Investigation into the circumstances surrounding the death of a man at hospital in November 2008, whilst in the custody of HMP Birmingham

Report by the Prisons and Probation Ombudsman for England and Wales

July 2009

This is the report of the investigation into the death of a man in November 2008. He died of natural causes at hospital, whilst a prisoner at HMP Birmingham.

I offer my sincere condolences to the man's family. I am pleased that they felt well supported by the prison following his death.

The investigation was conducted by one of my investigators, on my behalf. I would like to thank the Governing Governor of HMP Birmingham and another Governor colleague for assisting the investigation.

The local Primary Care Trust commissioned a doctor to undertake a review of the clinical care the man received whilst at Birmingham. I am grateful for his timely review.

The man arrived at Birmingham in April 2008 with a few current health problems. He told staff in reception that he was waiting for a hip replacement. For the first five months of his sentence, he enjoyed reasonable health and had little contact with healthcare staff. However, in September he began to complain of chest pains. When he was assessed, he told healthcare staff that he was not eating and had difficulty walking. It seems he had become reliant on his cellmate who collected his food and generally helped to look after him.

The man was admitted to hospital in November. He was told that he might have cancer, but tests proved inconclusive. In fact, up to the point of his death, medical staff had not been able to confirm the diagnosis. Unfortunately, this meant that the prison was not able to apply for him to be released from prison on compassionate medical grounds.

The clinical reviewer and I conclude that, in respect of his terminal condition, the man received a good standard of medical care whilst at Birmingham. However, the investigation has identified omissions in other aspects of the healthcare he received at the prison.

In addition, I am concerned to learn that wing staff do not routinely record important information about prisoners. I make two recommendations which concern the interactions between wing staff and prisoners, and two about communication with prisoners' families and local hospitals.

This was the third natural causes death to have occurred at Birmingham in 2008. I have not found any similarities between the circumstances of the deaths.

Stephen Shaw CBE
Prisons and Probation Ombudsman **July 2009**

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SUMMARY

The man appeared at the Crown Court In April 2008, charged with racially aggravated common assault. He was sentenced to 12 months imprisonment with a 12 months extended licence period to follow. He arrived at HMP Birmingham later that day. He told healthcare staff in reception that he needed a hip replacement, was asthmatic and had been consuming about 200 units of alcohol per week prior to being sentenced. He was placed on an alcohol detoxification programme and prescribed the appropriate medications. He was also prescribed medication to help with his hip pain and asthma.

Shortly after his arrival at the prison, the man was briefly monitored under suicide and self harm support procedures because he told staff that he had thought of harming himself. Within a few days, staff were satisfied that he had settled into life at the prison and that he no longer posed a risk to himself.

In June 2008, the man was transferred to HMP Stocken for two weeks and was then returned to Birmingham. During the first five months of his sentence, he had few health concerns and little contact with healthcare staff. However, in mid-September he began to complain of chest pains and was referred to the cardiologist at the local hospital.

On 26 October, the man once more complained of chest pains. During assessments by medical staff, he said he had not been eating and relied on his cellmate to collect his meals. He said he had not been able to get out of bed for several days. A wing officer told a member of healthcare staff that the man had not been able to get out of bed to use the toilet, and that his cellmate had had to help clean him up. (No entries to reflect his difficulty walking or inability to look after himself were made by wing staff in either the wing observation book or his prison file.)

The following day (27 October 2008), the man was admitted to healthcare. He complained of abdominal pain and related symptoms and so a blood test was carried out. The results revealed a number of abnormalities and he was referred to the local hospital. The man was admitted to hospital on 5 November, and remained there for a week. Hospital staff carried out a number of tests that indicated that he might have cancer. His family was contacted and told that he was unwell.

The man discharged himself from hospital on 13 November. At this stage he was not considered to be seriously unwell, but staff monitored his condition. As terminal cancer was a possibility, staff began the process of applying for him to be released from prison on compassionate grounds. However, without a confirmed diagnosis of a terminal condition, this was not an option. Sadly, the diagnosis was not confirmed until the post mortem was performed.

On 20 November, prison healthcare staff decided that the man needed to return to hospital for further treatment. Over the next ten days his condition deteriorated. His family was again contacted and told that he was seriously ill. He died at about 8.00pm on 30 November.

The investigation has focussed on the clinical care the man received whilst at Birmingham, and this was generally found to be of a good standard. I have also considered whether wing staff knew about and recorded that he was not eating, nor was properly able to look after himself, before his admission to healthcare.

I have made four recommendations. Two concern interaction between wing staff and prisoners, and two concern communication (with families when prisoners are admitted to hospital, and with local hospitals).

THE INVESTIGATION PROCESS

1. My office was notified of the death of the man on 30 November 2008. The investigation was allocated to one of my investigators on 3 December. My investigator issued notices to staff and prisoners at HMP Birmingham inviting them to contact her with any information they felt might be relevant to the investigation. No one responded to these notices. My investigator and her colleague conducted interviews with staff at the prison in January 2009.

2. Two prisoners who had shared cells with the man at Birmingham were identified. One had since been released and my investigator wrote to him at his home address inviting him to take part in the investigation. He did not respond. The second prisoner had been transferred to HMP Parc. Another investigator from my office visited Parc and requested an interview with him. This prisoner did not wish to contribute to the investigation.

3. The local PCT appointed a doctor to undertake a clinical review of the care the man received whilst at Birmingham. Both the clinical reviewer and my investigator were provided with copies of the man's medical records. My investigator also received a copy of his prison records.

4. HM Coroner was notified of the investigation and provided my investigator with the results of the post mortem. The Coroner will receive a copy of my report into the man's death to assist with his inquiries.

5. One of my family liaison officers contacted the man's sister to invite members of his family to be involved in the investigation process. The family had no specific questions or concerns about the care the man received whilst at Birmingham. However, I hope this report provides them with a picture of his time in prison and the care he received.

HMP BIRMINGHAM

6. HMP Birmingham is a large local prison serving the courts of Birmingham and much of the West Midlands. It holds up to 1,450 adult male prisoners, both on remand and sentenced. The prison has undergone significant improvement over the last few years, including the building of a new healthcare centre.

7. The HM Chief Inspector of Prisons last conducted a full announced inspection of the prison in February 2007. She noted that the prison was, once more, under "acute population pressure" which affected both staff and prisoners. Relationships between staff and prisoners were found to be problematic, with residential staff having little input to prisoners' progress or resettlement. Entries in prisoners' personal prison files were "mostly poor". The personal officer scheme, which had been criticised during the previous inspection, remained "ineffective".

8. Healthcare provision at the prison was found to be "mostly satisfactory". It was largely delivered from a "modern, purpose-built unit" by three distinct groups of staff working in primary care, in-patient care and in-reach. Relationships between healthcare staff and prisoners were identified as good, particularly on the in-patient wards. All in-patients had a care plan and a named nurse and officer.

9. All prisons are also monitored by an Independent Monitoring Board (IMB), members of which are drawn from the local community. They have full access to each prisoner and every part of the establishment. The last available annual report by the Birmingham IMB covers the period July 2007 to June 2008. The Board noted that overcrowding within the entire prison system, and at Birmingham specifically, remained a concern. Healthcare provision was recognised as having gone through significant changes over the year. The Board highlighted that healthcare facilities at Birmingham were viewed as both a local and national resource and that, as a result, "more robust partnerships" were necessary. Overall, however, the Board was "impressed … with the dedication and professionalism of the staff".

KEY EVENTS

10. The man appeared at the Crown Court in April 2008 charged with racially aggravated common assault. He was given a 12 month custodial sentence, with a 12 month extended licence period to follow his release. He arrived at HMP Birmingham at 4.10pm the same day.

11. At about 7.00pm, the man underwent the first reception healthscreen with a nurse. (The purpose of the healthscreen is to identify any immediate physical or mental health concerns and make necessary referrals to the doctor or other specialist services.) The man told the nurse who carried out the first reception healthscreen that, although he was registered with a doctor in the community, he had not had an appointment in the last few months. He said that he needed a hip replacement. The nurse recorded that the man was a smoker, and that he had asthma and used two inhalers but did not know their names. He told the nurse that he had experienced fits in the past (the cause of the fits was not recorded).

12. During the healthscreen interview, the man said that he had consumed about 200 units of alcohol in the week before he was sentenced. As a result, the nurse referred him to the doctor to be prescribed medication to combat any symptoms of alcohol withdrawal. The man said he had not used any drugs in the last month. He told the nurse that he had attempted to harm himself in the past, outside prison. However, he said that he currently had no thought of harming himself. He also said that he had never received any medical treatment for mental health problems. At the end of the interview, the nurse recorded that she had referred the man to the drug and alcohol service in the prison and to the mental health team (because of his history of self-harm). She concluded that he was fit for normal location, and for work, and could be located in any cell. He was located in a shared cell on D wing, the first night centre.

13. At 8.35pm, the man saw another nurse for a mental health reception screen. She recorded that he “appeared in distress” and said he was thinking of harming himself. He told the nurse that he did not have a plan to harm himself and that he was likely to feel better once he had taken medication to relieve the symptoms of alcohol withdrawal. As a result of the mental health screen, the nurse completed a Concern and Keep Safe form, the first stage of the Assessment, Care in Custody and Teamwork process (ACCT). (Prisoners considered to be at risk of harming themselves are monitored and supported under the ACCT process.)

14. Another nurse made an entry on the man’s medical record later the same day. She recorded that he was a “very heavy drinker”, who was experiencing withdrawal symptoms including moderate tremors, sweats and moderate anxiety. Following this assessment and the earlier first reception healthscreen, the prison doctor prescribed a number of medicines, namely chlordiazepoxide hydrochloride tablets (used to treat alcohol withdrawal), thiamine hydrochloride (frequently prescribed to patients who abuse alcohol), vitamin B tablets and ibuprofen (a pain relief medication). The doctor also prescribed an inhaler to treat the man’s asthma.

15. The following day (26 April 2008), an officer carried out the ACCT assessment interview with the man on D wing. The man said he felt low and depressed but had no thoughts or plans to harm himself. The officer concluded that the ACCT book should remain open, to be reviewed a week later. On 29 April, an SO, the officer who carried out the assessment and the man agreed the ACCT book should be closed.

16. Between 28 April and 19 June, the man had several contacts with healthcare staff for minor complaints, including hip pain and a cold. He continued to be prescribed ibuprofen tablets, thiamine and vitamin B tablets, and inhalers for his asthma.

17. On 19 June, the man was transferred to HMP Stocken for almost two weeks. It has not been possible to find out why this happened. Entries on his prison file indicate that it was an uneventful couple of weeks. My investigator asked Birmingham for copies of his medical records from Stocken but, to date, they have not been located.

18. The man was transferred back to Birmingham on 7 July and was located on K wing, which holds 180 prisoners. He was placed in a shared cell. Staff at Birmingham made no entries in his personal file after that date. His medical records indicate that, on his return to Birmingham, he underwent a further first reception healthscreen. Again, his asthma and hip pain were identified. The nurse that carried out the second first reception healthscreen referred the man to the doctor and to the mental health team. He was seen that day by another nurse for the mental health reception screen. She recorded his history of depression and previous attempts to harm himself in the community. She referred him to the doctor for a possible prescription of anti-depressants. The man did not attend his doctor's appointment on 14 July, but no reason for this is noted.

19. The man's next significant contact with healthcare staff occurred on 16 September when a nurse responded to an emergency radio call at 9.15am. She recorded on the man's medical records that he had complained of chest pain during a morning activities session. When she arrived to assess him, the man told her that he had suffered a heart attack in January 2008 and had been admitted to hospital for two weeks. The nurse recorded that the pain was "sharp and radiating to left shoulder". She gave the man aspirin and a spray used to ease heart pain, particularly angina. She decided to refer him to the doctor and recorded that she had made an appointment for him. The nurse checked the man a few hours later and recorded that he was "feeling better now" but that the pain was still there.

20. On 23 September, a second doctor assessed the man following the chest pain the previous week. He prescribed aspirin and advised the man to use the spray when necessary. The doctor recorded that the man was a Jehovah's Witness who had refused to undergo a blood test. He noted that he should be referred to a heart specialist, and made the referral that day.

21. A month later, on 25 October, the man complained of "feeling generally unwell" and having more chest pains. A second emergency radio call was made for healthcare staff to attend. A nurse assessed the man and recorded in his medical records that he "looked unwell". The man complained of a cough and chest pain. He told the nurse that he had not been eating. She referred him to the doctor, and a third doctor assessed him later that day. The doctor diagnosed a chest infection and prescribed antibiotics.

22. The following day (26 October), another nurse was called to see the man on K wing at about 7.00am. He was again complaining of chest pains, centred on his sternum, and of chronic hip pain. He told the nurse that his cellmate had had to lift him up from the floor. The nurse gave him a dose of paracetamol and aspirin. He made the following entry in the man's medical records:

    "Later officer came to tell me that [the man] is not able to get out of bed to reach toilet and so he was in a mess and the cellmate helped to clean (not good due to infection) and cellmate collects food for him. It is said he has not been out of bed for some days."

23. My investigator interviewed an officer as part of the investigation. He had been based on K wing since March 2008 and was identified as one of the man's personal officers while he was located on that wing. (Personal officer schemes operate in most prisons. Each prisoner is allocated a named officer or officers who act as their first port of call if they need help or advice. Usually, a prisoner's personal officer is expected to make entries in the prisoner's file on at least a fortnightly basis.) The officer said that the personal officer scheme at Birmingham had been restructured during 2008 and was re-introduced in October. He could not remember having met the man and had not made any entries in his prison file.

24. The officer was asked whether staff would be aware of prisoners who did not collect their food over a prolonged period. He explained that it could be difficult for staff to notice when a prisoner was not collecting their meals. My investigator asked if there was any system in place to monitor this, and he replied that there was no formal system:

    "Well the prisoners themselves actually, because we have a menu system on [K] wing and the prisoners deal with that side of things. So we don't actually know until he lets us know or basically if we're just on there we just notice that he's not taking it."

25. The officer was also asked whether wing staff would generally be aware of a prisoner who was physically unable to look after himself and get out of bed. He said that staff would "definitely" be aware of this. My investigator asked what wing staff would do if such a situation arose. The officer said that a prisoner who was not able to look after himself would need to be admitted as an in-patient in healthcare. He explained that wing staff would therefore inform healthcare staff. He was asked whether this kind of information would be recorded anywhere. He said that he suspected "it would be healthcare who'd be sort of writing down the notes or whatever the doctor says". He said staff would also normally record

such information in the wing observation book. (Each prison wing has an observation book which is used to record important information about individual prisoners or occurrences on the wing. It is used to pass information between staff working different shifts.)

26. The wing observation book for K wing contains one entry relating to the man. It was made by another officer on 26 October. The entry reads, “Prisoner suffering with chest pain. Seen by nurse at 07.30. Will return to check up on him.” There are no entries relating to the man’s mobility or ability to look after himself. No entries were made to record that he was not collecting food.

27. Following his assessment of the man, the nurse that saw him at 7.00am recorded that he had talked to healthcare to see if the man could be admitted as an in-patient. A bed was available and so the nurse wrote that he had informed K wing staff and they would take the man to ward 2. At 11.54am that morning, a different nurse recorded that an emergency radio call had been received for healthcare staff to attend to the man. This nurse noted that the man had apparently collapsed as he was being escorted to the healthcare ward. During her examination of him, she found him to be “pale, looks ill, in pain”. She recorded that he was “very weak and not eaten”.

28. Later that day, another nurse in the in-patient ward recorded that the man was still complaining of pain and weakness due to his loss of appetite. However, he was seen to eat his lunch and dinner. He appeared to settle and staff recorded that there were no further problems that night.

29. The following day, 27 October at 1.06pm, a nurse recorded in the man’s medical records that he was complaining of abdominal pain, with acid reflux symptoms (where acid from the stomach leaks into the gullet), diarrhoea and vomiting. He was examined and prescribed medication. The nurse wrote that the man was not to take any more ibuprofen, and that his weight should be monitored, blood samples taken, and he should be reviewed later that day. There was no further mention made of the man being a Jehovah’s Witness or of refusing the blood test, which was in fact carried out several days later. Another nurse recorded at 6.35pm that the man remained on his bed during association (the time of day when prisoners are unlocked and may mix with each other). He told this nurse that he had vomited sputum and that his left hip was painful. He said he did not want his evening meal.

30. In the afternoon of 28 October, the man told the nurse he had talked to the previous day that he had vomited sputum again. Over the following few days, he appeared settled and no further health concerns were reported. The third doctor recorded that the man missed an out-patient appointment with a cardiology specialist at an outside hospital on 30 October, apparently because healthcare staff were not aware of it.

31. On 4 November, the man’s blood was tested. The GP clinical lead at the prison provided my investigator with her own written review of the care the man received. She wrote that the results of his blood tests revealed that he had a “significantly raised white cell count indicating ongoing infection, raised

inflammatory markers and abnormal liver function tests". However, the most concerning result indicated that there might be problems with the man's kidney function. The third doctor reviewed the blood test results on 4 November. He recorded in the medical records that the man was not "acutely unwell" but that he presented with a "picture of Addison's disease" (a stomach disorder which causes fatigue, vomiting, diarrhoea and joint or muscle pains). The third doctor made an urgent referral for an out-patient appointment at the hospital.

32. The following day, the man was assessed by the GP clinical lead as he complained of feeling unwell. She recorded that he was "unsteady, looks and feels unwell". In her report, the GP recorded that, by this time, the man's blood pressure had "dropped significantly" and he had a very fast heart rate. She was concerned that his condition was deteriorating. In the light of his recent blood test results and her assessment that day, the GP decided that he should be taken to an outside hospital by ambulance as an emergency. (The records concerning the man's transfer to the hospital, the level of restraints used, and the number of officers assigned to supervise him whilst in hospital, were not provided to my investigator in time for inclusion in this report.)

33. The man remained in hospital for assessment. Three days later, on 7 November, the GP recorded in his medical record that hospital staff had identified that he had an abnormal heart rhythm. He was diagnosed with a build up of fluid in his abdomen, a sample of which was taken for analysis. The GP noted that the cause was as yet unknown, but cancer was a possibility. She wrote that the man would undergo a CT scan (computerised tomography – a type of x-ray which produces a two dimensional picture of the body) and a surgical review. The hospital would inform the prison healthcare centre when a diagnosis could be made.

34. On 10 November, the man underwent an ultrasound scan at the hospital. (An ultrasound scan uses sound waves to produce images of the internal organs and structures inside the body.) The following day, the GP recorded that the hospital had provisionally diagnosed the man with an advanced gastrointestinal malignancy (cancer). He was to remain in hospital and undergo further tests over the following days. A nurse made an entry on the man's medical record on 12 November, seven days after he had been admitted to hospital. She recorded that she had had a conversation with a governor grade and a probation officer from the public protection team, about the man's next of kin being informed of his condition. Following the necessary checks, it was decided that his partner would be contacted so she could visit him in hospital if she wished.

35. My investigator spoke to another governor grade, who acted as the prison's family liaison officer, by telephone. She said that when the man became ill she had contacted his partner. She had also made contact with his sister, whom he had not seen for a number of years. His sister was able to visit him in hospital.

36. Because there were indications that the man's condition might be serious, the prison began to explore whether he might be released on temporary licence (ROTL) or compassionately released in due course. This is in line with guidance contained in Prison Service Order (PSO) 6000, Parole Release and Recall, and

PSO 6300, Release on Temporary Licence. The first Governor grade received information about the nature of the man's offence and the risk he would pose to others if released. On 14 November, he advised the GP to request that the man be considered for release on compassionate grounds.

37. The GP was interviewed as part of the investigation. She said that the application was complicated because the hospital had not been able to provide a definite diagnosis at this point. Although his symptoms indicated that he might have cancer, they were also consistent with abdominal tuberculosis which is a treatable condition. Unless the man was diagnosed with a terminal condition, the GP was unable to go ahead with the application for compassionate release, and she had explained this to the hospital consultant. The consultant had said that staff would continue to take fluid samples from the man's abdomen and would perform a tissue biopsy if his condition stabilised. Without a tissue biopsy, medical staff agreed that a diagnosis would remain difficult.

38. On 13 November, the man decided to discharge himself from hospital. My investigators asked the GP about the circumstances of his decision. She explained that there were two common reasons why prisoners might decide to discharge themselves from hospital. Prisoners often wanted to return to prison, where they are allowed to smoke in their cells, rather than stay in hospital wards where smoking is not allowed. She also said that prisoners complained it was embarrassing to be on a hospital ward escorted by prison staff and held in handcuffs.

39. During interview, the GP explained that healthcare staff would discuss patients' decisions to discharge themselves, to ensure the prisoner had the capacity to make the decision. If staff had any doubts, they would arrange for the patient to be seen by a psychiatrist who would make an assessment of their mental capacity. She said that there had been occasions when staff had been able to persuade a patient not to discharge himself from hospital. The man told the GP that he was tired of undergoing medical tests and wanted to be able to smoke. She told my investigators that "part of him seemed to know that it was a terminal illness and the other part was very optimistic."

40. My investigators asked the GP whether the man's decision to discharge himself caused the prison's healthcare staff any difficulties or concerns. She replied that on 13 November he was "not too unwell" and was able to move around. The GP said that she discussed his condition with healthcare staff, who were aware that he would probably need to return to hospital to have fluid drained from his abdomen. She also explained that healthcare staff agreed he should be readmitted to hospital should his condition worsen.

41. The discharge letter sent from the outside hospital to the prison healthcare centre noted that the man had discharged himself against medical advice. It was recorded that he had been told he might have cancer. He was discharged with prescriptions to combat his irregular heart rhythm and constipation and an antibiotic, all to be taken under medical supervision. On his return to HMP Birmingham, he was given a bed in the in-patients ward in healthcare.

42. The third doctor made an entry in the man's medical records on 14 November. He recorded that he and the man had discussed his condition. The man had told the doctor that he had wanted to return to the prison for "a rest" but that he would be willing to go back to the hospital for further treatment. The doctor prescribed morphine to control the man's pain.

43. On 17 November, the man complained to healthcare staff that he had been vomiting during the night and that morning. The GP assessed him later that day and discussed the possible diagnosis of cancer. She noted in his medical records that he understood that "cancer is very likely". She then discussed whether he would like staff to resuscitate him if he became suddenly unwell or his heart was to stop. She recorded that "the man would like active treatment for symptoms control" but that he did not wish to be resuscitated. Also present during this conversation were a nurse and an officer. My investigators asked the GP about the conversation. She said that, as she thought that his condition was terminal, she had talked to him about the treatment he would like. She said that she did not ask him to sign a written statement to confirm that he did not wish to be resuscitated and so it did not constitute a legally binding advance directive. (This is a written document, often drawn up by a solicitor, which indicates a person's wish to refuse all or some forms of medical treatment.) This meant that healthcare staff would be able to call an ambulance or seek external medical attention for the man if necessary.

44. Shortly after their conversation, the man was visited by a mental health nurse and offered the support of the primary care mental health team. He told the nurse that he was tired and would speak to them another day.

45. When the man experienced pain, healthcare staff administered morphine to him. Over the next few days, he remained "poorly" and with a "grossly distended" abdomen. On 19 November at 10.08pm, he fell in his cell but did not want to be examined by healthcare staff, telling them that he was "okay". He was noted to be awake throughout the night, rubbing his swollen abdomen. The following morning, the GP assessed his condition and decided that he needed to return to the hospital to have the fluid drained from his abdomen.

46. An urgent medical escort risk assessment was carried out before the man was taken to hospital. The nurse who had discussed contacting the man's family recorded that the man was "too ill" to escape unaided from custody, that he was possibly suffering with cancer and a heart condition. She concluded, however, that there were no medical objections to the use of restraints. Wing staff and the prison's security department had no information to suggest that he might be an escape risk. It was decided that he should be accompanied by two officers and should be held in a single handcuff with an escort chain attached. (This is a long chain which runs between the prisoner and a member of prison staff.) On arrival at the hospital, he was admitted to a ward. Healthcare staff recorded in his medical records that they made contact with hospital staff twice a day to receive reports on his condition.

47. The next day, 21 November, a third governor grade and the Governing Governor, agreed that the man's restraints should be removed because he was quite

unwell. He was still to be escorted by two members of Prison Service staff (known as a bedwatch) and was not to be left alone, particularly if he had visitors. If his medical condition improved, the escort chain was to be reapplied. Officers undertaking bedwatch duties completed a log. They recorded that the man was becoming increasingly confused and restless. On 23 November, members of his family visited him in hospital.

48. On 26 November, healthcare staff contacted the hospital again and were told that the results of further tests were awaited. The man was too poorly to undergo a tissue biopsy which would confirm the cancer diagnosis. The hospital had arranged for Macmillan nurses to visit him. (Macmillan nurses are specially trained to provide palliative care for cancer patients. Palliative care is provided when patients will not recover from their illness, and are receiving treatment to reduce the severity of their symptoms.)

49. The man's medical records indicate that over the next few days his condition remained the same. On 28 November, the Safer Custody governor visited him in hospital. He asked her to contact his family and let them know he was seriously unwell. The Safer Custody governor telephoned both the man's partner and sister and left messages asking them to contact her.

50. On 30 November at 6.55pm, nursing staff advised one of the bedwatch officers, that the man's family should be contacted as his condition was worsening. His sister was contacted by telephone by a member of prison staff. At 7.35pm, two more officers arrived at the hospital to take over bedwatch duties. About half an hour later, one of the relief bedwatch officers recorded in the log that he had called for nursing staff to attend the man because of his condition. At 8.20pm, the ward sister told him that the man had died. This was confirmed by a hospital doctor an hour later.

51. The post mortem confirmed that the man died of natural causes, namely bilateral broncho-pneumonia and carcinomatosis (widespread cancer).

52. The prison family liaison officer told my investigators that the governor on duty on 30 November had telephoned the man's sister to let her know he had died. She made further telephone contact with her on 3 December. The prison arranged and made a financial contribution towards the man's funeral. His sister told my family liaison officer that staff at the prison, and in particular the prison family liaison officer, had been "wonderful". She said she had written to staff to thank them for their support and help.

Support for staff

53. My investigator asked the Safer Custody governor what support would normally be offered to staff who undertook bedwatch duties. She explained that staff who undertook bedwatch duties were not generally offered specific support. However, staff who were present when a prisoner died would normally be contacted by the staff care and welfare team. It has not been possible to confirm whether the relief bedwatch officers were offered support following the man's death.

Support for prisoners

54. The Safer Custody governor told my investigator that, following a death in custody, the Governor produces a notice to prisoners which is displayed around the prison. She confirmed that such a notice was issued following the man's death.

ISSUES

Wing staff's interaction with the man

55. In late October 2008, whilst located on K wing, the man complained to medical staff that he was not eating and that his mobility had reduced to such an extent that he was reliant on his cellmate. An entry in his medical records on 26 October noted that his cellmate had helped to clean him when he had been unable to use the toilet. No entries had been made in his prison file since 30 June, over three months before he was admitted to healthcare. Furthermore, there were no entries in the K wing observation book to indicate that wing staff were aware of, or concerned about, the man's health and ability to look after himself.

56. Quality entries in prisoners' files and wing observation books are an important means of assessing the level of interaction between wing staff and those in their care. The personal officer said in interview that wing staff would "definitely" be aware of the man's inability to properly care for himself. There is, sadly, no evidence to suggest this was the case.

    The Governor should remind all staff of the importance of making quality entries in prisoners' files and in wing observation books.

57. The personal officer told my investigators that there was no formal system for staff to identify prisoners who did not collect their meals. The GP said in interview that healthcare staff relied on wing staff to bring such prisoners to their attention.

    The Governor should introduce a formal system whereby wing staff can identify and record those prisoners who do not collect their meals.

The personal officer scheme

58. My investigator was told that the personal officer scheme was not fully functional on K wing in October 2008 when the man became unwell. I understand that it was reintroduced on the wings, after some restructuring, around that time. I believe that the man's health problems might have been identified more quickly had the personal officer scheme been effective. While I appreciate the difficulties of operating a personal officer scheme in a local prison with high levels of turnover, I hope that following the restructuring a robust system is now in place.

Clinical care

59. As noted above, the local PCT commissioned a doctor to undertake a review of the clinical care the man received whilst at Birmingham. The clinical reviewer has reviewed the man's medical record and concludes:

    > "I have not been able to identify any particular shortcomings in [the man's] care, necessitating any significant change in practice."

60. The clinical reviewer says that the management of the man's alcohol detoxification was worthy of note. When he arrived at Birmingham, he told staff he had been drinking approximately 200 units of alcohol per week. The clinical reviewer considers that the reduction from this level to nil was managed without any apparent problems.

61. When the man arrived at Birmingham, he told healthcare staff in reception that he was awaiting a hip replacement. During his time at the prison, he complained that his hip caused him pain. There is no indication in his medical record that staff contacted his doctor in the community to check whether he had any outstanding hospital appointments.

The man's chest pains

62. On 16 September, the man complained of chest pains and was seen as an emergency by the nurse. He told the nurse that he had suffered a heart attack earlier in the year. The nurse referred him to the doctor but he was not assessed by one until 23 September – five working days later. During the course of the investigation, the GP was asked whether, given his medical history, the man should have been assessed as a priority. She explained that the prison's nursing staff are trained to differentiate between "cardiac chest pain" and other types of chest pain which do not require urgent assessment by a doctor. The GP told my investigator that the nurse checked the man's condition later the same day and decided that, as his discomfort had settled, he did not need an urgent appointment. A routine appointment was requested as a consequence.

63. The GP was also asked why the man had missed his out-patient appointment with the cardiologist at the hospital. She provided further information about this by email. I understand that the man was sent confirmation of his hospital appointment directly. Healthcare did not receive a copy of the letter and so were not aware of it. Once they became aware that he had missed the appointment, they faxed the hospital to arrange a new appointment. Given that the referral to the hospital cardiologist was made by a prison doctor, I am concerned that healthcare staff had not been informed of his out-patient appointment.

    The Director of Healthcare and the PCT should review the procedures in place to ensure that healthcare staff are aware of external medical appointments.

64. My investigator found that, once he had been admitted to healthcare, staff looked after the man with care and consideration and responded quickly to his healthcare needs. Healthcare staff remained in regular contact with the hospital whilst he was a patient there. However, because staff at the hospital were not able to confirm the diagnosis of cancer, the prison could not arrange for him, to be compassionately released.

Use of restraints

65. My investigator has not yet been provided with the records relating to the man's first admittance to hospital on 5 November. They should detail the risk assessment carried out and the level of restraints used during his stay. When he was re-admitted to hospital on 20 November, it was decided that he should be escorted by two members of staff and should be restrained by a single handcuff and an escort chain. It was entirely appropriate that, the following day, the decision was made to remove the restraints.

Release on compassionate grounds

66. Very soon after it became clear that the man was seriously unwell, the prison considered whether he was suitable for release on compassionate medical grounds. Unfortunately, the lack of a confirmed diagnosis of a terminal condition meant that he could not be released prior to his death. I am pleased to note the speed with which consideration was given to his possible release.

Contact with the man's family

67. The man's sister told my family liaison officer that she and his family had received very good support from the prison. However, I am disappointed that it took seven days for the man's next of kin to be contacted when he was first admitted to hospital on 5 November.

    The Governor and the Director of Healthcare should ensure that they inform the next of kin at the earliest appropriate opportunity when a prisoner is admitted to hospital.

CONCLUSION

68. The man arrived at HMP Birmingham in April 2008. He had some physical health conditions on his arrival but they caused him few problems during the first five months of his sentence. He began to complain of feeling unwell in September, and by mid-October he had been admitted as an in-patient in the healthcare centre. In November, he was told that he probably had cancer, but up to his death a confirmed diagnosis had not been possible. This limited the steps the prison could take to release him from prison before his death.

69. The clinical reviewer and my investigator identified that the man received a generally good standard of care from medical staff at the prison. This was particularly the case once it was clear that he was seriously unwell. This investigation has revealed several omissions in the healthcare he received prior to that, although I do not believe they had an impact on his death. I have made recommendations to improve communication with prisoners' families and with local hospitals. Additionally, my investigator found that improvements could be made to wing staff records of their interactions with prisoners. Wing staff self-evidently have an important role in highlighting concerns about prisoners' health to medical staff, and there are steps that should be taken to make this more robust.

RECOMMENDATIONS

1. The Governor should remind all staff of the importance of making quality entries in prisoners' files and in wing observation books.

The Prison Service has accepted this recommendation. An Operational Order will be written reminding staff of the requirement to make quality entries in prisoner history sheets and observation books, either as part of the Personal Officer Scheme, or following interactions where necessary.

2. The Governor should introduce a formal system whereby wing staff can identify and record those prisoners who do not collect their meals.

The Prison Service has accepted this recommendation. A system for monitoring the collection of meals has been devised with a target completion date of June 2009.

3. The Director of Healthcare and the PCT should review the procedures in place to ensure that healthcare staff are aware of external medical appointments.

The Prison Service has accepted this recommendation. A tracker system is in place and regular statistics are recorded and audited.

4. The Governor and the Director of Healthcare should ensure that they inform the next of kin at the earliest appropriate opportunity if a prisoner is admitted to hospital.

The Prison Service has accepted this recommendation. Next of kin can be informed when a prisoner's condition has been diagnosed as critical, with the approval of the Governor or Duty Governor as per the Local Security Strategy. This information will be included in the bedwatch packs that accompany the prisoner to hospital.