

**Investigation into the circumstances surrounding the
death of a man who was a prisoner
at HMP Birmingham, in July 2006**

**Report by the Prisons and Probation Ombudsman for
England and Wales**

February 2007

This is the report of an investigation into the death of a man who was a prisoner at HM Prison Birmingham. The man died at a hospital in the city in July 2006. His partner was at his side.

A post mortem report has not yet been completed. The cause of death was provisionally recorded as amiodarone related liver disease, and COPD (chronic obstructive pulmonary disease) and heart disease. I offer my sincere sympathy and condolences to the man's partner, and to all of his friends and family, for their sad loss.

The investigation was carried out on my behalf by one of my investigators. An independent review of the man's medical care in prison was carried out by the Heart of Birmingham Primary Care Trust. I am most grateful to the clinical reviewer for his assistance.

The man's partner raised a number of issues with regard to the care that he received at both Birmingham and Hull prisons. I would like to thank the Governors and staff of both gaols for their full and ready co-operation during the course of the investigation.

I make ten recommendations and highlight one example of good practice.

Stephen Shaw CBE
Prisons and Probation Ombudsman

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SUMMARY

The man who died was received at HMP Birmingham on 10 January 2002, having been convicted and sentenced on the same day. He arrived at prison with a number of long-standing health problems, including chronic obstructive pulmonary disease (COPD).

The man did not report any serious troubles with his health during his first spell at Birmingham. On 17 October 2002, he was transferred to Hull in order to participate in the programmes required in his sentence plan. The man was not happy at Hull, and within two weeks of reception his solicitor wrote to the prison requesting a transfer back to the Midlands on medical grounds. The man continued to pursue a transfer throughout his three years at the prison, citing a number of different reasons for the request. He also made numerous complaints with regard to the late delivery of his repeat prescriptions whilst at Hull.

On 28 June 2004, the man was admitted to a hospital in Hull for one week on account of an exacerbation of his COPD. In November 2004, he began to cough up blood and experience a loss of voice. It is not clear when this was first reported to staff – in letters the man implies that this occurred before Christmas, but there is no note of such problems until February 2005 in his Medical Record. Tests were taken and, by 15 March, it was thought that the man might have contracted TB. It later became clear that this was not the case.

In April 2005, an agreement was reached to transfer the man to Birmingham. This was later cancelled, due to outstanding outpatients appointments at the hospital in Hull. The transfer eventually went ahead on 10 August. The man arrived at Birmingham on 11 August having stopped overnight at Leicester on the way.

The man was admitted to a local hospital in Birmingham on three occasions in the first six months of 2006, on account of exacerbation and deterioration of his COPD. On his return from the last of these, on 8 June, he was admitted as an inpatient to the prison's healthcare centre.

The man's condition progressively worsened, and he was admitted to the local hospital for short stays on two occasions in the following month. On 10 July, when he was experiencing shortness of breath, vomiting and showing signs of dehydration, the man was again admitted to the local hospital. By 14 July, he had developed liver failure and acute hepatitis, and his condition was described as "critical and likely to deteriorate". Sadly, his condition did continue to deteriorate, and he died at around 8.25am on 17 July with his partner at his side. The provisional cause of death was recorded as amiodarone related liver disease, and COPD and heart disease.

The man's partner has raised a number of concerns with regard to his care at both Birmingham and Hull, which I have addressed in this report. I have made a total of ten recommendations and highlighted one example of good practice.

THE INVESTIGATION PROCESS

The investigation was opened on 21 July 2006 when my investigator issued notices announcing the investigation to staff and to prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known to my investigator. No prisoners came forward. My investigator was also given access to the man's prison files, including his medical record.

My investigator visited Birmingham on 17 October 2006, and again on 25 October. He also visited Hull on 1 November. He interviewed eight members of staff during the course of the investigation.

An independent clinical review of the man's health needs whilst he was in custody at Birmingham was carried out by the Heart of Birmingham Primary Care Trust.

On 1 August 2006, one of my Family Liaison Officers, wrote to the man's partner to ascertain whether she had any concerns for the investigation to address. My Family Liaison Officer and investigator subsequently met with the man's partner on 12 October 2006. At the meeting, she expressed the following concerns about her partner's care at Birmingham and at Hull:

- When she was called to see him in hospital on 10 July 2006, her partner was chained to an officer.
- She was not normally told when her partner was taken to hospital, and only realised he was there when she did not receive her regular telephone call.
- She was upset that the chaplain, who was present after her partner's death, did not bless his body.
- On one occasion when the man was in hospital, his partner felt that two of the bedwatch officers were disrespectful and aggressive towards her. In addition, they refused to let her buy her partner any juice, even though he was not eating very much at the time.
- During the night of 9 July, before the man went to hospital for the last time, he told the night nurse that he was very ill. The nurse did not think that he needed to go to hospital, something that upset the man as he thought that he was very ill.
- When at Hull, the man often went for up to two weeks without receiving medication. This made him stressed and reduced his mobility. His inhaler was also changed regularly which also increased his stress levels as, having had this condition for some time, he knew which inhalers suited him and which did not.
- The man's medical condition deteriorated at Hull on account of the damp conditions at the prison. He continually asked for a transfer from the prison back to the Midlands, but nothing was done. Additionally, the man's partner

was on assisted visits, resulting in a bill of around £390 for each visit she made to Hull. This figure would have been greatly reduced if he had been transferred closer to home.

- The man's voice began to lose power in November 2004, and shortly afterwards he began to fetch up vast amounts of blood. His partner was very concerned with the amount of time it took for him to have any tests done.
- The man was diagnosed with TB after these tests were carried out, although it later became clear that he did not have TB. His partner was concerned that the delay in commissioning the tests meant that, if he did have TB, then the whole prison could have caught it.
- A number of months passed before the man's partner was able to visit him when he was at Hull. This was because she was not aware of the assisted visits scheme and, once she discovered how to apply, there was a delay in processing her application.
- The man's partner asked why it was only suggested in the last few days of his life that he might move to a hospice closer to home.

HMP BIRMINGHAM

Birmingham is a local prison for adult male prisoners. It serves the Crown and Magistrates' Courts of Birmingham, Stafford and Wolverhampton, and the Magistrates' Courts of Burton, Cannock, Lichfield, Rugeley, Sutton Coldfield and Tamworth.

A new healthcare centre was recently opened as part of a multi-million pound investment programme by the Prison Service. The provision of healthcare within the prison is the responsibility of the Heart of Birmingham Primary Care Trust. Primary care clinics are delivered by GPs and visiting consultants. The healthcare centre has the opportunity to draw upon the broader expertise and range of healthcare services at the local City Hospital. The healthcare team is made up of doctors, nurses and healthcare assistants. Medication is administered on a weekly and/or monthly basis to those prisoners who have been assessed as capable of holding it in their own possession. It is administered twice daily to other prisoners, when either they are considered to be at risk or the medication is unsuitable to be held in their cell.

There is an in patient ward where all cells have built-in sanitation. The ward is staffed by registered mental health nurses who provide care for patients with mental health needs and those with physical needs requiring 24 hour nursing presence.

KEY EVENTS

At his first reception health screening at HMP Birmingham on 10 January 2002, the man reported a history of emphysema (an accumulation of air in the lungs), as part of recurrent chronic obstructive airways disease (COAD). He also said that part of his right lung had been removed in 1989. The man was taking a variety of medication to help with his COAD, including a salbutamol inhaler. It was also noted that he was diabetic.

The man suffered a mild chest infection in June 2002, but other than that reported no problems with his health during his first months in prison. On 15 October, two days prior to his transfer to Hull, he attended an asthma clinic at which he complained that his combivent inhaler was giving him a sore mouth and sore eyes. He asked to revert to oxivent, which he said he had used for 14 years without problem, and this was accepted.

On 17 October, the man transferred to Hull. His initial healthcare assessment said that he had “reduced mobility due to chronic breathing (difficulties)”, and also noted severe COAD, bronchitis and asthma. The man was initially located in the healthcare centre due to a lack of ground floor accommodation on his allocated wing. On 4 November he moved into a ground floor cell on E-wing.

On 30 October, the man’s solicitor wrote to Hull requesting his transfer to Birmingham or to HMP Rye Hill on medical grounds. A reply was sent from the then Head of Resettlement, on 7 November. The Head of Resettlement noted that he would copy the letter to the OCA (Observation, Classification and Allocation) Unit to expedite a transfer to Rye Hill if space were to become available.

On 2 January 2003, the man submitted a complaint form to say that he had gone six days without oxivent, despite submitting applications for the medication on 25 December 2002 and 29 December 2002. The response, from a senior officer, said that he had spoken to the healthcare centre and discovered that the doctor had reviewed the man’s medication and, after finding that two drugs were inappropriately mixed, adjusted it accordingly. There is no note in his Medical Record of the man being taken off oxivent.

The man complained about being taken off oxivent, saying that he had used it successfully for a number of years. He was seen by an unidentified doctor (the signature is illegible) on 31 January 2003 who noted that he should have both oxivent and serevent.

On 4 April, the man saw a doctor after complaining of a cough, upper chest pain, shortness of breath and that he was producing a thick sputum. The medication prescribed is illegible. The man saw the same doctor on 29 April as he was still experiencing pain in his chest and producing a thick yellow sputum. The doctor sent him for a chest x-ray, the results of which showed that his lungs were emphysematous but clear.

On 12 June, the man’s solicitor wrote to Hull requesting his transfer to a prison in the Midlands. The reason for the request was that the man’s sole visitor was struggling

to travel to Hull on account of the distance and her health problems. The reply from the Head of Resettlement noted that there was only limited category B accommodation in the Midlands, with demand exceeding supply. He could not guarantee success in achieving a transfer for the man. A further letter was sent from the new Head of Resettlement on 28 August, in which he confirmed that the man was on a waiting list of prisoners wishing to transfer to the Midlands.

The man submitted a complaint form on 18 October in which he said that, despite submitting a complaint form one week previously, he had not received the medication that had been prescribed to him. The response, from the Head of Healthcare, on 24 October says, "I have responded a couple of days ago. I am told that the problem has now been sorted."

On 21 June 2004, the man submitted a healthcare application in which he said that he had submitted several request and complaint forms in the past few weeks. He said that these forms were with regard to not receiving his monthly medication, and that he would like some answers. The response, from the Outpatient Manager, says that she had discussed medication issues with the man since he completed the form, and that he could speak to her further should he wish. There is no record of this discussion in the Medical Record.

On 28 June, the man reported being breathless and it was subsequently decided to admit him to a local hospital. He was discharged on 5 July, having been kept in for observation on account of a raised temperature. The discharge sheet noted a mild exacerbation of COPD (chronic obstructive pulmonary disease, as COAD is now known) and no evidence of infection. At a follow up on 27 September, a consultant physician at the hospital diagnosed an element of COPD with an additional asthmatic component, and suggested associated changes to the man's medication. This included increasing combivent to four puffs, four times daily.

The man submitted a complaint form on 24 August. He said that he had not received his medication despite putting in an application through the correct procedures. The man also said that this had occurred on a number of occasions in the past two years. The complaint was answered by the Outpatients Manager, who decided to speak to the man on the wing rather than send a written response. She saw him on 4 September, when they discussed his transfer to another prison on medical grounds. The Outpatients Manager arranged for the man to see a prison GP on 4 October. No record was made of any review by the GP, although an unsigned entry on 5 October notes that Birmingham had been telephoned and the man's transfer discussed.

On 19 January, a different prison GP, contacted the Healthcare Governor at Birmingham, to discuss the possible transfer of the man. However, he was told that the Vulnerable Prisoner Unit at Birmingham was full, although the Healthcare Governor would try to place the man on the waiting list.

The man saw a third prison GP on 7 February 2005, and said that he had been experiencing a loss of voice since November 2004. He was referred to the consultant ENT (ear, nose and throat) surgeon at the local hospital the following day. On 17 February, the man was seen by the Outpatients Manager who noted that he

had lost weight and was not feeling well. She made him an appointment in healthcare on 22 February for a weight check and blood tests.

The man did not attend his appointment on 22 February. It is not known why he did not do so. Following a telephone call from his partner, the Outpatients Manager went to see him on the wing on 1 March. He said that he had been coughing up blood, and the Outpatients Manager booked him an appointment for a blood test in healthcare for the following day. On this occasion, the man attended the test.

On 3 March, the man was assessed by the GP who had contacted Birmingham on 19 January. He complained of coughing up blood "now and again" since November 2004, and said that he had pain in the right side of his chest. On the same day, the GP referred him to the Infectious Diseases Unit at Castle Hill.

The man was then admitted to the Infectious Diseases Unit on 15 March by the GP, as he considered that the man might have contracted TB. He was discharged on 5 April with TB having been ruled out. A bronchoscopy (an examination of the air passages of the lungs using a thin, flexible camera) confirmed mild bronchitis, and that the man's right vocal cord was partially paralysed.

On 19 April, an agreement was reached to transfer the man to Birmingham. However, on 27 April, Birmingham contacted the Deputy Head of Healthcare to express concern about an outstanding ENT appointment. The Deputy Head of Healthcare discussed this with the man, and it was agreed to postpone his transfer until the appointment could be completed.

Healthcare staff contacted the ENT department at the local hospital on 28 April to arrange an urgent appointment. However, they were told that the man had been seen by the consultant physician during his last inpatient stay and discharged at that time.

Outpatient appointments were made for the man at the ENT clinic on 8 June and 29 June. These appointments were discussed with the man, and he decided to attend them prior to his transfer to Birmingham. The transfer was subsequently delayed until after the man's outpatients appointments. On 6 July, he was seen by a nurse, at which time he expressed his wish to be taken off medical hold as he had now been discharged by the ENT surgeon.

On 10 August, the man was transferred to Birmingham. He arrived on 11 August, having stayed overnight at HMP Leicester. At Leicester, the man was accommodated in the healthcare centre as there were doubts that he would be able to cope with stairs. There is no evidence of a reception health screening being completed following the man's arrival at Birmingham.

The man experienced some shortness of breath over the coming months, as a result of which he attended a clinic at a Birmingham hospital on 24 November. In a letter of 9 December, the consultant physician recommended changes to his medication.

At 10.15am on 19 December, the man was seen on the wing by a member of the nursing staff as he was having difficulty breathing. He said that he had been feeling

unwell since his medication was changed, and that he was particularly affected by seretide as this made him very breathless. The man saw a doctor later that day, and his medication was consequently altered again.

The man attended a review on 2 February 2006, at which he was commenced on a ventolin nebuliser. He continued to experience shortness of breath and difficulty in breathing over the following weeks, but was able to use the nebuliser to good effect each day. However, in early March, the man began to complain of nausea, a cough and a chest infection. On 12 March, he was taken to hospital with an exacerbation of COPD. He remained under observation as an inpatient until 16 March.

The man continued to experience shortness of breath, and was again admitted to the same hospital from 12-16 April and from 29 May-8 June on account of an exacerbation of COPD. On his return on 8 June, he was admitted as an inpatient to the healthcare centre to stabilise on oxygen as required. A care plan was produced for the man by a nurse on his admission to the healthcare centre. The care plan included the instruction to administer oxygen when needed.

On 12 June at around 12.35pm, Hotel 2 (the response nurse) was called to see the man. He complained of right sided chest pain, spreading to his back. He was given salbutamol, following which he reported an improvement in his symptoms. During the following night, the man complained of being unable to catch his breath and of being panicky. He also said that his cell was extremely hot. The man was allowed out of his cell and onto the landing where he was cooled by a fan from one of the offices. His breathing stabilised and he became settled, and subsequently returned to his cell.

The man was reviewed by a prison GP on 14 June. The GP described his medium and long term prognosis as "very poor". She said that the man was likely to have further COPD exacerbations, and warned that he was at risk of fatal respiratory distress if these exacerbations were untreated. The doctor instructed that the man's cardiac function be monitored, and that he should be regularly reviewed.

On 16 June, the man was given amoxicillin (an antibiotic) to keep in possession by a prison GP, the clinical lead at Birmingham. She noted that the man knew the early warning signs of an infection, and would take the medication when appropriate. The man said at the time that he was feeling much better.

On the morning of 17 June, the man said that his breathing had not been good during the night despite having taken oxygen. He also complained of bringing up yellow mucus from his chest. He was subsequently transferred to a Birmingham hospital, with the admission sheet diagnosing an acute exacerbation of COPD.

The man was discharged from hospital on 19 June and returned to the healthcare centre at Birmingham. He said that he was feeling better, although it was noted in his Medical Record that he appeared breathless. On 21 June, he repeated that he was feeling a lot better, and it was now noted that his breathing had eased.

On 22 June, the clinical lead discussed with him the possibility of a future compassionate release on medical grounds. The man was keen on this. The

clinical lead noted that she would check with her colleague, who had seen the man on 14 June, whether the consultant had been contacted with regard to the man's prognosis.

At 11.40pm on the night of 22 June, Hotel 2 was called to see the man after he complained of chest pains. He was given paracetamol for his pain, and the on-call GP was consulted. The GP advised transferring him to hospital if his condition worsened. A later entry (the time is unrecorded) said that the paracetamol had had a good effect.

The man remained settled for around a week after this, before reporting difficulty breathing on 28 June and 30 June. On both occasions, he settled down after a while and his breathing was eased after taking his medication. The man also said on 30 June that he had been experiencing panic attacks, and that he was feeling low and under pressure. The clinical lead discussed this situation at length with the man and his partner. She prescribed citalopram 20mg (a drug used to treat depression and panic attacks) for four weeks.

At around 3.00pm on 2 July, the man complained of an upset stomach. Around ten minutes later, he pressed his cell bell and reported that he had vomited and was experiencing pain around his chest. His blood pressure (100/70) and pulse (102 beats per minute) were taken. These observations were repeated 15 minutes later when they were found to have risen to 116/87 and 110bpm respectively. An ambulance was subsequently called, and the man was transferred to hospital.

The man remained at hospital until the evening of 5 July when he returned to the healthcare centre at Birmingham. The discharge summary noted a diagnosis of exacerbation of COPD, and that he had an enlarged liver.

On 7 July, the man was seen by the clinical lead. He said that he was still vomiting. The clinical lead prescribed cyclizine, which had been recommended by the hospital were he to continue vomiting, and also stopped his citalopram to see if this helped the nausea. She again raised the possibility of compassionate release on medical grounds, and noted that she would discuss this with her colleague on her return from leave.

The man was more settled on 8 July, but complained of vomiting throughout the following night and again in the evening of 9 July. At 11.00am on 9 July, the response nurse was called to see him after he complained of vomiting overnight. Following discussion with the on-call doctor, urgent blood tests were sent to a local hospital. When the results were received, at around 2.00pm, the doctor prescribed an antiemetic (a medicine that prevents or alleviates nausea and vomiting).

At around 3.25am on 10 July, the man complained of chest pain and Hotel 2 was called out to see him. The man was on continuous oxygen by this time. Observations were taken and his condition was deemed to be stable.

At 8.15am on 10 July, the man refused to take his morning medication. When asked why, he said that he had "had enough and don't want any more." The nursing staff tried to persuade him to take the medication, and he accepted later that morning.

The man was seen by a doctor as he was showing signs of dehydration and weakness. He said that he was experiencing increased shortness of breath and was still vomiting. The doctor decided to admit him to hospital.

The man was transferred to hospital at around 11am. He was accompanied by two officers on a bedwatch, and was cuffed to one of these by means of a closing chain.

Later on 10 July, the clinical lead spoke to a member of the Community Respiratory Nursing Team. It was agreed that she would liaise with the consultant to obtain a letter outlining the man's prognosis. She would also investigate the possibility of finding in his home area.

By 14 July, the man had developed liver failure and acute hepatitis due to amiodarone (a drug used to treat abnormal heart rhythms). Following this diagnosis, the Consultant Cardiologist, faxed a letter to the clinical lead to request the man's release from cuffs. In his letter, Consultant Cardiologist said that the man's condition was critical and likely to deteriorate over the next few days. He also said that the chances of survival were "exceedingly low". Following this request, the cuffs were removed and the bedwatch reduced to one officer.

Sadly, the man's condition continued to deteriorate and he died at around 8.25am on 17 July. His partner was with him when he passed away. The provisional cause of death was recorded as amiodarone related liver disease, and COPD and heart disease.

The man's partner arranged the funeral herself, but the prison provided funding to cover all of her costs. The Head of Safer Custody, attended the funeral along with one other member of prison staff.

ISSUES

Issues raised in the Clinical Review

The clinical review, conducted by the Heart of Birmingham Teaching Primary Care Trust, concludes that the man's COPD and diabetes "appear to have been adequately managed by the Prison Medical Service." Indeed, the clinical reviewer considers the man's diabetic control to have been excellent, and an example of good practice. He also concludes that the man's repeated hospital admissions in the final stage of his illness "do not appear to be the consequence of inappropriate management by the Prison Medical Service."

However, the clinical reviewer suggests that the man's repeated hospital admissions whilst in the final stage of his illness might be considered as grounds for a Significant Event Audit to be conducted by the Primary Care Trust. He makes the following recommendation:

Four admissions to hospital in the space of six weeks could be considered an indication for a Significant Event Audit.

The clinical reviewer considers the discharge notes received from the local hospital in Birmingham to be uninformative and to give little indication of the patient's condition and progress. He notes that there were no formal discharge summaries. This point was also made by the clinical lead at Birmingham, during her interview with my investigator. The clinical reviewer makes the following recommendation:

The Primary Care Trust may wish to recommend an audit of the content of hospital discharge notes and provision of in-patient summaries.

The clinical reviewer reports that his review was not aided by the quantity and poor quality of the man's medical records. He notes that computerised medical records are now virtually universal in primary care in the NHS, and considers that such records are "essential for the demonstration of good quality care".

The Primary Care Trust in association with the Governor of HMP Birmingham should consider the introduction of an electronic system for recording medical notes.

Issues raised by the man's next of kin

As noted earlier, my investigator and one of my family liaison officers met with the man's partner on 12 October 2006. The issues raised by her were first outlined on pp 5-6 of this report.

- ***Cuffing arrangements***

The man's partner was concerned that, when she was called to see him in hospital on 10 July 2006, he was chained to an officer despite being very ill. During the course of the investigation, my investigator interviewed the Head of Security and Operations at Birmingham. He said that, when a prisoner is taken to hospital, a

'Hospital Escort Risk Assessment' is completed. This form is mainly used to determine the security level during transfer to hospital, but also contains a section to authorise the level of restraint to be used once the prisoner is being treated. As he was a category B prisoner, the man was double-cuffed whilst being transported to hospital, and was held on an escort chain following his arrival at hospital.

Within 24 hours of the commencement of a bedwatch, a 'Bedwatch Risk Assessment' is completed. This is a similar form to that described above, with the prisoner's comfort and treatment in hospital also given consideration. In the man's case, the form was completed on 10 July by the Head of Security. The Head of Security authorised the use of an escort chain and that two officers should remain on escort duty.

Both of the above forms contain instructions as to when it would be appropriate to remove restraints. The instruction is as follows:

"If a Doctor or Senior Healthcare Professional decides that the prisoner's medical condition is LIFE THREATENING, and requests the removal of restraints then THEY MUST BE REMOVED."

The instructions go on to say that restraints can also be removed in non-life threatening circumstances with the prior permission of the duty governor, should a doctor or senior healthcare professional request their removal.

The man had poor mobility, and in January 2006 had been assessed as requiring a wheelchair to take him to the visits area of the prison. At interview, the Head of Security said that the prisoner's level of mobility would be considered by the duty governor during his/her visit every 24 hours. However, it would be unlikely that a prisoner would be released from an escort chain on mobility grounds, especially in the man's case due to the nature of his offence. He reiterated that cuffing is not just about preventing escape, but also about protecting the public and staff in the vicinity.

I accept that security considerations are critically important on a bedwatch. However, the man was an elderly prisoner in a lot of pain. His level of mobility was poor and he required a wheelchair to travel substantial distances. I do not consider that the man's circumstances rendered it necessary for him to be chained to an officer over the period of 10-14 July 2006. Given his condition, I judge that the presence of one officer in the room would have been an adequate security arrangement.

This is not a criticism of prison staff who correctly followed local instructions, and who only removed the escort chain at the request of the consultant and with the permission of the duty governor. I consider that the duty governor should have more discretion to authorise the removal of cuffs in circumstances such as those experienced by the man.

The Governor should consider amending the Bedwatch Risk Assessment to give the duty governor further discretion to authorise the removal of cuffs in non-life threatening situations.

- ***Informing next of kin of hospital admissions***

The man's partner was concerned that she was not normally told when he was admitted to hospital. The Head of Security told my investigator that the prison would not inform the next of kin of a hospital admission unless the situation was serious or life-threatening. The decision as to whether to inform next of kin is made by healthcare staff, although the hospital can request that next of kin are told.

In the community, a hospital would contact a patient's next of kin following an emergency admission unless the patient requested that they did not. There is no indication that the man would not have wanted his partner, who was his next of kin, to have been contacted were he to be admitted to outside hospital. I consider that it is reasonable, in order to achieve equitable care (the extent to which a prisoner's medical treatment is the equal of that which would be expected in the community), that the prison inform next of kin on each occasion that a prisoner is admitted in an emergency for an inpatient stay in outside hospital.

The Governor should consider introducing procedures to ensure that next of kin are informed when a prisoner is admitted in an emergency as an inpatient to outside hospital, unless the prisoner does not wish them to be told.

- ***Conduct of staff on bedwatch duty***

In general, the man's partner was very complimentary about the conduct of prison staff on each occasion that he was receiving inpatient care at outside hospital. On one occasion, however, she felt that two of the bedwatch officers were disrespectful and aggressive towards her. She also said that these two officers refused her permission to buy the man juice, despite him not eating very much at the time.

She said that the man made a verbal complaint to the Investigation Manager at Birmingham about the conduct of the two bedwatch officers. My investigator spoke to the Investigation Manager about this, and he said that he had no recollection or record of the complaint. He confirmed that, if there had been a complaint, it would have been his job to investigate it. The Investigation Manager also said that there was no reason why the man's partner should not have been permitted to purchase the items in question.

Although the man's partner did not know the names of the two officers, she was able to provide a description of one of them. My investigator gave this description to the Investigation Manager and to the Head of Safer Custody at Birmingham. Both provided the same name in response. However, this officer did not appear in the bedwatch records.

It is unfortunate that the officers to whom the man's partner referred could not be traced. However, this episode acts as a reminder that, whilst on duty in outside hospital, bedwatch staff are representing the prison. It does not reflect well on the Prison Service when a visitor feels that they have been treated inappropriately. Staff should act professionally at all times and show the necessary respect to the prisoner and to their visitors.

In sharing the outcome of this investigation, the Governor should remind all staff of the need to act professionally and with respect whilst on bedwatch duty.

- ***The chaplain's actions following the man's death***

The man's partner was upset that the chaplain, who was present after his death, did not bless his body. During the course of the investigation, my investigator spoke to the chaplain at Birmingham. He said that, when a prisoner dies in outside hospital, he would only say a prayer at the request of the next of kin. He would normally ask the next of kin if they wanted a prayer. However, on this occasion the chaplain said that his main concern was for the man's partner, as she was very upset at the time and was worrying about what to do in the immediate future. The chaplain's priority was therefore to offer support to her, and he did not ask her if she would like a prayer to be said.

I am entirely satisfied that the chaplain did not intend to upset the man's partner, and that he was doing his best to see to her pastoral needs. It is unfortunate that there was a misunderstanding with regard to her wishes. In future, the chaplain may wish to ask next of kin if they would like him to perform any religious rites, so as to avoid any confusion over his actions.

- ***The man's care on the night of 9 July 2006***

The man's partner said that on the night of 9 July 2006, before he went to hospital for the last time, the man told the night nurse that he was very ill. The nurse did not think that he needed to go to hospital, and this upset the man as he thought otherwise.

At around 3.25am on 10 July, the response nurse was called out to see the man when he complained of chest pain. The response nurse took his blood pressure (100/60) and temperature (35 °C), and recorded that his condition appeared to be stable.

The clinical reviewer notes that the blood pressure and temperature observations taken were normal. The man's recent admissions to outside hospital had been associated with an increase in heart and respiratory rates which, the clinical reviewer concludes, "suggests that there was no immediate cause for concern on this occasion."

- ***The man's possible compassionate release on medical grounds***

The man's partner wished to know why it was only suggested in the last few days of his life that he might move to a hospice closer to home. Chapter 12 of Prison Service Order 6000 sets out the following criteria for compassionate release on medical grounds:

- the prisoner is suffering from a terminal illness and death is likely to occur soon; or the prisoner is bedridden or similarly incapacitated; and

- the risk of re-offending is past; and
- there are adequate arrangements for the prisoner's care and treatment outside prison; and
- early release will bring some significant benefit to the prisoner or his/her family.

Compassionate release on medical grounds was first discussed with the man on 22 June 2006, around four weeks prior to his death. The clinical lead and another prison GP had previously raised the possibility amongst themselves. Their discussions were mainly with regard to when the man would reach the 'terminal' phase, to satisfy the first criterion above. The clinical lead felt that, at this stage, it was very unlikely that an application would have succeeded.

By 10 July, the man had deteriorated further. The clinical lead spoke to a member of the community respiratory nursing team, and asked her to liaise with the consultant with regard to obtaining a letter outlining the man's prognosis.

On 14 July, the Consultant Cardiologist, faxed a handwritten letter to the clinical lead to request the man's release from cuffs. In his letter, the Consultant Cardiologist said that the man's condition was critical and likely to deteriorate over the next few days. He also said that the chances of survival were "exceedingly low". However, whilst this fax was sufficient for the purpose of enabling the man to be released from the escort chain, it did not contain the detailed prognosis necessary for an application for compassionate release.

A formal letter with prognosis, dated 21 July 2006, was received at the prison on 27 July. Sadly, the man had died four days prior to the letter being written. The letter noted that "his prognosis is likely to be quite poor and his physical condition may decline in the coming weeks to months requiring increasing medical help and physical support for his daily activities". It is unlikely that such a prognosis would satisfy the terms of PSO 6000. (The timing of the letter also raises serious questions with regard to internal communication procedures at the hospital.)

At interview, the clinical lead said that it is difficult to get the timing right in an application for compassionate release on medical grounds. By this she meant that it is difficult to make a judgement as to when a patient reaches the stage whereby a consultant can provide a specific prognosis to satisfy PSO 6000, without leaving it too late.

The Head of Healthcare should discuss the establishment of formal procedures with the City Hospital, to ensure that Consultants can provide formal letters of prognosis at the appropriate time.

- ***Medication at HMP Hull***

The man's partner expressed serious concern that, during his time at Hull, he often went for up to two weeks without receiving his medication. She said that this made

him stressed and reduced his mobility. She was also concerned that the man's inhaler was changed regularly, as this also increased his stress levels.

At Hull, the man kept his medication in possession and received new supplies on a monthly basis through a repeat prescription. His medical record and wing record, which have been considered by my investigator, contained formal complaint forms dated 2 January 2003, 18 October 2003, 21 June 2004 and 24 August 2004. These all concerned not receiving his medication on time. These forms also reference other complaints, which have not been seen by my investigator, with the last one claiming that the same problems had been occurring for two years.

Prior to June 2004, there was no in-house pharmacy at Hull and an external contractor was used. The Deputy Head of Healthcare at Hull, told my investigator that this system often resulted in delays in medication being delivered.

From 10 June 2004, an in-house pharmacy was established. Under this system, it is the prisoner's responsibility to put in an application for a repeat prescription. The pharmacist will then dispense medication on receipt of the application.

Records of medication dispensed from the opening of the pharmacy are stored electronically on a 'Patient Medication Report'. They show that the man was dispensed with a quantity of medication on 15 June 2004, six days before he submitted a complaint form. A further quantity was dispensed three weeks later, on 7 July. Given that one month's supply is dispensed at a time, the man would still have had one week's supply left at this stage.

The next quantity of medication was not dispensed until 23 August, other than two items prescribed 'PRN' (as required) which were dispensed on 17 August. This is nearly seven weeks after medication was last dispensed, and corresponds with the man's complaint form of 24 August. Following this, medication was dispensed at approximately four week intervals throughout his time at Hull, other than in April 2005 when he had spent a number of weeks as an inpatient at a local hospital.

The clinical reviewer, considered the issue of missed medication. He concludes that "failure of compliance with his particular medications for short periods is unlikely to have had any long term sequelae [consequences]". The clinical reviewer also says that it is "normal practice" for doctors to change inhaled medication to see if a change will provide a little extra breath. He goes on to say that he does not believe that either of these issues had "significant relevance to the man's final illness and death in custody."

Whilst the issue of missed medication may not have had any long term consequences, it is clear that such incidents caused the man considerable distress and upset. Other than in August 2004, it would appear that his medication was dispensed appropriately following the introduction of the in-house pharmacy.

The Head of Healthcare at HMP Hull should ensure that procedures for dispensing repeat prescriptions are regularly monitored and audited.

- ***Transfer from Hull***

The man's partner was concerned about the length of time that it took to transfer him out of Hull. She felt that his medical condition deteriorated on account of the damp conditions at the prison. She was also concerned about the amount of money that it cost for her to visit the man at Hull on the assisted prison visits scheme, and felt that this would be greatly reduced if he were transferred closer to home.

The man was transferred to Hull on 17 October 2002 in order to undertake the Sex Offender Treatment Programme (for which Hull is a national centre). However, he did not participate in any programmes during his time there as he was appealing against his sentence.

On 17 February 2003, a doctor from the practice with which the man was registered outside of prison, wrote to the man's solicitor. In the letter, the doctor said that the man was a former patient of the practice and that "in view of his various longstanding medical problems his chest would be severely affected by damp conditions and would be detrimental to his health." The letter does not specifically refer to conditions at Hull.

The clinical reviewer says that he has "no knowledge of the environment of Hull prison and its likely effect on the man's health." However, he goes on to say that he does not believe that the issue has "significant relevance to the man's final illness and death in custody."

The man first applied for a transfer on 30 October 2002, when his solicitor wrote to the prison to request a transfer to Birmingham or Rye Hill on medical grounds. A second letter was sent on 12 June 2003. In this the reason for transfer was given as his partner's health and the distance that she had to travel to visit. The man made other representations with regard to transferring to the West Midlands throughout his time at Hull.

Numerous attempts were made by staff at Hull, beginning shortly after the man's arrival at the prison, to arrange a transfer to the Midlands. Applications were made to Birmingham, Rye Hill and Dovegate. Unfortunately, with the population pressures of the last few years, it is very difficult to move prisoners around the estate, even for progressive moves, as there is little spare capacity. This was especially so in the man's case as, due to his need to be accommodated on a Vulnerable Prisoners Unit, the options were more limited. Staff at Hull were unable to force a move through and were reliant on other establishments finding suitable accommodation. I consider that the efforts made by staff at Hull to transfer the man closer to home were entirely reasonable in the circumstances.

- ***Medical issues from November 2004***

The man began to cough up blood and experience a loss of voice in November 2004. His partner criticised the amount of time it took for him to have any tests. In March 2005, it was suspected that the man might have contracted TB, although this was later ruled out. His partner was concerned that the previous delay in commissioning the tests meant that, if he had contracted TB, the whole prison could have caught it.

The medical record shows that the man first reported problems with his voice on 7 February 2005. He was referred to a consultant at a local hospital on the following day. The man was then seen on the wing on 17 February, and an appointment was made for a weight check and blood test on 22 February. There is no record of the man mentioning coughing up blood at this stage. He failed to attend his appointment on 22 February, the reason for which is unknown.

The first record of the man saying he had been coughing up blood is on 1 March. An appointment for an urgent blood test was made for the following day. On 3 March, he was assessed by a doctor and is recorded as saying that he had been coughing up blood “now and again” since November 2004.

From the evidence contained in his medical record, it would appear that the man was appropriately referred for blood tests when he was first recorded to have complained of coughing up blood, on 1 March. He had failed to attend an appointment for tests the previous week, although the reason for this non-attendance is not known.

However, his partner was concerned that the man had reported coughing up blood to healthcare staff prior to it being recorded in his medical record. In a letter of 3 March 2005 to the Eastern Hull Primary Care Trust, the man said that when he first reported coughing up blood (no date is given) he was given antibiotics. He went on to say that he asked to see a doctor over Christmas but, as one was not available, he was given a further course of antibiotics. There is no record of either of these events in his medical record.

At her interview with my investigator, the Deputy Head of Healthcare at Hull, said that there were occasions when nursing staff are stopped by prisoners on the wing and a discussion is held that is not always recorded in the medical record. She was confident, however, that a report of coughing up blood would have been recorded. Nevertheless, there is a substantial discrepancy between the man's version of events and that contained in his medical record. Although I cannot know what actually happened in this case, I recommend:

The Head of Healthcare at HMP Hull should remind staff to record all health-related conversations with prisoners in their medical record.

- ***The assisted prison visits scheme***

The man's partner said that a number of months passed before she was able to visit him at Hull as she was unaware of the assisted prison visits scheme. Once she discovered how to apply, there was a delay in processing her application.

The man was transferred to Hull on 17 October 2002. Records held by the Assisted Prison Visits Unit (APVU) show that his partner's claim for assistance was received by them on 18 November 2002. This related to a visit made on 9 November 2002. On 22 November, the claim was initially rejected as no proof of her benefits was included with the application. A letter was subsequently sent to the Department for Work and Pensions on 29 November, with a positive reply received on 19 December.

On 29 November 2002, a letter was sent to Hull to confirm that the man's partner met the criteria for "sole visitor". A reply was received on 18 December, but the information given was unclear. APVU therefore sought further clarification from the prison. No response was received, and the "sole visitor" check was re-sent on 20 January 2003.

No response was received to this second request and, on 3 February, the Head of APVU, granted "exceptional" status to the man's partner. The first payment to her was issued on 4 February, and APVU continued to provide assistance until the man's death.

From the records held by APVU, summarised above, it would appear that the main reason for delay in issuing payment was that Hull did not provide a satisfactory or timely response to requests for them to confirm that his partner was the man's sole visitor. This failure is disappointing, and caused the man's partner a great deal of distress.

The Governor of HMP Hull should review the process of replying to "sole visitor" requests from APVU, and ensure that prompt and effective replies are sent in future.

Toxicology

The toxicology report on the man, dated 18 August 2006, shows a level of 22mg per 100ml of ethyl alcohol in the blood. The toxicologist concludes that, "it is not possible to completely exclude the possibility that this was formed by biological processes after death."

My investigator spoke to the toxicologist following receipt of the toxicology report. He said that the level in the man's blood was around one quarter of the drink-drive limit (which is 80mg per 100ml). He went on to say that, whilst the amount of alcohol was unusual, it could also be much higher through natural means and it was certainly possible that the level was formed by biological processes. The toxicologist also remarked that the conclusion of his report (as quoted in the above paragraph)

should not necessarily be read as an assumption that the man had had something to drink.

The bedwatch logs contain no entries to indicate suspicion that the man might have been passed alcohol illicitly. Given the toxicologist's comments above, I am satisfied that there is no evidence on which to base any further investigation of this matter.

Family response to the draft

I received a number of comments from the man's partner, on my draft report, which I have discussed below.

- The man's care on 7 July 2006

The man's partner was concerned that, when she visited him on Friday 7 July, he was very ill. She felt that he should have been taken to hospital on that occasion. My investigator put this question to the clinical reviewer.

The clinical reviewer notes that, at 6.55am on 7 July, the man complained of feeling sick. At 1.15pm he said that he was unwell and asked to see a doctor. The man was then seen by the clinical lead, who noted that he had been vomiting for five days and that this had responded to anti-sickness drugs. The clinical lead noted that his breathing was satisfactory at the time, and prescribed a further anti-sickness drug. The clinical reviewer concludes that "there does not appear to be a specific reason necessitating (hospital) admission on that day".

- Documentation from HMP Hull

The man's partner said that she was told by someone in healthcare at Hull that some paperwork relating to him was shredded following his transfer to Birmingham. My investigator put this to the Head of Healthcare at HMP Hull. She said that "on no account are patient records or documentation relating to patient care shredded unless the documentation life has expired as in a dead record".

My investigator was given access to the man's medical record at the start of the investigation. The record was badly disordered on receipt, and took some time to put into chronological order. However, once order was established there did not appear to be any obvious gaps in the record. I am satisfied that my investigator has had access to all information from the medical record.

RECOMMENDATIONS

Four admissions to hospital in the space of six weeks could be considered an indication for a Significant Event Audit.

Not accepted – the man as known to have and was being treated for Chronic Obstructive Pulmonary Disease (COPD). His admissions into hospital were as a result of an acute exacerbation of a condition which was known, being managed by the GPs and a Consultant Physician, using best practice.

The Primary Care Trust may wish to recommend an audit of the content of hospital discharge notes and provision of in-patient summaries.

Accepted – The Head of Healthcare will undertake an audit of the quality of both the formal discharge letter and inpatient summary forms from all secondary providers.

The Primary Care Trust in association with the Governor of HMP Birmingham should consider the introduction of an electronic system for recording medical notes.

Accepted – The EMIS system is being installed and will be operational in 2007.

The Governor should consider amending the Bedwatch Risk Assessment to give the duty governor further discretion to authorise the removal of cuffs in non-life threatening situations.

Accepted for consideration – This has been considered locally but it is felt that the duty governor does not have the right level of authority or information to make this decision. The duty governor should only be placed in this position if there is a threat to life or if a medical professional requests for health reasons.

The Governor should consider introducing procedures to ensure that next of kin are informed when a prisoner is admitted in an emergency as an inpatient to outside hospital, unless the prisoner does not wish them to be told.

Accepted for consideration – This has been considered locally but to inform the next of kin may compromise security. Where the escort is a life threatening emergency, consideration is given to contacting the next of kin. This is not the case in emergencies which are not life threatening.

In sharing the outcome of this investigation, the Governor should remind all staff of the need to act professionally and with respect whilst on bedwatch duty.

Accepted – During this investigation there was no evidence to show that staff did act unprofessionally, however a Governors order will be issued to remind staff of what is expected of them when carrying out bedwatch duties.

The Head of Healthcare should discuss the establishment of formal procedures with the City Hospital, to ensure that Consultants can provide formal letters of prognosis at the appropriate time.

Partially accepted – Following the audit outlined in recommendation two, the Head of Healthcare will have discussions with City Hospital to try and resolve the problems caused by poor communication. These communication problems however are frequently encountered in outside General Practice.

The Head of Healthcare at HMP Hull should ensure that procedures for dispensing repeat prescriptions are regularly monitored and audited.

Accepted – The system is now robust, all applications are collected from the wings daily (Mon-Fri). they immediately go into the pharmacy department and are turned around in 48 hours unless collected on a Friday. The pharmacist has been asked to implement a monitoring system to test the effectiveness of the system. We can also check the complaint level via PALS department in terms of not dispensing repeats on time. This gets fed back for action should the issue be identified.

The Head of Healthcare at HMP Hull should remind staff to record all health-related conversations with prisoners in their Medical Record.

Accepted – We have purchased an electronic patient record system (system 1). This should be operational by January/February 2007. this means that clinical staff will have access to patient records in all clinical areas, so records can be updated at the point of contact in most cases.

The Governor of HMP Hull should review the process of replying to “sole visitor” requests from APVU, and ensure that prompt and effective replies are sent in future.

Accepted – We will review how we operate the AVPU system, including sole visitors, and develop an action to remedy any negative findings.

GOOD PRACTICE

The man’s diabetic control appeared excellent, with minimal complications arising during his four year prison stay.

Accepted – Work is continuing to ensure that all chronic disease continues to be managed effectively using NHS best practice standards and NICE guidelines.

