

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jason Callaghan, a prisoner at HMP Elmley, on 13 February 2020

A report by the Prisons and Probation Ombudsman

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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Summary

1. 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.
2. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr James Callaghan died in a hospice on 13 February 2020 of aspiration pneumonia and pneumonitis due to gastric cancer while a prisoner at HMP Elmley. He was 47 years old. I offer my condolences to Mr Callaghan's family and friends.
4. The clinical reviewer concluded that overall the clinical care Mr Callaghan received at Elmley was equivalent to that which he could have expected to receive in the community, and that the care provided by the GPs and healthcare staff throughout his time at Elmley, including his end of life care, was of a very high standard. She made seven recommendations, three of which are reflected in this report. The other recommendations have not been repeated here but will need to be addressed by the Head of Healthcare.
5. We found that consideration of Mr Callaghan's compassionate release application was delayed because the hospital would not provide details of his life expectancy. Mr Callaghan died before a final decision could be made.
6. This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Recommendations

- The Head of Healthcare should ensure newly arrived prisoners have an initial reception screen and a full initial health assessment screen in line with NICE guidelines.
- The Head of Healthcare should ensure that all significant medical events are documented in a prisoner's medical record. These should include:
 - multi-disciplinary team meetings; and
 - end of life pathways.
- The Governor and Head of Healthcare should:
 - work with Medway Maritime Hospital to clarify and agree the process for obtaining a prognosis for the purposes of the compassionate release process; and
 - ensure that the applications are processed in a timely manner.

The Investigation Process

7. NHS England commissioned an independent clinical reviewer, to review Mr Callaghan's clinical care at HMP Elmley.
8. The PPO investigator has investigated non-clinical issues, including Mr Callaghan's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
9. The PPO family liaison officer wrote to Mr Callaghan's next of kin, his partner, to explain the investigation. Mr Callaghan's partner wanted to know if Mr Callaghan had medical assessments when he transferred to Elmley; if there were any delays in him having hospital tests; and whether Mr Callaghan had hepatitis C. The clinical reviewer has addressed these questions in the clinical review report.
10. Mr Callaghan's partner received a copy of the initial report. She raised a number of questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.
11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Previous deaths at HMP Elmley

12. Mr Callaghan was the seventh prisoner to die at Elmley since February 2018. Of these deaths, four were from natural causes, one was self-inflicted, and one was a drug-related death. There are no similarities between our findings in the investigation into Mr Callaghan's death and our investigation findings for the previous deaths. There have been five deaths since Mr Callaghan's death all of which are currently under investigation.

Key Events

13. In June 2019, Mr Jason Callaghan was sentenced to two years and three months in prison for burglary offences. He transferred to HMP Elmley on 23 August 2019.
14. On 22 November, a prison GP completed an urgent referral under the fast-track cancer pathway to Medway Maritime Hospital because Mr Callaghan had complained about vomiting after eating, weight loss, abdominal pain and passing dark coloured stools.
15. On 4 December, the hospital diagnosed Mr Callaghan with metastatic oesophageal cancer (cancer of the gullet which had spread to other parts of the body).
16. On 8 January 2020, hospital staff referred Mr Callaghan for palliative chemotherapy. It was explained to him that his cancer could not be cured.
17. On 15 January, Mr Callaghan was offered the opportunity to move into the prison's inpatient unit but said he preferred to stay on the wing.
18. Mr Callaghan began to deteriorate on 20 January. He told staff that he was unable to tolerate any foods or fluids and had pain in his left leg. A prison GP arranged for him to be transferred to Medway Maritime Hospital for symptom control. Hospital tests showed that the cancer had spread to Mr Callaghan's bones.
19. On 21 January, healthcare staff asked the hospital for a prognosis for the purposes of applying for compassionate release. On the same day, the prison received a letter from the hospital indicating that the prognosis for Mr Callaghan's condition was months, not years.
20. On 22 January, the prison submitted an application to HM Prison and Probation Service (HMPPS) for early release on compassionate grounds on Mr Callaghan's behalf. On 24 January, the prison received a response from HMPPS asking for information about Mr Callaghan's life expectancy. Healthcare staff repeatedly asked the hospital for a letter confirming Mr Callaghan's life expectancy but were told that it was not the hospital's practice to provide such letters.
21. On 30 January, Mr Callaghan was transferred to Wisdom Hospice and released on temporary licence (ROTL) on the Governor's authority while waiting for a decision about compassionate release.
22. On 31 January, the hospice provided a letter setting out Mr Callaghan's prognosis and life expectancy and this was sent to the Deputy Governor to help with the compassionate release application.
23. At 3.27am on 13 February, Mr Callaghan died at Wisdom Hospice.

Post-mortem report

24. The post-mortem found that Mr Callaghan died of aspiration pneumonia and pneumonitis (inflammation of the lung tissue) caused by disseminated gastric carcinoma (widespread gastric cancer). Toxicology results showed the presence

of morphine and fentanyl (strong opioid painkillers) in his system which did not cause but may have contributed to his death.

25. In the light of the post-mortem report, the clinical reviewer found that Mr Callaghan had been prescribed buprenorphine as a weekly skin patch and the last dose was prescribed on 18 January. The patch provided a slow release of morphine and was within the recommended prescribing guidelines. Mr Callaghan was not prescribed fentanyl during his time at Elmley but may have been prescribed it at the hospice.

Non-Clinical Findings

Compassionate release

26. 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 HMPPS.
27. On 22 January, the prison submitted an application for Mr Callaghan's early release on compassionate grounds to the PPCS. Consideration of the application was delayed because the hospital was unwilling to confirm Mr Callaghan's life expectancy and he died before a final decision was made. We cannot say whether or not Mr Callaghan would have been released early if his application had been completed.
28. We recommend:

The Governor and Head of Healthcare should:

- **work with Medway maritime Hospital to clarify and agree the process for obtaining a prognosis for the purposes of the compassionate release application process for obtaining a prisoner's life expectancy; and**
- **ensure that the applications are processed in a timely manner.**

Lisa Burrell
Assistant Ombudsman

February 2021

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