Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jamie Lees, a prisoner at HMP Birmingham, on 13 October 2022

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

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 Jamie Lees died of pneumonia in hospital on 13 October 2022 while a prisoner at HMP Birmingham. He was 54 years old. We offer our condolences to Mr Lees' family and friends.

4. The clinical reviewer concluded that the clinical care Mr Lees received at Birmingham was equivalent to that which he could have expected to receive in the community. The clinical reviewer makes no recommendations.

5. We are concerned about family liaison and early release on compassionate grounds processes at Birmingham. We found that contact with Mr Lees' family was not in line with his wishes and there were delays in the processing of Mr Lees' application for release on compassionate grounds. These factors did not impact on the outcome for Mr Lees but should be addressed to improve future care of prisoners who are seriously ill and whose families require contact and support.

Findings

Family liaison

6. On 11 October, when Mr Lees became seriously unwell and was transferred to hospital by ambulance, staff asked if his family should be told. Mr Lees said no, but the FLO proceeded. The FLO did not check Mr Lees' prison records before making contact and telephoned Mr Lees' ex-partner, instead of his sister, against his wishes. That evening, Mr Lees repeated his request for no contact with his ex-partner. The FLO log was updated, but the FLO continued to contact Mr Lees' ex-partner, against his wishes. Mr Lees' nominated next of kin was not contacted until after his death.

Application for early release on compassionate grounds

7. Healthcare started Mr Lees' application for early release on compassionate grounds (ERCG) on 16 August, but it did not progress to the relevant governor for approval due to a section of the form not being completed. We found a breakdown in communication between the offender management unit and healthcare team which meant the missing section was not identified or addressed so that the form could be submitted. We also found that staff were unsure who was overseeing submission of the form to the Governor.

Recommendations

- The Governor should review family liaison processes to ensure that contact is made in line with a prisoner's wishes.

- The Governor and Head of Healthcare should review the local process for early release on compassionate grounds applications and clarify responsibilities for prison and healthcare staff, including the importance of timeliness in line with the Early Release on Compassionate Grounds Policy Framework 2022.

The Investigation Process

8. NHS England commissioned an independent clinical reviewer to review Mr Lees' clinical care at HMP Birmingham.

9. The PPO investigator investigated the non-clinical issues relating to Mr Lees' care, including Mr Lees' location, the security arrangements for his hospital escorts, liaison with his family, and whether compassionate release was considered.

10. The PPO family liaison officer wrote to Mr Lees' sister, and next of kin (NOK), to explain the investigation and to ask if she had any matters she wanted us to consider. She was concerned that when Mr Lees was taken to hospital on 11 October, the prison contacted his ex-partner against his wishes. She also had some questions about Mr Lees' clinical care. We have addressed these concerns in our report and clinical review.

11. Mr Lees' family received a copy of the initial report. They raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

12. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS found no factual inaccuracies in the report.

Previous deaths at HMP Birmingham

13. Mr Lees was the 15th prisoner to die at HMP Birmingham since October 2020. Of the previous deaths, 10 were from natural causes, three were self-inflicted and one was a homicide. There are no similarities between our findings in the investigation into Mr Lees' death and our investigation findings for the previous deaths.

Key Events

14. Mr Lees was diagnosed with oesophageal cancer in 2017 while serving a sentence for burglary offences in HMP Birmingham. Mr Lees' chemotherapy treatment was unsuccessful, and he underwent surgeries to remove the cancer in 2019, while at HMP Stoke Heath. Mr Lees was released from Stoke Heath on licence on 21 September 2021.

15. On 9 March 2022, Mr Lees was recalled to custody for breaking his licence conditions. During his arrest, he complained of abdominal pain and was admitted to hospital. Mr Lees underwent surgery to treat a diaphragmatic hernia (a birth defect where there is a hole in the diaphragm) and said he was concerned his cancer had returned. Hospital doctors completed a scan and found that Mr Lees' cancer had returned and spread to other parts of his body. Further treatment was not considered viable, and Mr Lees was transferred to palliative care (care that improves quality of life for people with life-threatening conditions). He was taken to HMP Birmingham on 12 March.

16. On 18 March a member of the prison Resettlement Team interviewed Mr Lees as part of the pre-release process. Mr Lees said he was registered with a GP in Birmingham, where he was due to be released, and been prescribed medications while in custody which would need to be continued in the community. He said he had cancer and surgery had left him with problems. He was concerned about the return of his cancer.

17. On 25 April, Mr Lees attended hospital for an endoscopy (when an instrument is introduced into the body to give a view of its internal parts). This was unsuccessful because Mr Lees was physically unable to tolerate the procedure. The procedure was rearranged for 6 May.

18. On 3 May, Mr Lees reported pain in the left side of his chest and was given paracetamol by a prison GP.

19. On 4 May, Mr Lees said he was feeling unwell, and staff completed regular welfare checks. He also had a key work session (where prisoners have an allocated officer that they meet with regularly) with an officer. Mr Lees told the officer that the previous day, he had been told he would be attending a hospital appointment and could not eat on the morning of the appointment due to the procedure he was having. However, a nurse had visited his cell at 7.30am and told him if he wanted a drink, he could have one before a certain time. When Mr Lees attended the hospital, his scan was cancelled because he had consumed fluids that morning. Mr Lees was upset that he could not have the necessary checks and told hospital staff that he was worried his cancer had come back. They informed the prison healthcare team that the scan had been cancelled and rearranged.

20. On 6 May, Mr Lees told a nurse he was experiencing pain in his chest again. She recorded that Mr Lees had asked for pregabalin (used for pain relief) and said that his regular prescription of amitriptyline (an antidepressant) was not 'holding' the pain. She referred him for an urgent GP review. The same day, Mr Lees attended hospital for his endoscopy. The hospital doctor said the procedure could not be

completed because Mr Lees' cancer had returned. He was transferred back to prison.

21. On 7 May, Mr Lees was still experiencing pain in his chest. He told a nurse that he would hang himself because of the pain. An Assessment, Care in Custody and Teamwork (ACCT - the planning process for prisoners identified as being at risk of suicide or self-harm) was opened with immediate effect, to monitor Mr Lees' wellbeing. A Custodial Manager (CM) conducted Mr Lees' first ACCT review in consultation with other staff. Mr Lees provided a letter from the doctor at an outside hospital containing recommendations for his medication. A nurse explained to Mr Lees that medications were managed by prison GPs, who he could make an appointment with. Mr Lees said that his behaviour was due to the pain that he was in, and the nurse repeated that he should speak to the GP. Mr Lees responded with 'what is the point in this then?' and walked out of the room.

22. On 8 May, Mr Lees' ACCT was closed when staff felt the risk of suicide and self-harm had reduced.

23. On 10 May, a prison GP prescribed new pain relief for Mr Lees. The same day, an officer spoke with Mr Lees about his ACCT. Mr Lees said nurses were not taking him seriously about his cancer returning, about the pain he was in, and not getting his regular medication. He said his endoscopy appointment had been cancelled by the hospital.

24. On 11 May, Mr Lees had a Positron Emission Tomography (PET scan – for checking the activity of cells in different parts of the body) in hospital.

25. On 31 May, Mr Lees met with a prison GP for an assessment of his pain management. They discussed pregabalin and Mr Lees' history of misusing it. The GP agreed to prescribe pregabalin but said it would be stopped if Mr Lees misused it.

26. On 20 July, a prison GP received Mr Lees' PET scan results. The next day, he met with Mr Lees to discuss the findings which showed metastatic nodal (lymph nodes that have been infected by cancer from elsewhere in the body) and bone disease. The hospital had planned a follow up appointment with a Consultant Gastroenterologist on 26 July, but this was cancelled by the hospital. Medical records say that this was due to 'staffing level problems'.

27. On 16 August at 12:44am, a nurse was called to assess Mr Lees, who was complaining of increased chest pain and producing brown coloured mucus. His National Early Warning Score (NEWS2) was recorded as 2. The NEWS2 assessment is a nationally recognised tool for monitoring health deterioration by categorising a patient's severity of illness and prompting nursing staff to request a medical review at specific trigger points. Mr Lees was given paracetamol and referred for an urgent GP appointment the following day. A nurse assessed Mr Lees again at 2:25am, and a NEWS2 score of 4 was recorded due to a drop in Mr Lees' blood pressure. Mr Lees declined an admission to hospital and stated that he would wait to see a prison GP the following day. A nurse went to Mr Lees' cell for a follow-up assessment at 4:40am, but found Mr Lees was sleeping and left him undisturbed.

28. On 16 August at 9:48am, a nurse assessed Mr Lees, and his NEWS2 score was recorded as 8 which indicates a high risk of deterioration. She advised Mr Lees that he should be transferred to the healthcare unit, but Mr Lees stated he would only go if a particular prison GP was there. The GP was not on duty, and Mr Lees did not want to speak to another GP. At 12:43pm, a nurse discussed the NEWS2 8 score with another prison GP, who advised that Mr Lees should attend hospital because of his fluctuating oxygen levels. Healthcare requested an ambulance. A prison GP shared Mr Lees' assessment results with paramedics and Mr Lees was transported to hospital. At 4:04pm, hospital staff called Birmingham to say that Mr Lees had discharged himself. Prison staff collected Mr Lees and returned him to prison.

29. The same day, the healthcare team started an application for early release on compassionate grounds (ERCG) for Mr Lees. They requested confirmation of Mr Lees' diagnosis from his hospital consultant, which they needed in order to complete the healthcare section of the application form.

30. On 17 August, hospital staff contacted the prison healthcare team to confirm that Mr Lees was terminally ill. A senior nurse created a care plan for managing Mr Lees' needs and recorded that he was still unwilling to move to the prison healthcare unit.

31. Later the same day, Mr Lees' ERCG application was sent to the Offender Management Unit (OMU). The Duty Prison Offender Manager completed the opening request. A nurse informed her that the healthcare team were awaiting confirmation of Mr Lees' official diagnosis from his hospital consultant, to support the application.

32. On 24 August, Mr Lees' NEWS2 score was recorded as a 5, and an ambulance was called. Mr Lees refused to attend hospital and signed a disclaimer to that effect. Healthcare completed welfare checks during the night and raised no concerns about Mr Lees.

33. On 25 August at 7.57pm, Mr Lees' oxygen levels reduced significantly. Staff made a request for an ambulance which transferred Mr Lees to hospital.

34. On 26 August, Mr Lees met with a prison GP, who discussed the risks associated with resuscitation if his heart or breathing stopped. Mr Lees agreed to sign a Do Not Attempt Resuscitation (DNAR) and the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) process was put in place. The ReSPECT process creates a summary of personalised recommendations for a person's clinical care in a future emergency in which they do not have capacity to make or express choices. At 5.56am, Mr Lees discharged himself from hospital against medical advice and asked to return to his cell. Prison staff met with Mr Lees in the prison reception area to check on his wellbeing. They recorded that he was alert but upset about how he had been treated in hospital. Staff took Mr Lees to his cell and arranged for healthcare staff to visit him later. By then, staff noted that Mr Lees appeared to be in good spirits, despite being in pain, and declined a wheelchair to bring him back from reception, preferring to walk.

35. On 1 September, a family liaison officer (FLO) met with Mr Lees to discuss his wishes about family contact. The FLO noted that Mr Lees had changed his next of kin (NOK) contact to his sister, replacing his ex-partner, due to a disagreement. This was reflected in Mr Lees' prison records.

36. On 6 September, Mr Lees was taken to hospital, as healthcare suspected he was showing signs of aspiration pneumonia. He was accompanied by officers but was not handcuffed. He returned later the same day, following a self-discharge.

37. On 7 September at 11.00am a nurse visited Mr Lees and completed his observations. Mr Lees said that he did not feel well. The nurse recorded that Mr Lees looked dazed and confused and had a short attention span. Mr Lees' oxygen levels and blood pressure were low. The nurse looked at Mr Lees' medical notes, spoke with colleagues, then returned to Mr Lees' cell around 20-25 mins later with another nurse and completed Mr Lees' observations again, which although higher than before were still low. They asked Mr Lees whether he would discharge himself from hospital if they organised a transfer, and he said yes. Mr Lees agreed to go to the healthcare unit for a period of observation. Nurses continued to monitor Mr Lees and at 2.55pm he was admitted to the healthcare unit.

38. On 9 September, Mr Lees' hospital consultation sent confirmation of his diagnosis to the prison healthcare team for the purpose of his ERCG application. The application form template had recently changed, so the application needed to be updated.

39. On 12 and 20 September, a Speech and Language Therapist completed swallowing assessments for Mr Lees. She recommended that Mr Lees have a percutaneous endoscopic gastrostomy. (PEG - a procedure in which a flexible feeding tube is placed through the abdominal wall and into the stomach to aid nutrition.)

40. On 22 September, a prison GP reviewed Mr Lees. Mr Lees said that the swallowing assessment was incorrect because he had just eaten a cheese and ham cob. He said that he did not require a PEG tube insertion.

41. On 27 September healthcare recorded that Mr Lees had been declining his special diet and was eating meals from the servery.

42. On 28 September, the OMU team confirmed they had received the diagnosis information for Mr Lees' ERCG application from healthcare. They transferred the application onto the new template.

43. On 10 October healthcare staff found Mr Lees was struggling to breathe and vomiting blood. They called a code blue (signalling that someone is not breathing and triggering a call for an ambulance). The Duty Governor decided that handcuffs would not be necessary, given Mr Lees' poor health. Mr Lees was asked if he wanted prison staff to contact his family, which he declined. A Governor asked for an update on Mr Lees' ERCG application from the OMU and found it had not been submitted to the Governing Governor for approval.

44. On 11 October at approximately 4:50am, Mr Lees was taken to hospital by ambulance. In hospital, Mr Lees' health continued to deteriorate, and the FLO called his ex-partner, his previous next of kin, but she did not answer. Later the same day, Mr Lees told his bedwatch officer (an officer responsible for accompanying prisoners spending time in outside hospital) that he did not want his ex-partner to be contacted.

45. At approximately 8:30am on 13 October, Mr Lees passed away in hospital. The FLO visited Mr Lees' ex-partner to notify her of his death, but she was at work. The FLO contacted Mr Lees' ex-partner later in the day by phone.

46. On 14 October, a Governor told the FLO that Mr Lees' next of kin had been changed in September, to his sister. The FLO contacted Mr Lees' sister, to notify her of his death.

Post-Mortem Report

47. The provisional post-mortem examination concluded that Mr Lees died of pneumonia, caused by small bowel obstruction, which was caused by metastatic oesophageal squamous cell carcinoma (cancer that forms in the thin, flat cells lining the inside of the oesophagus).

Findings

Family liaison

48. National Prison Service policy requires prisons to record a next of kin or nominated person for each prisoner during the reception or early days process. This information must be kept up-to date, in accordance with Prison Service Instruction (PSI) 07/2015 'Early Days in Custody' and PSI 64/2011 'Safer Custody'.

49. On 1 September, the FLO met with Mr Lees to discuss his wishes for family contact. Mr Lees asked for his nominated next of kin to be updated to his sister, following a disagreement with his ex-partner. The FLO updated Mr Lees' prison records. When Mr Lees became seriously unwell and an ambulance was called on 10 October, a different FLO was nominated. Mr Lees was asked if his family should be told about his transfer to hospital. Mr Lees said no, but the FLO contacted his ex-partner to notify her. This was not in line with Mr Lees' wishes.

50. That evening, Mr Lees repeated to a bedwatch officer (an officer responsible for accompanying prisoners spending time in outside hospital) that he did not want any contact with his ex-partner. The FLO log was updated. However, when Mr Lees died on 13 October, the FLO visited his ex-partner to break the news of his death and offer support. This was not in line with Mr Lees' wishes.

51. The next day, a Governor told the FLO that Mr Lees' next of kin was his sister, not his ex-partner. The FLO contacted Mr Lees' sister to notify her of his death and offer support.

52. We are concerned about this practice at Birmingham. Mr Lees' wish for no family to be contacted on 10 October was not adhered to. In addition, the FLO contacted the wrong person to notify them of Mr Lees' deteriorating health, and after he died. The FLO should only have made contact with Mr Lees' nominated next of kin, his sister, after his death. We make the following recommendation:

    The Governor should review family liaison processes to ensure that contact is made in line with prisoners' wishes.

Application for early release on compassionate grounds

53. His Majesty's Prison and Probation Service's (HMPPS) Early Release on Compassionate Grounds Policy Framework 2022 says "it is imperative that applications are expedited as far as possible … those making the application should take account of the urgency of the case and be minded that the Public Protection Casework Section require adequate time to consider the application".

54. Mr Lees' application for early release on compassionate grounds (ERCG) was started on 16 August. However, a section of the application was not completed, and this was not identified or addressed in order for it to be submitted to the relevant governor for approval. We found that there was confusion between the healthcare team and offender management unit (OMU) about who was overseeing the process and responsible for submitting the application to the Governor for approval. Records

of the journey of the application form varied between teams and we were unable to verify where the breakdown in communication occurred.

55. We are concerned about the lack of progress on Mr Lees' application over the course of nearly two months. We are unable to measure the impact on Mr Lees, but it is important that the process is clarified to prevent unnecessary delays in future. The staff we spoke to acknowledged the issues and need for improvement. We make the following recommendation:

    The Governor and Head of Healthcare should review the local process for early release on compassionate grounds applications and clarify responsibilities for prison and healthcare staff, including the importance of timeliness, in line with the Early Release on Compassionate Grounds Policy Framework 2022.

Inquest

56. The inquest into Mr Lees' death concluded on 3 July 2023. The Coroner confirmed that Mr Lees died of natural causes.

Kimberley Bingham **August 2023**
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