

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Barry Hall, a prisoner at HMP Warren Hill, on 17 October 2021

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 Barry Hall, who was 78 years old, died in hospital of lung cancer on 17 October 2021, while a prisoner at HMP Warren Hill. We offer our condolences to Mr Hall's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Hall received at Warren Hill was of a good standard and equivalent to that which he could have expected to receive in the community. She made one recommendation which we repeat below.
5. We did not find any non-clinical issues of concern.

Recommendation

- The Head of Healthcare should ensure that blood sample tubes are on a continued stock rotation checking system so that there are no expired blood sampling tubes.

The Investigation Process

6. NHS England and NHS Improvement (NHSE&I) commissioned an independent clinical reviewer to review Mr Hall's clinical care at HMP Warren Hill.
7. The PPO investigator has investigated the non-clinical issues in Mr Hall's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
8. The PPO family liaison officer wrote to Mr Hall's next of kin, to explain the investigation. He did not respond to our letter.
9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at HMP Warren Hill

10. Mr Hall was the second prisoner to die at Warren Hill since October 2019. The previous death was drug related. There were no similarities between the findings in the two investigations.

Key Events

11. On 20 May 2020, Mr Barry Hall, who had previously received a life sentence for murder, was recalled to prison for breaching his licence conditions. Mr Hall was transferred to HMP Warren Hill on 6 January 2021.
12. On 27 September, Mr Hall told a nurse that he had ringing in his ears, neck and back pain and excessive sweating. She referred him to the prison GP, who reviewed him the next day. The GP made a referral for a chest X-ray and to the physiotherapist for Mr Hall's back pain.
13. On 3 October, a nurse visited Mr Hall as he was feeling unwell. She checked his observations and found they were all within the normal range. She advised him to take pain relief as she noted he was due to have a chest X-ray soon.
14. On 4 October, a prison GP visited Mr Hall as he was still feeling unwell. His observations were all within the normal range. The GP arranged blood tests and an electrocardiogram (ECG -a test to check the heart's rhythm). Later that day, a nurse visited Mr Hall in his cell and offered pain relief.
15. A nurse reviewed the blood test results and noted that the liver function and alkaline phosphate levels were abnormal. The other blood test (D-Dimer test for suspected deep vein thrombosis or pulmonary embolism) had to be repeated as the blood collection tube was found to have been out of date.
16. On 8 October, hospital staff contacted the prison and said that Mr Hall needed to go to hospital because of abnormal blood test results. Two prison officers escorted him, and he was restrained using an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.)
17. Mr Hall had a CT scan in hospital which showed he had cancer in his lungs, liver, stomach and pancreas. His restraints were removed. They were reapplied briefly when Mr Hall tried to assault a nurse.
18. Mr Hall continued to deteriorate, and he died in hospital on 17 October.

Cause of death

19. The Coroner gave Mr Hall's cause of death as metastatic carcinoma of the lung (lung cancer).

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