

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Leonard Cartell, a prisoner at HMP Rye Hill, on 12 December 2022

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 Leonard Cartell died from lung cancer on 12 December 2022 at HMP Rye Hill. He was 76 years old. We offer our condolences to Mr Cartell's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Cartell received at Rye Hill was in part equivalent to that which he could have expected to receive in the community. She raised several concerns, including that prison GPs did not follow the correct hospital referral processes, which potentially delayed Mr Cartell's diagnosis of cancer.
5. We found no non-clinical issues of concern.

Recommendations

- The Head of Healthcare should investigate, with the prison attached lead GP, the referral process undertaken as part of Mr Cartell's assessment for cancer.
- The Head of Healthcare should investigate, with the prison attached lead GP, the rationale for there being no anticipatory medication in Mr Cartell's palliative care plan.
- The Head of Healthcare should investigate why Mr Cartell was not reviewed again on 11 December 2022 when he was initially found to be deteriorating.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Cartell's clinical care at HMP Rye Hill.
7. The PPO investigator investigated the non-clinical issues relating to Mr Cartell's care, including Mr Cartell's 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 Cartell's next of kin, his friend, to explain the investigation and to ask if she had any matters she wanted us to consider. She 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 Rye Hill

10. Mr Cartell was the thirteenth prisoner to die at Rye Hill since December 2020. All the previous deaths were from natural causes. There are no similarities between our findings in the investigation into Mr Cartell's death and our investigation findings for the previous deaths.

Key Events

11. In October 1994, Mr Leonard Cartell was sentenced to life imprisonment for murder. On 17 March 2022, he was moved to HMP Rye Hill.
12. Mr Cartell had several long-term health conditions, including chronic obstructive pulmonary disease (COPD – the term for a collection of serious lung diseases) and type 2 diabetes.
13. On 27 July 2022, Mr Cartell was admitted to hospital following a hypoglycaemic event (when blood sugar levels fall too low). While in the hospital, a routine chest X-ray indicated that there was a suspicious lesion in his left lung. The prison GP made a referral for a CT scan on 29 July. (The GP made a ‘routine urgent’ referral, which has a four-week wait, and not a suspected cancer referral, which has a two-week wait.)
14. On 23 September, the CT scan results showed a right lung mass, which was suspected to be cancerous. The prison GP told Mr Cartell about the result and likely diagnosis. Mr Cartell attended hospital on 10 November for a lung biopsy to confirm the type of mass and prognosis.
15. On 17 November, Mr Cartell was diagnosed with terminal non-small cell carcinoma and doctors expected his prognosis to be weeks to months. On 21 November, a hospital consultant told Mr Cartell his diagnosis and explained that there was no treatment.
16. On 22 November, the prison healthcare team started a full palliative care plan. Mr Cartell did not want to be moved to a disabled cell or hospice and asked to remain in his own cell for as long as possible.
17. On 28 November, Mr Cartell said he did not want anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect.
18. On 29 November, the safer custody team completed paperwork to start the application for Mr Cartell’s early release on compassionate grounds. On 2 December, the healthcare team requested a letter from the hospital to confirm Mr Cartell’s prognosis to progress the application.
19. At around 3.00pm on 11 December, Mr Cartell’s health rapidly deteriorated. A nurse took his clinical observations, but there is no evidence she gave any medication to treat Mr Cartell’s nausea. There is no evidence he was assessed in full again that day.
20. Healthcare staff saw Mr Cartell the next morning and noted that he was nauseous and breathless. Staff maintained a close watch on Mr Cartell while arrangements were made to transfer him to a hospice. However, he died in his cell at around 1.00pm before a transfer could be arranged.

Cause of death

21. The coroner accepted the cause of death provided by a prison GP and no post-mortem examination was carried out. The GP gave Mr Cartell's cause of death as non-small cell lung cancer. He listed asthma, COPD and type 2 diabetes as contributory factors.

Louise Richards
Assistant Ombudsman

May 2023

Inquest

The inquest, held on 28 June 2023, concluded that Mr Cartell died from natural causes.

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