

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

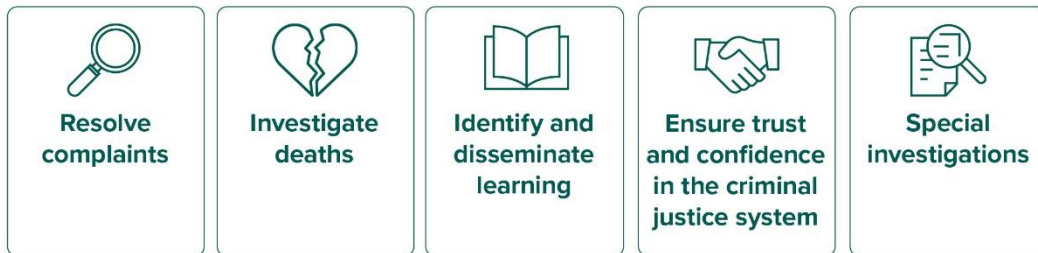
# **Independent investigation into the death of Mr Terence Jeffery, a prisoner at HMP Brixton, on 1 May 2020**

**A report by the Prisons and Probation Ombudsman**

## OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

## WHAT WE DO



## WHAT WE VALUE



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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 we oversee can improve their work in the future.

Mr Terence Jeffery died in hospital from cancer on 1 May 2020, while a prisoner at HMP Brixton. He was 75 years old. I offer my condolences to Mr Jeffery's family and friends.

Mr Jeffery was sent to hospital on 6 April, when a nurse suspected that he may have had a stroke. He underwent a series of tests in hospital, which showed not only that he had had a stroke, but also that he had lung cancer. His health rapidly deteriorated and he remained in hospital until his death.

The clinical reviewer was satisfied that the standard of care Mr Jeffery received at Brixton was equivalent to that which he could have expected to receive in the community. Mr Jeffery had showed no symptoms of cancer at Brixton.

However, the clinical reviewer was concerned that Mr Jeffery was not examined by healthcare staff after he suffered a series of falls in late March and early April. Given that Mr Jeffery was an elderly man whose poorly controlled diabetes meant that he was at high risk of stroke, this was a missed opportunity to assess him and caused a potential delay in the stroke diagnosis.

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 2020**

# Contents

Summary .....	1
The Investigation Process.....	2
Background Information.....	3
Key Events.....	4
Findings .....	6

# Summary

## Events

1. On 15 July 2014, Mr Terence Jeffery was sentenced to 12 years in prison for sexual offences. On 31 August 2017, he was moved to HMP Brixton.
2. On 31 March and 3 April 2020, Mr Jeffery fell over. He told healthcare staff that he was not injured and returned to his cell. Healthcare staff did not examine him or take his clinical observations.
3. On 6 April, a nurse was called to Mr Jeffery's cell because he could not get down the stairs to collect his medication. The nurse examined Mr Jeffery and noted that he had no power in his right arm or right leg. She suspected that he may have had a stroke so arranged for him to be sent to hospital. Hospital doctors later confirmed that Mr Jeffery had had a stroke.
4. On 17 April, Mr Jeffery's health deteriorated further. Tests showed that he had pneumonia and chronic obstructive pulmonary disease (COPD – the term for a collection of lung diseases including chronic bronchitis and emphysema).
5. On 24 April, further tests showed that Mr Jeffery had lung cancer. Mr Jeffery's health deteriorated rapidly and he died on 1 May. A hospital doctor gave the cause of death as multiple organ failure caused by cancer.

## Findings

6. The clinical reviewer found that the standard of care Mr Jeffery received at Brixton was equivalent to that he could have expected to receive in the community.
7. Mr Jeffery showed no symptoms of cancer at Brixton. However, the clinical reviewer was concerned that healthcare staff did not examine Mr Jeffery or take his clinical observations after his falls in late March and early April. The clinical reviewer was concerned that given Mr Jeffery was a 75-year old man whose poorly controlled diabetes meant he was at high risk of stroke, this was a missed opportunity to assess him and caused a potential delay in his stroke diagnosis.

## Recommendations

- The Head of Healthcare should ensure that when a prisoner has a fall, healthcare staff:
  - examine them and take their observations; and
  - consider whether underlying conditions may have caused the fall.

## The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Brixton informing them of the investigation and asked anyone with relevant information to contact her. No one responded.
9. The investigator obtained copies of relevant extracts from Mr Jeffery's prison and medical records.
10. NHS England commissioned a clinical reviewer to review Mr Jeffery's clinical care at the prison. The clinical reviewer conducted joint interviews with the investigator. Due to the restrictions of coronavirus, these were conducted by telephone.
11. We informed HM Coroner for the Inner South District of Greater London of the investigation. The coroner gave us the cause of death. We have sent the coroner a copy of this report.
12. One of the Ombudsman's family liaison officers contacted Mr Jeffery's wife to explain the investigation and to ask if the family had any matters they wanted the investigation to consider. Mr Jeffery's wife asked the investigation to consider why Mr Jeffery had not been sent to hospital for a scan sooner. She also said that she was disappointed that the prison had not contacted her when Mr Jeffery was initially taken to hospital on 6 April.
13. Mr Jeffery's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.
14. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

## **Background Information**

### **HMP Brixton**

15. HMP Brixton is a medium security resettlement prison in London that holds up to 810 convicted and sentenced adult male offenders. Care UK, an independent company providing health and social care, provides healthcare services. The prison has five wings, including a sex offender unit and a drug recovery unit.

### **HM Inspectorate of Prisons**

16. The most recent inspection of HMP Brixton was in March 2019. Inspectors reported that health services were good. Prisoners could make written applications for a health care appointment or directly approach staff with their health concerns. Wing-based nurses and pharmacy-led triage clinics provided patients with timely access to health care support.
17. The health care team adopted a pragmatic and effective approach to chronic disease management and a practice nurse, supported by the GP, oversaw care. Access to external specialist input was good. However, local care plans were too generic and some review dates had been rescheduled. A multi-professional complex case clinic ran every week and was attended by senior managers and professionals to discuss and review patients with challenging needs. A lead professional was assigned to each case, which was positive.

### **Independent Monitoring Board**

18. 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 2019, the IMB reported that, most waiting times for appointments reflected those in the community. However, heavily subscribed services like smoking cessation and sexual health clinics had long waiting lists, causing anxiety for men. Age-related and other screenings available outside prison were provided.

### **Previous deaths at HMP Brixton**

19. Mr Jeffery was the fourth prisoner to die at Brixton since May 2018. Of the previous deaths, one was from natural causes, one was self-inflicted and one was drug-related. There are no similarities between our findings in the investigation into Mr Jeffery's death and our investigation findings for the previous deaths.

## Key Events

20. On 15 July 2014, Mr Terence Jeffery was sentenced to 12 years in prison for sexual offences. He was sent to HMP High Down.
21. On 31 August 2017, Mr Jeffery was moved to HMP Brixton. A nurse completed Mr Jeffery's initial reception screening. She noted that he had type two diabetes.
22. Over the next few years, healthcare staff saw Mr Jeffery for regular reviews about his diabetes, but because he would not engage, his diabetes was poorly controlled.
23. In January 2020, staff noted that Mr Jeffery's diabetes was getting worse. A prison GP noted that Mr Jeffery said he was not bothered as he did not feel unwell.
24. On 31 March, Mr Jeffery fell over and was found on the floor by another prisoner. A nurse noted that Mr Jeffery was sitting in a chair when he arrived, and that Mr Jeffery said he had not injured himself. The nurse noted that Mr Jeffery could walk with no problems.
25. On 3 April, Mr Jeffery fell on the stairs. A nurse noted that he checked Mr Jeffery for injuries and then Mr Jeffery walked back to his cell.
26. On 4 April, Mr Jeffery was unable to attend for his insulin injection because he said he had pain in his legs. A nurse went to Mr Jeffery's cell and gave him his insulin injection, but he did not examine Mr Jeffery or explore the pain in his legs.
27. On 6 April, a nurse was called to Mr Jeffery's cell because he was unable to get down the stairs for his medication. Mr Jeffery's cellmate told the nurse that Mr Jeffery had fallen over three times in the last week. The nurse examined Mr Jeffery and was concerned that he had no movement and no power in his right arm and his right leg. Mr Jeffery said that he had first noticed loss of movement and strength on his right-hand side the previous day. The nurse suspected that Mr Jeffery might have had a stroke so arranged for him to be sent to hospital. He was accompanied by two prison officers but was not restrained.
28. Mr Jeffery was admitted to hospital for further tests. Mr Jeffery told staff that he did not want his wife to know that he was in hospital. The tests showed that he had suffered a stroke.
29. On 17 April, Mr Jeffery's health deteriorated; he had developed pneumonia and was not responding to antibiotics. He was also diagnosed with chronic obstructive pulmonary disease (COPD – the term for a collection of lung diseases including chronic bronchitis and emphysema). Mr Jeffery agreed that the hospital nurse could contact his family to say that he was in hospital, but he did not want them to know his diagnosis.
30. On 24 April, Mr Jeffery was diagnosed with lung cancer.
31. On 29 April, a multi-disciplinary team meeting noted that Mr Jeffery was very unwell and had type 2 respiratory failure. Hospital staff discussed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order with Mr Jeffery who agreed that if he stopped breathing, he did not want to be resuscitated.

32. On 30 April, Mr Jeffery agreed that the hospital nurse could tell his wife about his diagnosis.
33. On 1 May, Mr Jeffery died with his wife at his bedside.

### **Contact with Mr Jeffery's family**

34. On 24 April, when Mr Jeffery was diagnosed with lung cancer, the prison appointed a family liaison officer (FLO). The FLO did not contact Mr Jeffery's family immediately because Mr Jeffery said that he did not want them to know his diagnosis. When Mr Jeffery died on 1 May, the FLO was not in work so a prison manager took over as the FLO. As Mr Jeffery's wife was at the hospital when he died, the prison manager waited to contact her until the following day.
35. The prison contributed for Mr Jeffery's funeral in line with national guidelines.

### **Support for prisoners and staff**

36. After Mr Jeffery's death, a prison manager debriefed the staff involved in Mr Jeffery's care to ensure they had the opportunity to discuss any issues arising, and to offer support.
37. The prison posted notices informing other prisoners of Mr Jeffery's death, and offered support.

### **Cause of death**

38. No post-mortem examination was carried out as the coroner accepted the cause of death provided by a hospital doctor. The doctor gave Mr Jeffery's cause of death as multiple organ failure caused by cancer (primary site unknown). Brain infarcts (brain damage caused by stroke), emphysema and diabetes were listed as contributory factors.

# Findings

## Clinical Care

39. The clinical reviewer concluded that the clinical care Mr Jeffery received at Brixton was equivalent to that which he could have expected to receive in the community.
40. Mr Jeffery had poorly controlled diabetes and did not engage with healthcare staff and sometimes did not take his medication. Throughout Mr Jeffery's time in prison, healthcare staff continued to make efforts to educate him about the complications of poorly controlled diabetes.
41. Mr Jeffery's health gradually deteriorated leading up to his admission to hospital but he did not show any symptoms suggestive of lung cancer.
42. When Mr Jeffery had falls on 31 March and 3 April, the nurse who saw him did not examine him or take clinical observations. Given Mr Jeffery was a 75-year old man whose poorly controlled diabetes meant an increased risk of stroke, the clinical reviewer was concerned that healthcare staff missed an opportunity to assess him and explore the reasons why he might have fallen. She noted that signs of a mini stroke resolve within 24 hours but can resolve within minutes, so an examination post-fall may have revealed little. However, good practice would have been to assess Mr Jeffery to see whether there was an underlying reason for his falls. This was a missed opportunity to assess Mr Jeffery and caused a potential delay in the stroke diagnosis. We recommend:

**The Head of Healthcare should ensure that when a prisoner has a fall, healthcare staff:**

- **examine them and take their clinical observations; and**
- **consider whether underlying conditions may have caused the fall.**

## Inquest

43. The inquest, held on 29 August 2023, concluded that Mr Jeffery died from natural causes.

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