

**Investigation into the circumstances surrounding the death
of a prisoner, while in the custody of HMP Birmingham,
at Sandwell General Hospital in 20 February 2008**

Report by the Prisons and Probation Ombudsman
for England and Wales

October 2008

This is a report of the investigation into the circumstances surrounding the death of a 60 year old man at Sandwell General Hospital on 20 February 2008, whilst in the custody of HMP Birmingham.

The man had been diagnosed with prostate cancer and chronic lymphatic leukaemia in 2005 and received regular treatment at City Hospital, Birmingham. On 19 February 2007, he complained of severe stomach pain. He was taken by ambulance to Sandwell General Hospital where he was admitted to intensive care. He underwent an emergency operation during which it was discovered that he had further cancer of his bowel. Following the operation, his condition deteriorated further, resulting in major organ failure. Consultants at the hospital informed the family that, in their opinion, life support should be withdrawn. The sudden deterioration in the man's condition surprised staff that had been caring for him at the prison. Despite the best efforts of the medical team, he died on 20 February, with his family at his bedside. I would like to offer my sincere condolences to the man's family for their loss.

An investigator carried out the investigation on behalf of the Ombudsman. I would like to thank the Governor of Birmingham, and in particular the Safer Custody Governor, for their assistance and the prompt provision of the man's documents. I am also grateful to the Joint Director of Healthcare, HMP Birmingham who, on behalf of Heart of Birmingham Primary Care Trust, oversaw the clinical review process. In conducting this investigation, the investigator was heavily reliant upon the medical notes as well as the clinical review. I have, however, raised some concerns about the impartiality of the clinical review process carried by the Primary Care Trust and urge them to consider how best to ensure independence in future investigations of this nature.

The investigation has found that there was initially some delay in arranging the man's medical appointments with the hospital, but this had not impacted on the diagnosis or prognosis. However, a recommendation in respect of this, as well as recommendations regarding urgent referrals and access to medication has been made.

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SUMMARY

The man was a prisoner at HMP Birmingham. He had been in custody since November 2002, and was sentenced to 22 years imprisonment in October 2004. He had a history of heart problems that had been identified on his reception into custody. During his remand, he had received treatment for these conditions but they were not considered to be life threatening and were managed with medication.

In September 2004, he reported having trouble in passing water. One of the doctors at the prison made an urgent referral to the Urology Department at City Hospital, Birmingham. However, due to administrative errors, the prison failed to make an appointment and this caused a significant delay. He was finally seen in May 2005. At this appointment, the consultant indicated that the man would require a biopsy. There were delays carrying out the biopsy as his existing medication was incompatible with the procedure and because he was unable to tolerate the biopsy under local anaesthetic. The biopsy was finally carried out in December, together with a biopsy of his lymph gland that had been identified as enlarged at an earlier appointment. The results of the biopsies indicated that he was suffering from prostate cancer and chronic lymphocytic leukaemia (CLL).

Treatment for the man's prostate cancer was arranged immediately as it was thought to be the more serious of the two conditions. The treatment was in the form of hormone injections every three months. In addition, he attended regular appointments at both the Urology Clinic and Haematology Department of City Hospital. He responded well to the treatment on his prostate gland and, as a result, the Haematology Department was able to begin treatment for CLL in May 2006.

In August 2006, the man initiated a clinical negligence claim against a doctor who, at the time, was a lead doctor at HMP Birmingham. The man listed a number of issues in his claim, which was handled by his solicitors. However, the prison and the doctor responded to all the points raised and the claim was subsequently dropped.

The man had applied for release from custody on compassionate grounds soon after being diagnosed. One of the criteria for such release is that the prognosis for the patient's life expectancy is less than three months. As he did not meet the criteria, his application was refused. The man continued to pursue the application and the requirements initially influenced him to refuse further treatment after his first course of chemotherapy. He was of the impression that he would be able to continue his treatment after he was released, but specialists at City Hospital informed him that he urgently needed further treatment and any delay could be detrimental. He was informed in March 2007 that his second application for compassionate release had also failed. After this and, on the advice of his specialist, the man agreed to undergo a second course of chemotherapy.

He responded well and in October 2007, during a routine appointment, the possibility of stem cell collection was discussed with him. If the man continued to make good progress, it was planned to begin this process in January 2008 with a possible transplant in March or April.

On 19 February, the man was suffering from stomach pain and was examined in his cell by a doctor. Although she was not immediately concerned, given the man's

ongoing problems, the doctor contacted a consultant at City Hospital for his opinion. Following this conversation, the decision was taken to admit the man to Sandwell General Hospital for further checks.

On his arrival at the hospital, a number of doctors assessed him and initially his stomach pain seemed to be subsiding. However, later that afternoon, the escort staff became aware that the man was experiencing increased pain and they immediately alerted the doctor. The man was moved to the Intensive Care Unit (ICU) and prepared for possible surgery and the escort staff removed the restraints to allow medical treatment to be unhindered.

On the advice of the hospital, the prison informed his family of his condition. In the meantime, the man had gone into cardiac arrest and, after being stabilised, was taken into theatre for an operation on his stomach. His condition continued to deteriorate during the operation and he had a further cardiac arrest. During the operation, it was discovered that he had suffered a perforated colon and that cancer had spread to his bowel.

Following surgery, he was returned to the ICU and placed on life support. His family arrived at the hospital during the evening of 19 February to spend time with him. When they returned the following morning, the doctor advised them of the prognosis for his condition. The doctor informed the family that he had taken the decision to withdraw life support and explained that to do otherwise would just prolong the inevitable. The man's family were at his bedside when, at 11.45am on 20 February, the doctor pronounced him dead.

After the man's death, the duty governor visited the hospital and spoke to his family. She also ensured that staff who had been involved in his care and security had access to support.

I have made three recommendations relating to hospital referrals and appointments, as well as access to medication. I have also registered my concern about the independence of clinical reviews commissioned by the Heart of Birmingham Primary Care Trust (PCT).

THE INVESTIGATION PROCESS

1. An investigator conducted the investigation on behalf of the Ombudsman. On 21 February, he contacted the Safer Custody Manager at HMP Birmingham. The Governor produced prison records of the man who died, including his medical record, for examination. Notices were issued to staff and prisoners to inform them of the investigation process and to give them the opportunity to speak with the investigator. No responses were received. During the investigation, the investigator was in regular contact with the healthcare centre at HMP Birmingham. His requests for further information from the doctors at the prison, was supplied without delay.
2. At the start of the investigation, the investigator wrote to Heart of Birmingham Teaching PCT to request a clinical review into the man's medical care. The Director of Healthcare at HMP Birmingham contacted the investigator to inform him that she would be overseeing the process. The investigator questioned the independence of this arrangement. However, despite the prison's best efforts to obtain further assistance from the PCT and much correspondence from the investigator, a doctor at Birmingham Prison, carried out the review. I consider this a conflict of interest and my investigator informed both the Director of Healthcare at Birmingham and the reviewer that the independence of the report had been called into question. The prison therefore arranged for the papers and the clinical reviewers report to be reviewed by a General Practitioner (GP) at HMP Swinfen Hall. The doctor at Swinfen Hall confirmed that he was content with the documentation and that, in his opinion, the report was un-biased. I have therefore attached the review as an annex to this report.
3. One of the Ombudsman's Family Liaison Officers (FLO), contacted the man's mother. She was happy to talk with the FLO and spoke about her son's life and sadness at his death. She informed the FLO that she would prefer her other son to deal with any details concerning the death and gave the FLO his contact details. The FLO attempted to make contact but unbeknown to her the mobile number she had been given had changed. She sent the family information about the Ombudsman's office and its role as well as her contact details. The man's brother discussed the family's concerns and the FLO indicated that the draft report was ready for issuing and that many of these concerns had been considered.
4. The investigator wrote to HM Coroner to inform him of the nature and scope of the investigation. The investigator was also provided with copies of statements taken by West Bromwich Police. These proved very useful and I am grateful to them for making these available. A copy of the report will be sent to the coroner to assist with his enquiries.
5. A copy of the draft report was sent to the Prison Service and the man's family. The Prison Service accepted the recommendations and their response can be found on page 24. The man's family provided my FLO with a number of concerns following sight of the draft report. A majority of these related to the healthcare afforded to him. I have included their concerns in the appropriate sections of my final report.

HMP BIRMINGHAM

6. HMP Birmingham is a local prison for adult male offenders, holding up to 1450 prisoners. It has recently undergone a programme of refurbishment that has provided new workshops, educational facilities, a new healthcare centre and gymnasium. Improvements to existing facilities have also been made.
7. Heart of Birmingham Primary Care Trust is responsible for the delivery of healthcare. General Practitioners (GPs) deliver primary care clinics. Registered nurses, mental health nurses and discipline officers staff the in patient facility during the day. At night, there is a nurse and discipline officer on duty.
8. There have been seven previous deaths from natural causes at Birmingham since the Ombudsman took over responsibility for investigating deaths in custody in April 2004. I am not aware of any similarities between recommendations made following these deaths and those made following this investigation.
9. An announced inspection by HM Chief Inspector of Prisons, Ms Anne Owers, was carried out in February 2007. The inspection concluded that:

“Birmingham was suffering from many of the pressures of an overcrowded prison system. Those pressures made it much more difficult to deliver safe, decent and purposeful outcomes for prisoners. It was a credit to staff and managers that the prison remained a much better place than it had been in 2000, and the scale of the task should not be underestimated. But this inspection found that the prison was not responding sufficiently proactively and robustly to the challenges it now faced, and indeed that some of the old culture was now reasserting itself. We do not underestimate the difficulty of sustaining progress, with increased pressures and increased expectations of delivery. The fact that Birmingham was not performing sufficiently well against three of our four key tests is a measure of the challenge facing its managers.”

10. The Independent Monitoring Board (IMB) published their last annual report in 2007. The Board commented on healthcare provision:

“The EMIS system – a computerised management information system working across the NHS – promised for December came into operation in May. It is working extremely well having started in reception and then throughout healthcare.

“Primary care nursing vacancies have now been filled but they are not yet in post. There should be little need to use agency nurses except in emergencies.

“The complement of doctors is complete and some of them do extra duties in reception rather than using Locum Doctors, although there is still a need to use Locum Doctors to fulfil the medical demand.”

KEY FINDINGS

Initial custody and medical treatment

11. In November 2002, the man was remanded into custody at HMP Blakenhurst. On arrival, a member of the healthcare staff recorded his medical problems. He told medical staff that he had been under the care of a doctor at the Glenfield Hospital in Leicester. He was being treated for cardiomyopathy (abnormality of the heart muscle), hypertension (high blood pressure) and atrial fibrillation (irregular heart beat). He was receiving medication to treat all these symptoms when he arrived into custody.
12. The man was at Blakenhurst for a short period. He transferred to HMP Winchester on 28 November after being sentenced to two years imprisonment. When he arrived at Winchester, a healthcare officer (HCO) saw him. A follow up appointment with the doctor was scheduled for the following day. The man settled into the prison regime quickly. This was not his first period in custody.
13. He was due to appear at Wolverhampton Magistrates' Court on 2 December, on further charges. While in reception, he complained of chest pain and the escort was postponed until the prison doctor could see him. Following tests, including an electrocardiogram (ECG), it was concluded that the symptoms were most likely to be anxiety related. The HCO contacted the Observation, Classification and Allocation (OCA) department at Winchester prison. He explained that it would be preferable for the man to return to Blakenhurst in order to attend his court appearances, as it was closer to the court.
14. Two days later, on 4 December, he collapsed on the wing and had to be taken to the Royal Hampshire County Hospital (RHCH). After examination by a doctor, he was admitted for observations. The man returned to the prison on 11 December following treatment. There were no other problems relating to this and no further healthcare involvement at Winchester.
15. Due to his outstanding further charges, the man was confirmed as a category A prisoner on 16 December 2002. This meant that he could no longer be held at Winchester, a local category B prison. He was transferred to HMP Woodhill on 17 December, one of eight prisons designated as high security.
16. On arrival at Woodhill, the man was seen by a HCO in reception. His medication including warfarin (a tablet used to thin a patient's blood and prevent clotting) was recorded. He was also placed on the sick list. The HCO arranged for him to have an International Normalised Ratio (INR) test. The purpose of this test is to monitor the thinning of the blood. The blood needs to be thin enough to prevent clots but not too thin to increase the risk of bleeding. He attended regular INR tests while at Woodhill and throughout his time in custody.
17. On 19 May 2003, the man was temporarily transferred to HMP Blakenhurst to attend his ongoing court case. He returned to Woodhill on 16 June but continued to be transferred back and forth during his court case. His medical treatment continued in both prisons. He was considered not to pose such a

Transfer to HMP Birmingham

18. The man was transferred to HMP Birmingham in January 2004, as his trial had been moved to Dudley Crown Court. He was subsequently sentenced on 25 October 2004 to 22 years imprisonment. Before sentencing, the judge in his case had requested a report from his cardiologist, which was administered by the healthcare team at Birmingham. His cardiac problems remained stable throughout his time in prison.
19. On 13 September 2004, he reported sick. He discussed problems he had encountered in obtaining a repeat prescription and, as a result, changes to his medication were made. During the consultation, the man also mentioned that he had been having difficulty urinating. Further tests were arranged and an appointment made for him to be seen again in one week.
20. When the doctor saw him on 20 September, she recorded a more detailed history. She noted that he was getting up at least five times a night to go to the toilet. The man also said that he sometimes had symptoms during the day. There was no sign of weight loss or back pain which may have indicated infection. However, upon examination the doctor found that the man had a soft enlarged prostate. In view of this, a blood test for prostate specific antigen (PSA) was arranged. The PSA test is done as a prostate cancer-screening test. A normal PSA level is less than 3.5 with a raised level being an indication of possible cancer and the need for referral. His PSA level was 7.9.
21. The doctor referred him for an urgent urology appointment on 27 September. The hospital confirmed that the waiting time for a urology appointment was 13 weeks. The healthcare department at Birmingham received a letter in December 2004, which invited them to arrange an appointment for the man with the Urology Department at City Hospital. However, for reasons that remain unclear, this was not done and he was removed from the waiting list. The prison healthcare team referred him again. This meant another 13 week wait for an appointment. On 14 February 2005, a letter from the Urology Department invited healthcare at Birmingham to arrange an appointment again. This was finally booked for 17 May 2005.

In response to the draft report, the man's family said they felt that the missed appointment demonstrated the lack of 'duty of care' provided to him by the doctor. They also said that the comments 'reasons that remain unclear' in relation to the failure to book an appointment were unacceptable to them.

22. As is the usual procedure for escorts out of prison, the prison conducted a risk assessment before the appointment took place. This assessment indicated that, due to his perceived level of risk, two members of staff would have to escort the man and he would be handcuffed. As my report highlights below, he went to hospital on a number of occasions and this level of risk remained the same. He was seen in a consultant's clinic on 17 May. Tests showed that he might have diabetes, which might account for his symptoms. Due to his raised

23. The man attended for the appointment on 10 August, but it had to be postponed as he was still taking warfarin. warfarin increases the risk of bleeding, therefore patients have to stop taking it before any operation. The hospital wrote to the prison to reiterate the instructions advising that the man would need to stop taking the drug at least five days prior to the appointment, and requesting that the prison inform them of a satisfactory time for the procedure. The prison doctor contacted the consultant's secretary on 23 August to rearrange the biopsy.

In response to the draft report, the man's family said that as the doctor who contacted the hospital was the doctor responsible for INR testing she should have been aware of the need for his warfarin to be stopped prior to the biopsy. The family said this again highlighted where the doctor failed in her 'duty of care' towards the man.

24. Between September and December, the man attended the hospital on four separate occasions. On 28 September 2005, he attended City Hospital for the biopsy on his prostate. Unfortunately, this time he was unable to tolerate the procedure under local anaesthetic and it was rebooked to be carried out under a general anaesthetic. He was admitted on 6 December. During his pre-assessment, doctors found an enlarged lymph gland in his neck so the biopsy was cancelled. He returned to the prison on 9 December. The hospital gave instructions for the man to remain off warfarin until after the biopsy had been completed.
25. He underwent both the prostate biopsy as well as a biopsy of his lymph gland under general anaesthetic on 12 December. City Hospital notified the prison healthcare team on 20 December that the biopsies found him to have both prostate cancer and chronic lymphocytic leukaemia (CLL). He remained in hospital until 22 December. He had a catheter inserted following his biopsy as he had developed urinary retention. Arrangements were made by the hospital for the man to attend the Haematology Department to discuss treatment for the CLL and to return to the Urology Clinic in three months to check his progress.
26. Through his solicitors, the man applied for compassionate release after he was initially diagnosed with prostate cancer and leukaemia. The criteria for a prisoner to be released on compassionate grounds include a prognosis that the prisoner's life expectancy is less than three months.
27. The man was prescribed hormone injections to treat the prostate cancer, but these could not be given at the prison. As a result, the prison doctor contacted City Hospital on 30 December, to arrange for a nurse from the prison to accompany the man and be shown how to administer them. In spite of some confusion between the security department and healthcare, he attended with a nurse on 3 January 2006. The man continued to receive the hormone injections every four weeks, which later reduced to every three months.

28. A consultant saw the man in his clinic at City Hospital in February. He assessed him for possible radiotherapy as additional treatment for his prostate cancer. During the assessment, the man told the doctor that he had been diagnosed with testicular cancer in 1971 for which he had received radiotherapy at Leicester Royal Infirmary. The doctor arranged for information to be obtained on the level of radiotherapy that the man had previously received in order to plan future doses.
29. He was admitted to City Hospital on 4 April. His catheter, inserted in December, was removed from his bladder for a trial period to determine whether he was able to pass urine spontaneously. The trial was successful. While admitted for this procedure, the Haematology Team at City Hospital also took a bone marrow sample from him.
30. Another consultant at City Hospital, Haematology Department had seen the man in January 2006. At that time, the doctor considered his most pressing need was for the treatment of his prostate cancer. In view of this, no other immediate treatment was considered for leukaemia. However, the doctor recorded in a letter on 25 January to the medical officer at Birmingham prison, that anti-CLL treatment might be necessary in the next six months.
31. The man responded well to treatment for prostate cancer and tests showed his PSA to be 0.3 in April 2006. This indicated a good response to the hormone injections. The urology team at City Hospital continued to see him regularly and his PSA dropped further to 0.1. A doctor saw the man again in clinic in May 2006. The doctor said that the man remained asymptomatic (no noticeable symptoms) in relation to his prostate cancer. In view of this, and the man's good response to the hormone treatment, the doctor felt that there was no need to offer radical radiotherapy. As a result, he was happy for his colleagues to proceed with treating the man's CLL.
32. In May, the prison doctor contacted the hospital on the man's behalf in order to get information on his prognosis, as he continued to pursue his application for compassionate release. However, his prognosis did not meet the criteria and he was informed that his application had been unsuccessful in July 2006.
33. In August 2006, he instigated a clinical negligence claim against the doctor at Birmingham prison through his solicitors. He considered aspects of his treatment had been unsatisfactory. In an exchange of correspondence over the following months, the healthcare department responded to the man's solicitor addressing the points raised. It is my understanding that following this correspondence the claim was not pursued any further.

In response to the draft report, the man's family said that his claim against the doctor for clinical negligence was not subsequently dropped. They confirmed that in the event of his legal aid being withdrawn the family would have provided financial support for him to continue the case. The family also said that the man had asked them to pursue the case on his behalf, in the event of his death, as a matter of principle.

34. The man began treatment for CLL in May. Following the first cycle of treatment, he was seen again at City Hospital where he complained of feeling fatigued. The consultant considered it was too early to say whether the treatment was having any effect, but the dosage was nevertheless increased from 4mg to 6mg. This was increased again at the next two reviews over the following eight weeks. When he was seen in the clinic on 21 September, he complained of backache but said that he had no other symptoms. It was also noted that the man had missed one of his cycles of treatment. The doctor prescribed his fifth cycle and booked a CT scan after his sixth cycle of treatment in November.
35. The man attended the clinic in November. Tests showed that he had not responded to the first line of treatment and a second line of chemotherapy treatment was recommended. A doctor saw the man again on 16 November, at the clinic. He explained the course of treatment and what it would mean if that treatment was delayed. However, despite all the risks and benefits being explained, the man said that he wanted to wait until January 2007 before deciding on treatment. His reasons were that he was continuing to pursue his release from prison on medical grounds. The man believed that his application would be successful and he would be in a position to continue his treatment after his release.

During the investigation, it was apparent from hospital correspondence that the man's application for compassionate release featured heavily in his decision-making. In response to the draft report, his family comment that he had discussed his concerns regarding the dangers of the second course of chemotherapy. In their view, he did not refuse this on the basis of his application for compassionate release, or the grounds associated with the criteria.

36. When a doctor saw the man in the clinic in January 2007, he explained that he was still awaiting a decision regarding his release on compassionate or medical grounds. The doctor said that treatment would not be initiated until it was clear whether he would remain in Birmingham or return to Leicester. He also said that they would only be able to postpone it for a few weeks but it might have to be started sooner if the disease progressed. Arrangements were made for the man to be seen again in five weeks.
37. The man's consultant had received a letter from him regarding his treatment and ongoing application for release. On 8 February, the consultant addressed the issues raised by the man in a letter to his solicitors. In the letter to the consultant, the man had expressed concern about a number of issues regarding his prison custody, including unsatisfactory conditions within the prison's medical wing. The consultant replied that he considered the decision to offer the man intravenous chemotherapy was correct. It was also apparent from the consultant's response that both he and his team had concerns about the man's decision to delay this treatment. In responding to his concerns about the prison environment, the consultant said that while some of his points could possibly be upheld, there was no justifiable reason for the man to delay his treatment. The consultant referred to another prisoner from Birmingham prison that he had treated without complication. He also commented on the good liaison between

38. On 14 March 2007, the man was informed that his second application for compassionate release had been refused. It was explained that despite his medical problems the Secretary of State felt that his case did not meet the criteria for compassionate release. However, the Governor was advised to monitor his condition and refer his case again if there was a significant deterioration.
39. When the consultant saw the man on 22 March, he recorded that in his opinion he had lost a considerable amount of weight since his previous attendance at the clinic. However, the man said that his appetite was good and any weight loss was attributable to a healthier diet. The consultant made it clear to him that the CLL was progressing and that he was in urgent need of chemotherapy. He told the man that with good communication between his team and the medical staff at the prison, he saw no reason for the treatment to be delayed while he was still in custody. However, the man again raised concerns regarding the level of medical support that he would receive at the prison. Based on his previous experience of administering the same treatment to another prisoner, the consultant disagreed with his concerns.
40. A palliative care plan was put in place by the prison healthcare team to ensure that the man was cared for in line with NHS standards. When he was seen in April, the consultant informed him that earlier tests had shown that the prognosis for his leukaemia had become poorer. Because of this, he considered the chemotherapy should be started without further delay. The man again discussed his medical care at the prison and told the consultant that he had now been made 'Priority 1'. This meant that if he became unwell he would be given immediate access to healthcare. He finally agreed to begin chemotherapy and his consultant arranged for him to return for his first cycle.
41. In total, the man underwent four cycles of R-CHOP chemotherapy (R-CHOP refers to the drugs used during the treatment), which required regular attendance at the hospital. When he attended the consultant's clinic in July 2007, he asked again about his life expectancy. He was still focused on obtaining compassionate release. The consultant told him his concerns that despite improvements in his circulating disease, his lymph nodes had shown little response to the first line of chemotherapy. Faced with the prospect of the man having to undergo a second line of treatment in the form of FC chemotherapy (FC refers to the drugs used during the treatment), the consultant assessed that the man's estimated survival could be less than 12 months. This prognosis, although relatively short, still did not meet the criteria for release from custody. All the risk factors and benefits of further treatment were explained to him, and the consultant arranged for this further treatment to start within two weeks.
42. Following the first cycle of the FC chemotherapy, tests showed a regression in the disease in the man's lymph nodes. It was also recorded that he was gaining weight. His second cycle of treatment was scheduled to be given orally over three days. Between this and his final course of treatment, he attended an appointment in October at the Haematology Clinic. A doctor who discussed

43. When the consultant saw him at the end of October, he too discussed the possibility of the man undergoing a stem cell transplant. The consultant had received a positive report on the man's prostate cancer indicating that it was in remission. This meant that, in spite of the prostate cancer, there were no reasons for the transplant not to proceed. During the appointment, the man said that he was feeling very well and was maintaining a good appetite despite losing some weight. Further appointments were scheduled, including scans of his abdomen to check on the progress of the leukaemia.
44. The progress of his request for compassionate release was again mentioned when he was seen at the consultant's clinic. He told the consultant that he believed his latest application would be successful before Christmas. He also said that, when released, he would like to continue his treatment at City Hospital rather than returning to Leicester as he had previously mentioned. During the appointment, a scan was carried out to enable the decision on his stem cell transplant to be made. The results were very positive and communicated to him in late November 2007. The consultant told him that tests would be carried out again once he had completed his chemotherapy and if results remained the same, a stem cell transplant would be arranged for early 2008.
45. The man had a routine appointment at the haematology clinic on 13 December. Doctors explained to him that the test results had indicated that stem cell collection could be started prior to him undergoing any further chemotherapy. During the appointment, he said that he was feeling well apart from having suffered from a bout of food poisoning the previous week. The man was told that, once sufficient stem cells had been collected, he could proceed to a transplant in either March or April 2008.
46. Throughout his illnesses and between attending for treatment, the man was employed in the kit store on his wing, looking after and issuing clothing to other prisoners. Staff commented that he continued to work well and remained in good spirits, despite his ongoing treatment. Entries in his wing history file indicate that he continued to work until February 2008.

Events leading to the man's death

47. The prison nursing staff saw the man on three occasions during the first week of January 2008. He complained of further abdominal pain and some of his medications were stopped as a result. He told the doctor on 17 January that the pain was colicky but he had not vomited. He felt that his symptoms were the result of food poisoning that he attributed to butter that he had been given. Following an examination, the doctor said that she did not consider that his symptoms were due to food poisoning and, in her opinion, antibiotics were not appropriate.

48. His complaints of abdominal pain and intermittent diarrhoea continued. A stool culture was tested, which indicated no infection. Nursing staff at the prison continued to review him on his wing every few days during January and February. On these occasions, he said that he was happy and had no real concerns or other problems.
49. However, on 19 February one of his wing officers asked a nurse to see him as they were concerned about his condition. The man told a nurse that he had been suffering from diarrhoea and vomiting and had been unable to get out of bed due to abdominal pains. The nurse contacted the prison health centre and asked for the man to be seen in cell by a doctor.
50. At around 9.30am, the doctor saw him in his cell. The man told her that he had been to Russells Hall Hospital the previous afternoon for further stem cell collection. He said that he had vomited on his return, but not since. He had continued to suffer from diarrhoea and was finding it difficult to get to the toilet due to the cramps. The doctor examined him and considered he looked unwell. She recorded that he had 'cold peripheries' and looked in pain. His pulse rate was not raised, but was irregular due to atrial fibrillation (AF). She also recorded that the lower part of his abdomen was particularly tender. However, there was nothing to indicate peritonitis (inflammation of the peritoneum).
51. Following her assessment, the doctor considered that the man did not require immediate hospital treatment. However, given her knowledge of his history and her previous consultations with the man's consultant, she contacted him for his advice. The doctor's impression was that he might have picked up an infection the previous day while attending for treatment. After talking to the consultant, it was decided to admit the man to Sandwell General Hospital, Birmingham.
52. An ambulance was called and it arrived at 10.43am. After discussions with the healthcare team and ensuring the man was comfortable, the ambulance left the prison for Sandwell General Hospital at 11.23am. He was escorted, handcuffed, by prison staff. On arrival at the hospital, the man was admitted to a ward. His handcuffs were removed and the escort chain applied. This gave him more freedom of movement and allowed the medical staff better access to carry out their observations.
53. Despite continuing pain, the man appeared settled for the remainder of the morning and was checked regularly by nursing staff and doctors. However, during the afternoon, he became increasingly short of breath and appeared to the escort staff to be in more pain. A nurse saw him at an officer's request, but the man continued to deteriorate. An officer went to the nurse's station about ten minutes later and asked a doctor to see the man. The first doctor to examine him immediately asked other doctors to assess him and he was then moved to the Intensive Care Unit (ICU) at 3.00pm.
54. A doctor explained to the escort staff that they considered that something had burst in the man's stomach for which he would require immediate surgery and requested that the restraints be removed. After consultation between the escort staff and Duty Governor at the prison, the restraints were removed at 3.25pm.

55. At 3.30pm, two other prison staff arrived at the hospital to take over the escort. They were informed by the doctor that the man was in a serious condition which might be life threatening. It was decided that his next of kin should be notified. They informed the Orderly Officer and the chaplaincy team at the prison and the process of contacting his relatives was begun. It was clear to the investigator that events on the afternoon of 20 February moved very quickly and the prison acted as soon as the hospital indicated that the man's condition had deteriorated at 3.30pm.

In response to the draft report, the man's family said that they felt that the Governor should have informed them of the man's condition when he was moved to intensive care at 3.00pm. They considered that not informing them until he was in a critical condition was 'most disgraceful'.

56. The man continued to deteriorate and, at 4.00pm, he went into cardiac arrest. Nursing staff and doctors began resuscitation and he was stabilised. He remained in a serious condition and was moved to theatre to undergo an operation on his stomach. While in theatre, the man had a further cardiac arrest. It was discovered that the pain had been caused by a perforated colon but also that the cancer had spread to his bowel. The prognosis for recovery was not very good and medical staff informed the escort at 6.00pm that the man could die within the next few hours. Following the operation, he returned to the ICU, on life support, where he remained unconscious.
57. The prison chaplain arrived at the hospital and was informed of the man's condition. He told the escorting staff that he had managed to contact the family and they would be attending the hospital but had to travel a long distance.
58. The man's family arrived at the hospital at around 9.30pm and were understandably upset. They spent about an hour at his bedside and spoke to the escort staff. His brother told the escort staff that they did not expect him to survive the night. Throughout the night, nursing staff attended to him but there was no improvement in his condition.
59. At 7.45am the following morning, the prison staff changed shifts. They remained in view of the man's bed but were positioned across the ward to give him a degree of dignity. His family returned to the hospital at 10.50am and the doctor explained the man's condition. That he was being maintained on the machine and was unlikely to survive without it. His family accepted the doctor's decision that treatment should be withdrawn. Without the support of the machines, he passed away peacefully with his family by his side at 11.45am on 20 February.

Events following the man's death

60. A governor visited the hospital at 12.30pm, along with a member of the prison's care team. The governor met the man's elderly mother, brother, sister and partner. His brother spoke highly of the care that the man had received at the hospital and confirmed that they had given permission for treatment to be withdrawn.

61. The man's brother was upset that his brother's requests for compassionate release had not been successful. The man's partner informed the governor that he had belonged to the Holy Trinity Church in Leicester. The family spoke of concerns regarding his medical treatment while in custody, including missed hospital appointments, which the governor was unable to comment on at that time. I hope that these concerns have been addressed in my report.
62. The governor remained at the hospital until 3.50pm. During this time, she spoke to the hospital about the man's medical records and confirmed that all personal effects had been accounted for. On her return to the prison, she liaised with the prison care team to ensure that all staff involved were contacted and offered support as required.

ISSUES

Access to healthcare

63. After seeing the man in September 2004, the doctor made an urgent referral to the Urology Department at City Hospital. On receipt of the referral, the hospital indicated a waiting time of 13 weeks, which was normal for this particular clinic. However, the man did not attend until 17 May 2005, some seven months later. This delay was caused by the failure of the healthcare department to respond to requests from the hospital for an appointment to be booked. Consequently, he had to be re-referred, incurring a further 13 week wait. There is no evidence to suggest that these delays made any difference to the man's prognosis, but to wait seven months for an appointment originally listed as an urgent referral is unacceptable. It is unclear whether the original referral was made under NHS policy guidelines in which patients with suspected cancer should be seen by a specialist within two weeks and, if not, why this was not the case.

In order for external healthcare providers to make timely clinical interventions and provide continuity of care, the Head of Healthcare should introduce procedures to check that appointments have been booked.

The PCT should ensure that if the 'two week rule' for patients suspected of having cancer is being used for referrals in the wider community, it is also implemented for those being held in custody and requiring the same treatment.

64. The treatment that the man received at hospital impaired his immune system and meant that he was more likely to contract illnesses. In view of this, the healthcare team recommended that he spent time on the healthcare wing during his treatment so that he could be monitored more closely. However, it was his wish to remain in his cell on the wing and the healthcare team respected this. As his illness progressed, the man's care was based upon the NHS Gold Standard Framework for End of Life Care.
65. Between December 2007 and January 2008, the man developed a stomach upset which was a new symptom. During this time, he was seen on a number of occasions by the healthcare team and by staff at the hospital's Haematology Department. Investigations were undertaken that included blood tests to identify an underlying cause for his stomach upset but the results of the tests were normal. In her review, the clinical reviewer considered that the man's final illness was not predictable.

Provision of medication

66. It is necessary for a person who is taking warfarin and requires an operation to be reviewed and, if necessary, the medication should be suspended to prevent the risk of bleeding. When the man attended for the biopsy on 10 August, it had to be postponed as he was taking warfarin. Given that they were aware of the impending biopsy, I am surprised that the prison healthcare had to be told to withdraw this medication. The postponement of the biopsy led to an

67. The man was taking a variety of medications and he was concerned about access to them. He had returned from hospital with medication which was taken from him and this led to a delay in him obtaining it. The warfarin required regular monitoring and it is evident that this was done. The clinical review acknowledges that some doses of warfarin had been missed and says that this is clearly not acceptable in any situation. In her review, the clinical reviewer also says in relation to prisoners' access to medication:

"Warfarin poses particular problems within the prison due to the need for close monitoring and frequently changing doses. We have attempted on several occasions to put robust management protocols in place to facilitate the safe and effective management of Warfarin. The situation has improved but we are constantly looking at the problem and seeking to improve the quality of our care. In-possession, medication is now being recorded on EMIS (Electronic Medical Information System) on the day it is delivered to the patient. This will allow for tighter control of in-possession medication and make monitoring easier and more reliable."

I welcome the steps being taken by the healthcare team at Birmingham and make no further recommendations in relation to this.

68. Given the potential for the misuse of prescription medication within the prison environment, it is essential that the prison has in place facilities that allow in-possession medication to be stored safely. In the clinical review, the reviewer confirms that there are currently no such facilities available at Birmingham and goes on to say:

"Steps are now being taken to provide every prisoner with a lockable cabinet. This will improve safety and security of medication and reduce the risks of medication being stolen. It will also hopefully allow more prisoners to have a wider range of daily medication in-possession."

Again, I welcome the steps being taken by the healthcare team and endorse this with the following recommendation.

I recommend that the Governor and Director of Healthcare at HMP Birmingham ensure that the initiative to provide lockable cabinets is progressed promptly, to ensure that delays in prisoners getting access to their medication are avoided.

The man's complaints regarding his medical care

69. The man had made numerous complaints about the medical treatment he was given at Birmingham, which culminated in a claim in respect of medical negligence against a doctor. The points raised by him, via his solicitors, related to missed appointments and access to medication. It was acknowledged that, due to unforeseen circumstances, the man had indeed missed one appointment but this had not been detrimental to his treatment. In relation to medication, there had been instances when he became concerned about not taking warfarin. The reasons it had been withdrawn were normally due to the ongoing cancer treatment but it was also acknowledged that some doses should not have been missed. The doctor responded in full to the man's solicitors, addressing all the points raised. I understand that following this the matter was not pursued further.
70. The clinical reviewer also acknowledges the breakdown of the relationship between the man and the doctor. The reviewer says that following the man's complaints she took over the management of his care and was able to maintain a good working relationship with him. She further adds:

“Problems such as this cannot be planned for but the healthcare department must be clear that it is our responsibility to find a workable compromise, where possible, to ensure that patients medical needs take priority and that the patient care does not suffer when problems such as this arise.”

I endorse the clinical reviewer's views.

71. The healthcare team at Birmingham and staff at City Hospital liaised well in the delivery of the man's treatment. The good working relationship between the consultants and the doctor ensured that, once the man started to attend his appointments, treatment was delivered in a timely manner and his imprisonment did not present a barrier to this.

Application for compassionate release

72. When the man was diagnosed with both prostate cancer and leukaemia, he immediately applied for compassionate release. Given that he was in the early stages of his sentence and a definitive prognosis could not be given, he was unlikely to be successful. However, both prison staff and those involved in the man's medical care continued to support his application. Again, this highlighted the good working relationship between the team at City Hospital and the healthcare team at Winson Green.
73. This was an area of concern for the man's family who felt that his illness might progress too quickly for there to be time to re-apply for compassionate release. The man's family told my Family Liaison Officer that they had even written to the Queen just before Christmas 2007 to ask her to become involved. However, the family did not receive a response. This demonstrates the family's efforts in trying to make it possible for the man to spend his remaining time with them.

Escort staff and restraints

74. When hospital staff notified the escort officers of the deterioration in the man's condition on 19 February, they quickly removed the restraints to allow treatment to be delivered. After it became clear that the man's condition was critical, the escort staff positioned themselves in such a way that provided his family some degree of privacy and dignity. That said, his family felt that it was unnecessary for three officers to be present, and I agree. I would like to remind the Governor of Birmingham of the revised guidance issued in February 2008, in relation to restraining prisoners who are seriously or terminally ill. The guidance requires prisons to balance the sensitive nature of a prisoner's changing physical condition against the need to provide the public with adequate protection when deciding on the level of restraint or escort.

Family Contact

75. The man's family felt that there had been a delay in them being informed that he had been taken to hospital, and that it was 5.00pm before they were contacted. Due to this they felt that they had lost time to spend with their son and brother. However, I have found nothing during the investigation to suggest that there was an unnecessary delay. The man arrived at hospital around midday and at that time was said to be comfortable. The prison would have treated this at that point as any other discharge to hospital as there was no indication that it was life threatening. It is not the procedure to contact the families of prisoners on each occasion that a prisoner attends hospital. When it became apparent that the man's condition had deteriorated and could be life threatening, the escort staff immediately contacted the prison and a member of the chaplaincy made contact with the family. It is regrettable that the man's family were unable to spend any longer with him I believe that every effort was made by the prison to make contact as soon as it was apparent that his life might be at risk.
76. Following the man's death, the Safer Custody Manager maintained regular contact and made a number of visits to the man's mother ensuring that all of her son's property was returned. The family have appreciated this assistance and thoughtfulness.

Independence of the clinical review

77. Since this office took over responsibility for investigating deaths in custody in 2004, there have been 16 deaths at HMP Birmingham. All but two of these required a clinical review to be conducted. The clinical reviews for the first nine deaths were carried out independently, by medical practitioners unrelated to the prison. However, the last five reviews commissioned by my office have been undertaken by senior healthcare staff employed at Birmingham. While I have found the quality of the reviews to be of a high standard, I am concerned that the Heart of Birmingham Teaching PCT appears to have moved away from the use of independent medical practitioners for such reviews.
78. A doctor conducted the man's clinical review in spite of being the clinical lead GP at Birmingham. While her review was thorough and addressed a number of

RECOMMENDATIONS

1. In order for external healthcare providers to make timely clinical interventions and provide continuity of care, the Head of Healthcare should introduce procedures to check that appointments have been booked.

The Prison Service accepted this recommendation in full and said:

There is now a detailed Protocol in place for making and following up any internal / external appointments to be made for any prisoner requiring one.

All client data and all referrals are registered and followed through and tasked via the computer system EMIS. The system used by all clinical and administration staff, to ensure continuity of care is maintained.

To ensure the waiting times are not excessive, there is also a tracker system in place used alongside a Calendar to chase up if necessary. The target date was immediate.

2. The PCT should ensure that if the 'two week rule' for patients suspected of having cancer is being used for referrals in the wider community, it is also implemented for those being held in custody and requiring the same treatment.

The Prison Service accepted this recommendation in full and said:

This is part of our referral system, and all patients are seen within the hospital waiting time protocols. The target date was immediate.

3. I recommend that the Governor and Director of Healthcare at HMP Birmingham ensure that the initiative to provide lockable cabinets is progressed promptly, to ensure that delays in prisoners getting access to their medication are avoided.

The Prison Service accepted this recommendation in full and said:

The feasibility and practicalities of adopting this system are being piloted in HMP Featherstone. We will be arranging a visit to the prison discuss/review the scheme in conjunction with the SMT. The plan would then be to pilot a similar scheme on one of our wings at Birmingham. The target date is March 2009.