PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the circumstances surrounding the death of a man at outside hospital in July 2012, while a serving prisoner at HMP Birmingham.

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is the report of an investigation into the death of a man, a prisoner at HMP Birmingham, in July 2012. He was 36 years old and died of metastatic oesophageal cancer. I offer my condolences to his family and friends.

The investigation was carried out by one of my investigators. The Quality Improvement Lead at NHS Staffordshire carried out an independent clinical review of the man's care during his time in custody. HMP Birmingham cooperated fully with the investigation.

The man had suffered from oesophageal cancer before arriving at Birmingham in November 2011. Following surgery in 2008, and chemotherapy in 2009, the cancer appeared to be in remission. He was due to have a follow-up appointment with his oncologist in December 2011, but asked for all future appointments to be cancelled as he did not want to attend in handcuffs. We cannot know whether, had he attended, this would have made a difference to the outcome. However, I consider prison healthcare staff should have been more proactive in discussing this with him.

The man appears to have begun experiencing new symptoms, including pain, in February 2012. At the beginning of May, he was told that the cancer had returned and spread. The clinical reviewer considers the man's cancer was appropriately diagnosed but his pain was not always managed well, partly because he was reluctant to take opioid-based medication. He was admitted as an inpatient on 8 May where he remained for almost two months until his death.

The man received generally satisfactory care at the prison. However, I am particularly concerned about the conduct of the officers who escorted him on 25 April and apparently kept him waiting in handcuffs in full view of the public for 40 minutes. I am also concerned that there was inadequate risk assessment to determine the appropriate level of security needed for such a sick man attending hospital. This is something I have raised previously with Birmingham. The prison needs to ensure that it appropriately balances security with humanity when making such decisions. An unduly risk averse approach also characterised the prison's handling of possible temporary release or release on compassionate grounds. Finally, the Director needs to remind his staff that terminally ill prisoners and their families should be treated with greater sensitivity than was accorded to this man and his family.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **June 2013**

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SUMMARY

1. The man arrived at HMP Birmingham on 1 November 2011. He had previously been treated for oesophageal cancer, although this appeared to be in remission. He spent his first two weeks in the prison's healthcare inpatient unit while his needs were assessed, but then moved to the vulnerable prisoners' wing. He told his wife that he did not want to have any hospital appointments while he was in prison, but healthcare staff did not discuss this with him.

2. In February 2012, the man told his wife that he was experiencing pain. He saw a GP and was given antibiotics. In March, he again told his wife about his pain, and she arranged an appointment with his consultant oncologist, without the knowledge of the prison. The appointment was cancelled for security reasons and rescheduled for 22 March, two days later. The consultant examined the man and found a lump. He told him that it appeared his cancer had returned.

3. The man told his wife that he thought he had found another lump in April, although there is no record that he discussed this with healthcare staff. On 25 April, he again saw his consultant and had a scan. While waiting to return to the prison, he recorded that the escort staff went to a food outlet and kept him handcuffed to one of the officers for 40 minutes in full public view which the man found degrading. The consultant had asked for him to return the next day for the results of the scan but this message does not seem to have reached the prison. The appointment was rescheduled for May.

4. A prison GP sent the man to hospital on 5 May as he was in so much pain. He returned to prison the same day, but continued to experience pain. There is no evidence that any thought was given to admitting him to the prison's inpatient unit to help manage his pain. His hospital consultant saw him on 8 May for an outpatient appointment and admitted him to hospital as the results of his scan had indicated that the cancer had returned. Further tests confirmed that he had cancer in his pancreas which had spread. Despite this prognosis and his poor condition, the man remained restrained in hospital until 29 May and was further restrained for a time on 11 June. He remained in hospital until he died in July. During this time his family complained twice about the inappropriate conduct of prison staff accompanying him.

5. The clinical reviewer has found that the diagnosis of the man's cancer was appropriate, although the management of his pain was not always as good as it might have been. This investigation highlights serious concerns about the use of risk assessments to determine the appropriate level of restraints, and about the conduct of staff escorting prisoners to hospital. It also appears that staff acted inappropriately on 25 April when escorting the man to hospital.

THE INVESTIGATION PROCESS

6. The investigator visited Birmingham on 12 July 2012, and collected copies of the man's prison files and medical records. She met the Head of Healthcare, viewed the man's cell and introduced herself to the staff on the wing. Notices were issued announcing the investigation to staff and prisoners, and asked anyone with information about the man's death to contact her. No-one came forward.

7. The investigator returned to Birmingham on 3 September, to interview a prison GP and meet the prison liaison (and family liaison officer (FLO).

8. A review of the clinical care the man received in prison was conducted by the Quality Improvement Lead at NHS Staffordshire. The final review was received by the investigator on 12 November 2012.

9. This report will be forwarded to the Coroner's office. A post-mortem examination was not carried out as the man had been under hospital care for some time and the Coroner accepted the cause of death.

10. The investigator and one of the Ombudsman's family liaison officers (FLO) visited the man's wife on 20 September. The man's brother and a solicitor were also present. The man's wife and her brother-in-law explained that the prison FLOs were good and financial assistance was offered and accepted towards the funeral cost. However, they raised the following concerns about the care their relative received.

    - The standard of his clinical care while in custody including the management of pain relief.
    - The lack of access to clinical care, including access to a doctor and missing important external hospital appointments.
    - Their relative's diet – the man had previously suffered from oesophageal cancer and had specific dietary and nutritional needs. His family do not believe these were met while in custody.

11. The man's wife commented that her husband had kept a detailed journal while he was in prison. She explained that a number of her concerns reflected entries in his journal. His family also raised concerns about the behaviour and attitude of some of the prison staff, which they considered insensitive and inappropriate.

12. The man's wife provided the investigator with contact details for her husband's cellmate who had been released from prison. The investigator spoke to him on 17 October. She also spoke to the Independent Monitoring Board (IMB) lead at Birmingham, who confirmed that the man had not made any applications or complaints to the IMB about this treatment during his time in prison.

13. Because of concerns about the conduct of specific members of staff, a version of this report was advance disclosed to Birmingham on 26 November 2012.

14. The man's wife and brother-in-law received a copy of the draft report and given the opportunity to comment on the contents. She said that they thought the report was very fair and were pleased that it covered so many issues. Her

solicitor sent a letter to the investigator on 18 February 2013, providing more formal feedback on the draft report. In this letter he explained that his client was unhappy with the record of events in relation access to her husband in his final days in hospital. The official prison documentation showed that open access was given to the man's family after a certain date. His client felt that this was not the case. Given that the two accounts are very different, it was explained that we are unable to make a judgement on this issue.

15. The man's wife sent a letter of complaint to the prison three days after her husband died. This letter criticised the care her husband had received. Her solicitor explained that his client had not received a reply to this letter. The investigator had sight of this letter during the investigation and all the issues highlighted were covered in her investigation. Initially the investigator was advised by the prison that all correspondence received from the man's wife had been replied to. However, after a copy of the letter was provided to the prison they confirmed that they had not received this particular letter, but would now respond to the concerns raised.

HMP BIRMINGHAM

16. HMP Birmingham is a large prison in the Winson Green area of Birmingham. It holds a maximum of 1450 men, both sentenced and unsentenced. The prison is the first public sector prison to have its management transferred to the private sector. Since 1 October 2011, it has been managed by G4S Care and Justice Services.

17. Healthcare services are commissioned by NHS Birmingham and Solihull. The prison healthcare centre is in operation 24 hours a day.

Previous deaths in custody

18. Since 2010, there have been three deaths from cancer at Birmingham. In one of these cases, which we reported in March 2012, we recommended that Birmingham should ensure that all relevant sections of the escort risk assessment are completed so that full account is taken of a prisoner's health and physical condition and the impact this has on his actual risk. We also recommended that a prisoner's next of kin should be informed when they are seriously ill and in hospital. Both of these issues are of concern in this investigation.

Her Majesty's Inspectorate of Prisons (HMIP)

19. HM Inspectorate of Prisons conducted a full unannounced inspection of Birmingham in January 2012, and commented:

> "There was a wide range of physical and mental health provision, underpinned by comprehensive clinical governance. In-house and visiting health professionals provided a service equal to that in the community but prisoners' views about the overall quality of services were relatively poor. There was easy access to a good GP service … NHS appointments were well managed".

Independent Monitoring Board

20. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. The most recent IMB annual report for Birmingham covers the year to June 2011.

21. The IMB commented on healthcare at the prison:

> "There remain concerns about missed medical appointments to Health Care but the external appointments function well. In general the IMB has observed a good level of care being provided by staff towards a sometimes very difficult group of prisoners

ISSUES

The diagnosis of the man's terminal illness

22. The man was convicted of serious offences on 15 August 2011. Before his arrest, he had been diagnosed with oesophageal cancer, and his oesophagus and part of the stomach had been removed by surgery. A clinical nurse specialist produced a report for the court which outlined the man's specific health care needs, his prognosis and her opinion of the impact a custodial sentence would have on his health. She wrote:

> "The operation is usually expected to have a curative intent but due to often advanced stage of the disease at the time of the presentation overall there is a significant risk of disease recurrence after surgery. In [this man's] case post operative histology reported T3N1 disease, which means locally advanced tumour with metastasis. These finding have clear indications in terms of his prognosis with a high risk of disease recurrence. Since the surgery he has remained well.
>
> However, taking into account that he has already been diagnosed with metastatic disease the prognosis remains poor as his cancer may progress quite rapidly at anytime. I strongly believe that any custodial sentence would have a very negative impact on [his] health, in particular to his nutrition and an adverse effect on his survival."

23. On 1 November, the man was sentenced to 11 years imprisonment and was taken to HMP Birmingham. A nurse conducted a reception health screen. He told the nurse that his cancer was in remission and that no disease had been detected at his last CT scan in October 2011. (A CT scan is a computerised tomography scan that produces images of the inside of the body.)

24. On 9 November, the man reported having lower back pain and a physiotherapist advised on positioning to avoid future pain. On 15 November, a doctor saw the man who had lower abdominal pain, which he said he had suffered before, but otherwise felt fine. A urine test showed traces of protein but the doctor felt no further action was needed.

25. A prison healthcare administrator spoke to the man's consultant's secretary on 2 December, to check his next hospital appointment. The secretary told her that his wife had contacted the hospital to say that her husband did not want to be seen at the hospital while he was in prison as he did not wish to attend in handcuffs. On 14 December, the consultant wrote to the prison healthcare department and said:

> "I note that [the man] does not want to come to the department handcuffed. His last CT scan … showed no evidence of relapse. It would be reasonable to investigate him should he develop symptoms, but I do not think any screening tests are necessary so I will not be making any routine outpatient appointments for him".

26. The man kept a journal and wrote on 17 February 2012 that he was "still having pain in my chest don't know what it is…. I think its muscle but [I'm not] sure. Will get into bed in a bit to relax and see how it is tomorrow". There is no entry

in his medical records to show that he reported this pain to healthcare or any indication as to how long he had suffered with this pain.

27. On 20 February, the man wrote in his journal “my whole body is aching, got to be flu”. He applied to see the doctor on 27 February. A doctor saw him on 1 March. He noted, “persistent cough over last 2 weeks. No vomiting, nausea, sob [shortness of breath]. Swallowing ok. No other problems”. He prescribed an antibiotic, amoxicillin.

28. According to his journal, the man told his wife on 4 and 6 March that he was in pain and had discovered a lump in his abdomen. His wife said she would arrange an appointment with the consultant at outside hospital. He wrote in his journal, “I should do an app [application] to see our doctor but I think we will get further through the prof [the consultant]”.

29. The man’s wife made an appointment for her husband to see the consultant at outside hospital on 20 March. He received a letter from the hospital on 15 March, confirming the appointment, but this was cancelled for security reasons. (Appointments for prisoners to attend hospital are usually arranged through the prison healthcare department.) The prison healthcare administrator spoke to the consultant’s secretary on 16 March, who told her that the man wanted to see the consultant as he had back pain, left sided shoulder/arm pain and had found a lump in his abdomen. The appointment was rescheduled for 22 March.

30. A prison GP visited the man in his cell on the afternoon of 16 March. The man explained that he had pain in his left ribcage for roughly three weeks and had discovered a lump in his abdomen. The GP examined him and found a lump. He prescribed tramadol for the pain.

31. The man saw his consultant at outside hospital on 22 March. He wrote to prison healthcare that “in the abdomen there is a subcutaneous nodule [growth under the skin] on the left flank which is very suspicious of skin metastasis [cancer]. I fear very much he might have relapsed and I have told him so.” He recommended that tramadol be increased from one to three times daily.

32. The man wrote in his journal that, on 27 and 30 March, he telephoned his wife and said he was in pain. There are no entries in his medical record about this. He also told his wife on 11 April, that he had found another lump, under his armpit. He made an application to see a prison GP who saw him eight days later. He prescribed additional pain relief but there is no record to show that the lump was discussed. The man wrote in his journal that the GP did not examine him.

33. On 25 April, the man attended outside hospital for a CT scan of his thorax, abdomen and pelvis. The consultant asked that the man return the next day to discuss his results. However, the prison was seemingly unaware of this and did not take him. The appointment was rearranged for 8 May.

34. A prison GP examined the man in his cell on 4 May, after he had again complained of pain. He decided to refer him to outside hospital and sent a referral letter detailing the man’s medical history. He was seen in the Accident and Emergency department that day and returned with advice to see a physiotherapist for muscle-related pain.

35. The man said he was unable to attend an appointment with his consultant at outside hospital on the morning of 8 May, as he was in great pain and could not get into a taxi. An ambulance was organised to take him to a rearranged appointment that afternoon. At hospital, a CT scan suggested that his cancer might have returned and he was admitted to hospital for a skin biopsy and liver and bone scans.

36. On 18 May, doctors confirmed that the scans had revealed nodules in the pancreas which indicated that his cancer had returned and spread.

37. The clinical reviewer notes that the man returned to see his consultant after his wife contacted the hospital, rather than because of a prison healthcare referral. However, the clinical reviewer believes that the diagnosis of the man's cancer was made appropriately.

Informing the man about his condition and treatment

38. When the consultant saw the man in the oncology department on 22 March, he told him that the lump in his abdomen could be a reoccurrence of his cancer. Prison records suggest that he was given all available information. The consultant explained that he would need to return for a CT scan to confirm any diagnosis.

39. The scan took place on 25 April. The man was supposed to return the next day but missed his appointment. He returned to the hospital on 8 May, and was told that the scan showed "a 1.6cm thoracic node… and 0.5cm subcutaneous nodule over the left scapula", indicating a relapse of his cancer. On 18 May, doctors told him that they had discovered further nodules on his pancreas.

40. The man's prison medical record contains detailed notes on the care he received at hospital. While he was an in-patient, he was informed of his proposed treatment plans and met the palliative care team to discuss pain relief options. It appears that he was given full information about his condition and treatment. The missed appointment on 26 April led to a delay in informing him of his likely diagnosis, but we are satisfied that he was fully and appropriately informed of his condition and treatment options.

The man's medical appointments and treatment

41. When he arrived at Birmingham, the man told healthcare that he had an oncology appointment at outside hospital in December. On 17 November, he told his wife that he did not want to attend any further hospital appointments while he was in prison because he did not want to be seen handcuffed. His wife then cancelled all his future outpatient appointments. No one from healthcare spoke to him to discuss this. The healthcare administrator was aware but the prison GP told the investigator that the first time he became aware of this was in February 2012, when he was asked to authorise a repeat prescription and noticed that the man had not been for the follow-up appointment at the hospital.

42. We consider that someone from healthcare should have spoken to the man when it became clear that his appointments had been cancelled to ensure that this was what he wanted. We make the following recommendation:

    The Head of Healthcare should ensure that decisions not to attend hospital appointments are fully discussed with the prisoner with the reasons recorded on his medical record.

43. His wife made a hospital appointment for her husband to see his consultant and the man received a letter on 15 March, confirming a 20 March appointment. As he was aware of the date well in advance, the appointment was re-scheduled for security reasons. (This is to prevent prisoners planning escape attempts coinciding with hospital appointments.) His appointment was rearranged for 22 March, so there was only a short delay before he saw his consultant.

44. On 25 April, the man attended outside hospital for a CT scan of his thorax, abdomen and pelvis. The appointment was at 12.00pm; although he was advised to arrive an hour earlier to drink a prepared solution used for the scan. His wife told the investigator that her husband arrived at the hospital one hour late and nearly missed his appointment.

45. The escort record shows that the man was late as the taxi booked to take him arrived late at the prison. It is clearly important that taxis used to take prisoners to hospital arrive in good time. We make the following recommendation:

    The Director and Head of Healthcare should ensure that transport arrangements for hospital appointments enable prisoners to attend on time.

46. A taxi was booked for the man to return to the prison with his two escorts. The man made the following entry in his journal about the wait for the taxi:

    > "As we head for an exit we go by Greggs [the bakery] and the officers want something to eat so I have to stand by the wall handcuffed with everyone looking at me I feel so sick. They ask if I want something but I say no my stomach is all over the place. The [queue] is massive so we are there a while and it feels like it. Finally we make our way to the front of A&E where the guards eat their food and I just stand there. 40 mins we are there waiting, people [staring] at me it's the worst day of my life."

47. The man then described his journey back to the prison, noting that it took a long time because of the traffic on the motorway.

48. There are some differences between the time the man said he left the prison and arrived at hospital and those on the escort records. The escort officers recorded that restraints were reapplied to him at 1.05pm and he was double cuffed. We note that a taxi was not ordered until 1.47pm, some 42 minutes later. This would suggest that his comment that he waited for 40 minutes was accurate. The taxi arrived back at Birmingham at 3.25pm and this gives credence to the man's account of traffic delays.

49. Escort staff have a duty of care and should take reasonable steps to preserve a prisoner's dignity while on an escort, especially in a public place such as a hospital. An Assistant Ombudsman wrote to the Director of Birmingham on 24 October, informing him that we intended to recommend that he held a disciplinary investigation into this incident. Following the advance disclosure of this report we were informed that an investigation had been concluded. However, the investigation report has not been shared with us. We understand that Birmingham have discussed the issues raised with the members of staff and have commenced review of their procedures to ensure that there is no repeat. We make the following recommendation

    The Director should ensure that staff fully comply with the guidance on the conduct of escorts.

50. His consultant at outside hospital asked that the man return the next day, 26 April, to discuss the scan. However, the prison seems to have been unaware of this. The outside hospital called the prison's healthcare department the next day when the man did not arrive. The hospital said that escort staff were informed that he needed to return the next day, but this is not recorded in the escort record. On 3 May, his consultant wrote a letter of complaint to the Director of Birmingham in which he said that it was clear that staff at outside hospital had made the prison aware.

51. A prison GP told the investigator that the hospital had previously been asked to fax through any outpatient appointments to healthcare and this had not been done. Nevertheless, it does appear that escort staff were given information about an important follow up appointment which they should have reported to healthcare. This needs to be explored in the disciplinary investigation. The prison indicated that, had the man been told of the appointment, it would have had to be rearranged. We are concerned that there appears to be an acceptance by the prison that if the prisoner became aware of an appointment it should be cancelled automatically, rather than based on an individual risk assessment taking into account relevant factors such as the urgency of the treatment. The prison has since discussed arrangements with the hospital and reminded them of the need to send a fax about follow-up appointments and discharge summaries.

52. The clinical reviewer commented in her review that,

    > "While appointments and treatment were carried out to an appropriate standard, from the records and information reviewed it appears that communication between the hospital and prison healthcare could have been better in respect of attendance at appointments / investigations and subsequent communication … on the outcome of these".

The man's pain relief and medication

53. Healthcare staff were provided with a copy of the clinical nurse specialist's report for the court which set out the man's medical needs. The report suggested an adjustable electric bed so he could sleep in a supported upright position. (After he saw the physiotherapist, the man agreed that he was happy to use an angled cushion.) It indicated he needed regular meals (eight to ten small meals per day to ensure adequate nutrition), and a place to rest for up to

one hour following meals due to ‘severe dumping syndrome’ (where ingested foods bypass the stomach too rapidly and enter the small intestine largely undigested causing symptoms such as dizziness, nausea and tiredness). He was prescribed lansoprazole, Gaviscon and metoclopramide to prevent sickness and acid reflux, and Fortisip (a nutritional supplement drink).

54. In February and March, the man wrote several times in his journal of having pain and says he talked about this with his wife. His medical records do not indicate that he discussed this pain with prison healthcare staff at the time, although he was treated for a suspected chest infection on 1 March. On 15 March, the man recorded that he had spoken to his wife on the phone and told her “the pain is its getting too much to bear especially in the day at work”. Again there is no record of him reporting this pain to healthcare.

55. The man’s wife is concerned that her husband had difficulty getting medical appointments, commenting that he was only able to see a doctor on a Thursday and that he might have had to wait a week for an appointment if there were none available. She said that the week before he was admitted to hospital in May, he would phone her crying in pain. She said she called the prison several times but was told they could not talk to her about it because of patient confidentiality.

56. As a vulnerable prisoner, the man could only see a doctor on a Thursday for a routine appointment. However, there are wing based nurses and, if a matter is urgent, doctors see prisoners on the wing outside normal surgery times. We note that a doctor came to see him in his cell twice. His medical records show that, when he complained about pain, he was seen in his cell by a nurse or GP. While his family do not feel his pain was adequately managed, the records show that when the man told healthcare that he was in pain he was given pain relief. He was initially prescribed ibuprofen. When his pain increased he was given tramadol, which was first prescribed on 16 March. He told a prison GP three days later that tramadol was helping.

57. On 22 March, the man’s consultant at outside hospital wrote to prison healthcare advising that the man had reported pain which was not controlled by tramadol, and said that they should increase the level of tramadol. He also noted that he thought that the pain might be due to a relapse. However, in a subsequent letter typed on 29 March but date stamped in the prison on 16 April, the consultant noted that he had been informed that the level of tramadol had not been increased, or Oramorph (a morphine-based pain killer) prescribed instead. He suggested that if the medication was insufficient to control the man’s pain, he might need to be moved to hospital or prison healthcare.

58. On 20 April, a prison GP reviewed the correspondence from the consultant (including the discharge note sent on 22 March). He noted that Oramorph had not in fact been suggested on 22 March, but added it to the man’s prescription as suggested by the consultant.

59. The man saw a nurse on 24 April. The man told him that Oramorph did not seem to be working. He said that he preferred anti-inflammatory medication and did not want to become dependent on morphine which he declined that day, and requested a strong anti-inflammatory instead. The nurse noted that he was already taking tramadol, and gave him extra ibuprofen and

paracetamol. The following day the man again refused morphine and said he preferred to remain on tramadol and anti-inflammatories.

60. On 2 May, the man saw nurses three times because of pain. Despite telling staff that the pain in his back was unbearable and his current pain killers were not helping, he again declined morphine. He was given more tramadol. When a prison GP reviewed him later that day, the man told him that his pain had gone.

61. A prison GP explained at interview that the man refused to take morphine and, up until 4 May, when he was asked to visit the man in his cell he thought that his pain was being managed. He said that, although he (the man) told his wife he was in severe pain, he did not present like this when healthcare staff saw him. He said that it was only on 4 May that he thought the man was in considerable pain and sent him to hospital.

62. After returning from hospital, the man accepted one dose of morphine on 6 May. A prison GP reviewed him the next day, when the man told him that he could not sleep or eat properly as he could not sit up without being in pain.

63. The clinical reviewer sought advice from South Staffordshire Medicines Support Team. They advised that in the "spectrum of analgesia [pain relief] is essentially non opioids, non opioids/opioid combinations and then opioids". As the man refused to take morphine, healthcare staff could not give him the strongest available pain relief. The Medicines Support Team advised that because of the man's diagnosis, he was unlikely to live long enough to suffer addiction problems. They considered that he should have been counselled on the risks and benefits of taking morphine to make him as comfortable as possible.

64. The clinical reviewer commented that, at times, pain relief was not well managed, although this was in part because of the man's reluctance to take opioid-based medication. However, other than 4 May, when a prison GP spoke to the man, there was no record of a comprehensive discussion with him about his pain relief. We make the following recommendation:

    The Head of Healthcare should ensure that prisoners in severe pain are fully counselled on the risks and benefits of opioid based pain relief so that they are able to make informed decisions about medication.

The man's diet

65. The man had specific dietary and nutritional needs because of his oesophageal cancer. When he first arrived at Birmingham he lived in the healthcare unit. The clinical nurse specialist's report for the court indicated that the man needed a number of small meals each day. As a result, he often ate breakfast cereal in-between meals. He was also prescribed Fortisip (a therapeutic nutritional drink.) The ward manager contacted the kitchen to explain his dietary needs and he was provided with extra breakfast packs.

66. The man's wife told the investigator that her husband was supposed to have four Fortisip per day, but that he did not receive these at Birmingham. His community GP records were faxed to the prison on 10 November 2011, and

shows that he was advised by his GP to have only three Fortisip per day. The clinical reviewer noted that he was prescribed only one Fortisip a day at the prison, although this "should be considered against [the man's] ability to maintain an adequate nutritional intake and [monitoring] by regular weighing to check that his BMI [body mass index] remained within accepted parameters "

67. Regular entries in his medical record showed "eating and drinking his small portions, no concerns" or similar. The man's 'in-patient careplan' required him to be weighed weekly, to have Fortisips prescribed and for staff to liaise with the kitchen if he had trouble eating the food provided. He saw a prison GP on 11 November and said he no longer needed Fortisip, which was then stopped. Two days later, he weighed 11st 2lbs.

68. Although it was recorded in his medical record that extra breakfast packs were being provided, the man wrote in his journal on 14 November 2011, just before he left the healthcare unit, that he was not getting the extra snacks he needed. He said that he had to buy his own food from the prison shop. The prison said that healthcare provided extra breakfast packs but there is no record of what he ate.

69. On 16 November, a discharge meeting was held with wing staff to explain the man's medical requirements before he left healthcare and moved to P wing. The meeting was not minuted in full and the medical record does not document everything that was discussed. The clinical reviewer noted that the man's nutrition plan was followed while he was in healthcare, but that there were no further reviews recorded after he left healthcare.

70. The man saw a prison GP on 24 November. He noticed that the man had lost weight (although he noted that his weight was "ok) and re-prescribed Fortisip. The next day the man wrote in his journal that he would be giving one of his Fortisip drinks to his friend who worked in the laundry. Ten days later, on 5 December, he wrote in his journal "I've [given] one Fortisip away as well; I have extra so I'm ok".

71. On 12 December, the man wrote in his journal that he had eaten a bowl of cereal, noting that he had weetabix the following morning for breakfast. On 6 January, he wrote about having to put his breakfast pack away as a friend would "be after them when he sees them [however] I don't mind I've still got a lot of cereal to eat". He did not buy any cereal from the prison shop so this comment suggests he had sufficient breakfast packs.

72. Although the man lost some weight, he recorded in his journal that he bought various food items from the prison shop such as crisps and biscuits. His journal also showed that he was eating three prison meals a day, such as pie and mash, jacket potatoes and pasta. It was only shortly before he was admitted to hospital that he wrote that he could not stomach the food and often threw it away.

73. It seems that, for the majority of his time at Birmingham, the man's dietary needs were met. He was prescribed Fortisip when required, but chose to give some of it away. In his journal, he recorded the meals he ate and, after some difficulties at the start of his sentence, seemed to be mostly content with the meals provided. He was also able to buy some food from the canteen.

74. However, as the clinical reviewer has noted, after the man left healthcare on 16 November, there does not seem to have been any review of his diet with him. As he had previously had oesophageal cancer and specific dietary needs, it would have been beneficial to have held regular reviews of his diet. We make the following recommendation:

    The Head of Healthcare should ensure that prisoners with special dietary needs related to serious illness should have a care plan which ensure they receive a nutritionally balanced diet in line with their needs wherever they are held in the prison.

The man's location

75. When he arrived at Birmingham, on 1 November, the man was admitted to an inpatient ward in the healthcare unit because he had previously had oesophageal cancer. He spent 15 days in healthcare where his diet and general health was monitored. As he was eating well and was otherwise regarded as fit, he was then discharged to P wing following a meeting between healthcare and wing staff. We are satisfied this was an appropriate decision. He continued to live on P unit until he went to hospital on 8 May.

76. On 4 May, the man was sent by a prison GP to outside hospital because of his pain. He returned to the prison that day. He saw healthcare staff four times in the next few days because of pain, before being admitted to hospital on 8 May. There does not seem to have been any discussion about whether to readmit him to healthcare to manage his pain better. The clinical reviewer believes that, given the change in his presentation, this discussion should have happened. We make the following recommendation:

    The Head of Healthcare should ensure that staff consider admitting a prisoner to healthcare when they have returned following an emergency admittance to hospital.

77. The man was admitted to hospital on 8 May and remained there until his death. While he was in hospital, a move to a hospice was considered. However, when the prison's family liaison officer spoke to a doctor at outside hospital on 19 June, she was told that he was now too unwell to move.

Liaison with the man's family

78. The man was admitted to hospital on 8 May. He had previously called his wife every day and she became concerned when he did not call that day. His wife told the investigator that she called the prison several times but was told that they could not give her any information at that stage. She was not told until 10 May, that her husband had been admitted to hospital. (Bedwatch records show that at 11.20am on 10 May, prison staff were told that the man's wife had been informed and she would be visiting the hospital the next day.)

79. The investigator was told that Birmingham's Local Security Strategy (LSS) states that next of kin should be informed when a prisoner has been in hospital for 36 hours or more. We do not think this is acceptable. Prison Rule 22 says that if a prisoner becomes seriously ill, the Governor (in this case, the Director)

should “at once inform the prisoner's spouse or next of kin.” The man’s consultant at outside hospital wrote to healthcare on 8 May, explaining that he had given the man Oramorph as he was in such severe pain. He also said that his cancer might have returned. Although there was no clear diagnosis at this time, it was evident that he was seriously ill. We consider the man’s family should have been informed when he was admitted to hospital on 8 May. We have previously recommended to Birmingham that families should be informed quickly about hospital admissions, but it does not appear the prison has implemented the promised change. We make the following recommendation:

The Director should ensure that the next of kin of seriously ill prisoners are informed as soon as possible after they are admitted to hospital

80. On 25 May, the prison’s family liaison officer and a nurse attended a multidisciplinary team meeting at outside hospital to discuss the man’s diagnosis and prognosis. The family liaison officer contacted the man’s wife later that day to introduce herself and met her and her husband three days later. She and the man’s wife then kept in regular contact.

81. The man’s wife was with her husband when he died. The prison’s family liaison officer was away at the time. A member of staff from the prison contacted bedwatch staff to see if she could speak to the man’s wife to offer her support, but they could not find her. The member of staff spoke to her the following day. The man’s wife asked her not to contact her for a few days, but they agreed that she would visit her on 9 July. The man’s wife said that the prison family liaison officers were helpful.

Restraints, security and bed watch

82. The Prison Service has a duty to protect the public when escorting prisoners to hospital, and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes into account factors such as the prisoner’s health and mobility. A judgment in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgment indicated that medical opinion regarding the prisoner’s ability to escape must be considered as part of the assessment process. It deemed that handcuffing a prisoner receiving chemotherapy (and, by implication, other life saving treatment) was degrading and that such restraint would be likely also to be regarded as inhumane unless justified by other relevant considerations.

83. The man was a category B prisoner who was near the start of his sentence. In assessing his risk for the escort on 8 May, the prison used a points system based on the length of sentence, his offence, years left to serve, age, security category and the risk of escape, to the public, to hospital staff and of hostage taking. When he was taken to hospital on 8 May for an outpatient appointment, his risk score was 98 points. (His score on 4 May had been 109 and it is not clear why this changed.) When a prisoner scores over 80 points, staff are advised to consider a three person escort or extra security measures. In this

man's case, a three person escort was used, and staff were instructed not to remove the restraints for medical treatment without the authority of the Duty Director.

84. The risk assessment indicated that double cuffs should be used (where a prisoner is handcuffed to an officer using handcuffs, and his hands are handcuffed together in front of him using a different set of cuffs). The escort log for 8 May suggests that an escort chain might have been used instead because of the man's condition, but this is not entirely clear from the records.

85. There is no indication on the risk assessments that the man's physical condition was taken into account and no medical assessment was completed as required. The initial risk assessment was for an outpatient appointment but this was not reassessed as it should have been when he was admitted to hospital later that day. The risk assessment was not reviewed until 18 May, when the Security Intelligence Manager decided that the security arrangements should remain the same. He noted that this meant the use of single handcuffs and a two man bedwatch team. It is not clear at what point single cuffs were first used or when the escort was reduced from three to two. Again there was no medical assessment.

86. On 25 May, his consultant at outside hospital wrote that the man was incapable of committing further criminal acts and was only able to walk 10-20 yards due to his illness. He added that the man's pain was being controlled by opiates which caused him to be sedated. Despite this, a further review was not held until 29 May, at which point all restraints were removed because of his condition. The medical assessment was not completed and his points score remained at 98. On 11 June, a manager from the nearby HMP Oakwood (also run by G4S) carried out a daily management check and recommended to Birmingham's duty manager that day, that an escort chain be re-applied, as he believed there had been an improvement in the man's condition. This was done although there was still no medical assessment and no formal risk assessment was completed.

87. The man's wife and hospital staff were concerned about this, especially as he was connected to a syringe driver (to administer his medication) and had only limited mobility. A different manager went to the hospital to assess the man's escort arrangements later that day and authorised removal of the escort chain.

88. We consider that there was inadequate consideration of the security arrangements for the man's stay in hospital. There was too much reliance on an obscure points score completed for his escort to the hospital rather than an individual assessment of his condition at the time and how this affected his risk. At no point was there an appropriate medical assessment and the risk was not reviewed regularly as it should have been. We make the following recommendation:

    The Director should ensure that the risk assessment process used for hospital escorts at Birmingham complies fully with legal guidance and that restraints for hospital escorts accurately reflects the prisoner's actual risk at the time and take account of a prisoner's medical condition.

89. The man’s wife found the behaviour and attitude of two of the bedwatch officers, insensitive and inappropriate. She said that the officers talked loudly and played music on their mobile phones when she visited. The prison’s family liaison officer told the investigator that one of the officers had been spoken to and accepted that his conduct had been inappropriate. The standards required while on bedwatches was discussed. The other officer is currently off work sick.

90. On the day the man died, his family were with him and a management check was conducted by an Oakwood manager. His wife complained that the manager was insensitive to their situation and asked questions about their treatment by the escort staff when his family were sitting in tears around his bed as he was dying. The man’s brother had asked the manager to leave as he considered her conduct was inappropriate. The man’s wife was also concerned that his family were not given sufficient time alone with him before his death. The escort records do not clearly record what happened although, on 18 June, the duty manager had authorised that, if the man’s health deteriorated further, staff could remain outside the room to allow his family privacy.

The Directors of Birmingham and Oakwood should ensure that all staff involved in bedwatches are aware of the standards of behaviour expected of them, are sensitive to the needs of terminally ill prisoners and allow families appropriate privacy with their dying relatives at the end of their lives.

Palliative care plans

91. The man was seen several times by the palliative care team while he was in hospital. His medication was reviewed and he was given palliative chemotherapy and continuous oxygen. The clinical reviewer commented that this care was appropriate to his needs.

Compassionate release

92. The family liaison officer attended a multidisciplinary meeting at outside hospital on 25 May, to discuss the man’s diagnosis and prognosis. She was told by hospital staff that they thought that cancer had returned and that he was expected to live for one week to two months dependent on the treatment he received.

93. The possibility of the man being released on temporary licence (ROTL) was considered and his offender supervisor assessed him as a high risk to children and young persons. As Prison Service guidance states that “any offender considered to present a high risk to public safety must not be granted temporary release” the prison did not agree ROTL. ROTL would have allowed the man to remain at hospital unrestrained and without escorts. We are concerned that this assessment was based on when he was fit rather than when he was dying in prison and no longer a risk of reoffending.

94. Prisoners who are diagnosed with a terminal illness can be considered for early release on compassionate grounds. Prison Service Order 6000 (Parole release

and recall) explains that the principles underlying the approach for early release on compassionate grounds are:

- The release of the prisoner will not put the safety of the public at risk.
- A decision to approve release would not normally be made on the basis of facts which the sentencing or appeal court was aware.
- There is some specific purpose to be served by early release.

95. The prison asked the man's consultant at outside hospital to complete the medical section of the Early Release on Compassionate Grounds (ERCG) form. He noted that the man had terminal cancer and that his condition made him incapable of committing further criminal acts and was only able to walk 10-20 yards due to his illness. He said that "[the man] is suffering from extreme pain controlled by high dose of opiate causing sedation". The form was faxed to Birmingham on 25 May.

96. The Director wrote on the ERCG form that the man's behaviour in prison had been exemplary. He explained that "SWMPT [the probation service] have assessed his risk as high … this was done at a time when he was not critically ill. Although the risk cannot be dismissed completely [the risk] is clearly reduced while he is in the condition he is." However, he did not support the application. He listed his reasons as, "nature of offence, seriousness of offence, length of sentence and length of time left to serve".

97. The ERCG form was sent for consideration to the Public Protection Casework Section, who deal with these applications. On 7 June, a member of staff from PPCS wrote to Birmingham to explain that they would not make a decision because, as the Director did not support the application, it should be rejected locally. The guidance in PSO 6000 is confusing and contradictory. In the summary at 12.1 it says 'in medical cases and where a governor supports the application, the governor' should submit the application. At 12.8.1 it says 'All applications for ECRG must be sent to the Early Release and Recall Section.'

98. The Director clearly identified that the man's risk of harm was assessed by the prison probation officer before he was critically ill. The Director himself believed that the risk of re-offending was reduced because of his illness. However, he did not support an ERCG application because of pre-existing factors, such as the man's offence and the length of time he had left to serve. We believe that the risk posed by the man and his medical condition should have been the primary factors considered during the application process. It could have been argued that a release on compassionate grounds would have undermined the sentence of the court but, at the time of the sentence, the court was unaware of the man's short life expectancy. The nature of the offence should not be a reason not to support a compassionate release, but the Director was correct to note that length of time the man had left to serve as this is a factor which the PSO suggests should be considered. We believe all applications should be considered against the criteria in PSO 6000 by the Public Protection and Casework Section to bring a consistency of approach and not rejected automatically because a Director or Governor does not support a case. We make the following recommendation:

The Head of the Public Protection Casework Section at NOMS Headquarters should ensure that all applications for release on compassionate grounds are considered against the published criteria.

CONCLUSION

99. The man had previously suffered from cancer before he arrived at Birmingham in 2011. However, he soon became ill again and was re-admitted to hospital in May 2012, as the cancer had returned. The clinical reviewer has found that the diagnosis of the man's illness was appropriate, although there were some concerns about how well his pain was managed.

100. We are concerned about security arrangements and assessment of risk. Too much weight was given to historic risk factors rather than an assessment which fully considered the man's illness and how this impacted on his risk. This led to him being inappropriately restrained in hospital for three weeks. On a previous outpatient appointment, it appears that he was kept restrained in full view of the public for 40 minutes while the escorting officers ate their lunch. His family also reported other inappropriate behaviour from staff while he was in hospital. We are concerned that Birmingham did not give appropriate attention to ensuring that he was treated with dignity at the end of his life,

RECOMMENDATIONS

The Director of Birmingham

1. The Director and Head of Healthcare should ensure that transport arrangements for hospital appointments enable prisoners to attend on time.

   The National Offender Management Service responded with,

   Accepted - All Taxis are booked in on time. All escort staff are briefed to ensure transport is arranged to return back to the establishment on time

   Currently a maximum of five external hospital (excluding psychiatric hospitals) are available each day, three in the morning and two of an afternoon, with the option of additional appointments for emergencies, as required.

   Healthcare liaise with externals department, to ensure hospital appointment times are known, to allow time for prisoners to get to the hospital for their appointment, whist maintaining security, in respect of not attending too early.

   Six monthly audits to be carried out by the Head of Healthcare Administration to ensure adherence to this standard is met. Any occasions where a problem is encountered are to be reported to both the Healthcare Duty Manager and the Prison Duty Manager

2. The Director should ensure that staff fully comply with the guidance on the conduct of escorts.

   The National Offender Management Service responded with,

   Accepted - All staff are briefed by a security FLM prior to the escort

3. The Director should ensure that the next of kin of seriously ill prisoners are informed as soon as possible after they are admitted to hospital

   The National Offender Management Service responded with,

   Accepted - This will be subject to a public protection risk assessment (relating to victim issues). If it is established that there are no issues about this, then the next of kin will be notified as soon as possible

4. The Director should ensure that the risk assessment process used for hospital escorts at Birmingham complies fully with legal guidance and that restraints for hospital escorts accurately reflects the prisoner's actual risk at the time and take account of a prisoner's medical condition.

   The National Offender Management Service responded with,

   Accepted - All Risk assessments are appropriately endorsed for escorts in regards for restraints based on the information available at the time of Signing.

Escorting Staff are briefed to contact the Duty Director for any changes made and have the authority to remove in a life threatening situation.

All bed watches are checked daily by an appropriate manager who makes an assessment of each individual prisoner.

The Directors of Birmingham and Oakwood

5. The Directors of Birmingham and Oakwood should ensure that all staff involved in bedwatches are aware of the standards of behaviour expected of them, are sensitive to the needs of terminally ill prisoners and allow families appropriate privacy with their dying relatives at the end of their lives.

   The National Offender Management Service responded with,

   Accepted - All staff have received a notice to staff regarding their conduct during external escorts. An email has been confirmed with Oakwood. The conduct of their staff and they have published the Notice to Staff as well. The Notice to Staff is number 65/2013.

The Head of Healthcare

6. The Head of Healthcare should ensure that decisions not to attend hospital appointments are fully discussed with the prisoner with the reasons recorded on his medical record.

   The National Offender Management Service responded with,

   Accepted - A notice to prison GP's will be issued to confirm the need for any prisoner who has not attended an external hospital appointment in relation to a serious illness are to be seen and documented discussion is to be undertaken. Head of Primary Care will issue a notice to GP's and Primary Care Staff. Head of Primary Care to audit on a six monthly basis.

7. The Head of Healthcare should ensure that terminally ill prisoners are fully counselled on the risks and benefits of opioid based pain relief so that they are able to make informed decisions about pain relief medication.

   The National Offender Management Service responded with,

   Accepted - Any terminally ill prisoners, will have an agreed care plan, to include the use of pain relief, with a review period clearly stated and at a minimum monthly monitoring provided. Head of Primary Care to audit on quarterly basis

8. The Head of Healthcare should ensure that prisoners with special dietary needs related to serious illness should have a care plan which ensure they receive an nutritionally balanced diet in line with their needs wherever they are held in the prison.

   The National Offender Management Service responded with,

Accepted - Healthcare services will ensure a careplan is provided to any prisoner, who requires a special diet due to a serious illness and will formally advise the prison kitchen services of the patient needs, to include any changes in dietary needs post review.

Head of Primary Care will issue a notice to staff in relation to the above and monitor such care plans on a quarterly basis

9. The Head of Healthcare should ensure that staff consider admitting a prisoner to healthcare when they have returned following an emergency admittance to hospital.

   The National Offender Management Service responded with,

   Accepted - Any prisoner with a diagnosed serious illness or whose condition requires supervised monitoring will be returned to healthcare wards following discharge from hospital for an initial period of 24 hours.

   However, where there is no requirement for monitoring or the prisoner's diagnosis does not warrant acute inpatient care, these prisoners will be monitored on their return from hospital on general location by nursing staff

The Head of the Public Protection Casework Section

10. The Head of the Public Protection Casework Section at NOMS Headquarters should ensure that all applications for release on compassionate grounds are considered against the published criteria.

    The National Offender Management Service responded with,

    Accepted - The Head of Public Protection Casework Section has liaised with the policy lead for ERCG in Sentencing Policy and Penalties Unit and it has been agreed that the policy will be amended whereby in future, all ERCG applications which appear to meet the criteria should be considered by PPCS on their merits, even if the Governor does not support it