell door after 5.00am due to staff shortages. She was unable to assess Mr Jeffries' nutritional state or complete oral care because he was asleep.

47. On 13 January, Mr Jeffries was discussed at the multidisciplinary team meeting. The main concern was Mr Jeffries' breakthrough pain (a burst of sudden intense pain). The hospital's oncology team were contacted and they advised an increase in the dosage of Mr Jeffries' pain relief.

48. On 19 January, Mr Jeffries' pain relief was reviewed. He continued to experience severe pain on moving. His air flow mattress appeared to be faulty, causing additional discomfort. He had redness to some points of his body. Mr Jeffries asked that his pain relief be given hourly and a new mattress was ordered.

49. On 21 January, Mr Jeffries was seen by a prison GP. He appeared more comfortable after the increase in his medication. The GP discussed the possibility of further radiotherapy, which he declined.

50. On 22 January, a nurse noted her concern about pressure sores. She requested frequent turning, and a skin assessment to be completed. Concerns had been raised that Mr Jeffries was not being offered pain relief throughout the night and she spoke to the night nurses about gaining hourly access through the night.

51. On 23 January, a new air flow mattress arrived. On 28 January, Mr Jeffries was noted to have an area of redness on his lower back. Body maps were completed.

52. On 1 February, Mr Jeffries was reviewed by a prison GP. Mr Jeffries reported an increase in pain and additional pain in his right leg. The GP discussed radiotherapy but Mr Jeffries declined. The area on his back was reviewed and noted to be blistering due to the side effects of radiotherapy. Pressure-relieving adhesive dressing was applied. On 5 February, the GP spoke with the palliative care consultant at St Richard's Hospice for advice on Mr Jeffries' pain management.

53. On 6 February, Mr Jeffries was noted to have a broken area of skin on his right buttock and a dressing was applied to the area. Later that evening, healthcare staff were unable to access Mr Jeffries cell at 8.00pm due to prison staffing issues. They gained access at 11.00pm. Mr Jeffries appeared comfortable but refused an assessment of his pressure sores.

54. On 8 February, Mr Jeffries was noted to be very confused and was trying to get out of bed. The bed was lowered to reduce the risk of injury, crash mats were placed on the floor and a healthcare assistant was put in the room for one-to-one support.

55. At a meeting later that day, a nurse raised concerns about the ability of staff to administer sub-cutaneous injections to administer morphine, and the difficulty in accessing the cell over the weekend due to staff shortages. Mr Jeffries was not able to access hospice care due to his offending status and all staff agreed that A&E admission would be undignified and not in Mr Jeffries best interests. The Deputy Governor authorised an officer to sit outside Mr Jeffries' cell when nurses were not available for constant watch.

56. Healthcare staff continued to manage Mr Jeffries' care needs, day by day, and on 19 February, Mr Jeffries was visited by his daughters.

57. On the morning of 20 February, Mr Jeffries was observed to be sleeping but comfortable. He was surrounded by nursing staff, who supported him through his final hours. At 2.20pm, Mr Jeffries was pronounced dead.

58. The coroner concluded that the Mr Jeffries died from carcinomatosis (multiple cancers which have spread from a primary source) and metastatic cholangiocarcinoma (cancer of the bile duct).

59. The clinical reviewer is satisfied that Long Lartin was equipped to care for Mr Jeffries during his terminal illness. Additional equipment, such as a specialist air mattress, was sourced and when the inflation mechanism failed, staff had the knowledge to continue protecting Mr Jeffries pressure areas using good basic nursing care. There was a consistent group of staff who attended to him regularly to give continuity of care and support to Mr Jeffries and his family.

60. It was anticipated that during the final stages of his illness Mr Jeffries would not be able to swallow and would need pain relief administered subcutaneously. In order to maintain pain relief at a level equivalent to that Mr Jeffries would have received in the community, a GP trained healthcare staff to provide subcutaneous medication. This enabled Mr Jeffries to receive the subcutaneous medication as soon as it was required and not have to wait for other staff to be on duty.

61. We agree with the clinical reviewer that Mr Jeffries' clinical care at Long Lartin was equivalent to that he could have expected to receive in the community. Mr Jeffries was able to access outpatient appointments, his pain management was reviewed regularly and advice was sought from the community palliative care team. Appropriate care plans were put in place and Mr Jeffries was included in decisions about his treatment. Care and consideration was given to his wishes.

62. We are concerned, however, that there were occasions when a shortage of prison staff meant that nursing staff were not able to access Mr Jeffries in his cell as freely as they would have liked to administer pain relief.

Mr Jeffries' location

63. We are satisfied that Mr Jeffries' location was appropriate and that staff at Long Lartin reviewed his location as his condition changed.

64. Mr Jeffries initially refused to be moved to the healthcare unit and every effort was made to respect his wishes and care for him on a standard wing. Mr Jeffries was moved to the end of life care suite on 6 November when he became too ill to remain on the wing. Members of his family were able to visit him in the end of life suite. Mr Jeffries was supported in his cell with a commode, bed guards, a back brace and a Zimmer frame.

65. Healthcare staff raised concerns about being able to meet Mr Jeffries' needs toward the end of his illness. A prison GP asked about Mr Jeffries' receiving care in hospital or moving to a hospice. The oncology department refused to admit him, however, as Mr Jeffries was already receiving palliative care in the prison. Mr Jeffries could not move to a hospice because he was considered to pose too high a risk to children in the community.

66. Despite the staffing issues and lack of palliative equipment, the clinical reviewer is satisfied that healthcare staff managed Mr Jeffries' care well at Long Lartin.

Restraints, security and escorts

67. The Prison 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.

68. A judgment of 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.

69. On 2 August, Mr Jeffries attended hospital for an ultrasound. The investigator has not been provided with any of the escort documentation for this appointment, despite requesting this from the prison on several occasions.

70. On 16 August, Mr Jeffries attended hospital for a CT scan. He was restrained with double cuffs and escorted by two officers. Restraints remained in place during the procedure. There was no medical objection to restraints on the risk assessment form.

71. On 13 September, Mr Jeffries attended hospital for tests. Again, he was restrained with double cuffs and escorted by two officers. Restraints were reduced to an escort chain for the X-ray and double cuffs were reapplied for the liver biopsy. There was no medical objection.

72. On 4 October, Mr Jeffries attended hospital for an oncology appointment. He was escorted by two officers and restrained with double cuffs. There was no medical objection.

73. On 17 November, Mr Jeffries was transferred to hospital for a CT scan. The prison did not provide all the documentation for this transfer despite our requests. The information we do have states that Mr Jeffries was restrained both for transfer and during the appointment. On the health risks section of the risk assessment form it was noted that Mr Jeffries was unable to walk and would require the use of a wheelchair or a stretcher.

74. On 19 November, Mr Jeffries attended hospital for radiotherapy treatment. Again, the investigator has not been provided with any of the escort documentation for this appointment. We note that at this stage Mr Jeffries was unable to sit and needed to be transferred lying flat.

75. On 11 December, Mr Jeffries was admitted to hospital due to difficulties with pain management and a compressed spinal cord. He remained in hospital until 27 December. The investigator has not received the risk assessment or medical assessment for the escort, and the bedwatch report is missing. The information available to the investigator indicates that Mr Jeffries was escorted to hospital without the use of restraints. However, on 18 December, a nurse noted that Mr Jeffries was restrained in hospital with three officers present. She noted that this was excessive given that Mr Jeffries had spinal cord compression and was unable to walk or even to sit upright.

76. On 19 December, medical records show that an officer received a call from the prison's security department asking whether Mr Jeffries should remain in handcuffs for his bedwatch. She told them that for the sake of his dignity, and due to his condition and prognosis, she would recommend that his cuffs be removed. Security told her that restraints would be removed for escort but would remain on for the duration of his bedwatch.

77. Mr Jeffries was assessed as a medium risk to others in all the paperwork available to the investigator.

78. Whenever restraints are used, the risk assessments must accurately reflect the risk posed at that time to ensure proportionality and to maintain human dignity. We are not satisfied that the prison appropriately considered Mr Jeffries' level of risk or clearly justified the use of restraints as his condition deteriorated.

79. Although it is the Governor's responsibility to ensure that the risk assessment process is properly managed, the Head of Healthcare also needs to ensure that healthcare staff fully understand the requirements of the High Court judgement and contribute to risk assessments.

80. We make the following recommendations:

The Governor 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 the health of a prisoner and are based on the actual risk the prisoner presents at the time.

The Governor should revise the prison's escort risk assessment form to ensure that it requires:

- **healthcare staff to say whether the prisoner's current state of health has an impact on his mobility; and**
- **prison staff to show that they have taken this information into account in assessing the prisoner's current level of risk;**

and should send the Ombudsman a copy of the revised form

Liaison with Mr Jeffries' family

81. A supervising officer was appointed as the prison's family liaison officer (FLO) on 5 October when Mr Jeffries was diagnosed with cancer. The FLO contacted Mr Jeffries' daughter in accordance with Mr Jeffries' wishes and arrangements were made for her to visit her father.

82. The FLO kept Mr Jeffries' family up to date on his condition and provided on-going support. He explained the FLO role and the steps to be taken after Mr Jeffries' death, such as the coronial process and assistance with funeral arrangements. The FLO continued to provide support to Mr Jeffries' family after he died. In line with national guidance, the prison made a financial contribution to Mr Jeffries' funeral, which was held on 18 March.

83. We are satisfied that the prison liaised appropriately with Mr Jeffries' family.

Compassionate release

84. 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.

85. On 31 October, a prison GP submitted the compassionate release form to the prison's offender management unit. This was not supported by the Deputy

Governor, however, because Mr Jeffries had only served four years of his sentence, had not completed any offence-focused work and because he wanted to be re-located near his family home where his offending had taken place.

86. On 2 January, Prison Service staff informed the prison that Mr Jeffries' compassionate release application had been refused because he did not meet the required criteria and was considered to pose a high risk of offending.

87. We are satisfied that Long Lartin considered and applied for compassionate release in a timely manner.

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