



**Investigation into the circumstances surrounding the
death of a man in August 2011, a prisoner
at HMP Birmingham**

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

September 2012

This is the report of an investigation into the circumstances surrounding the death of a man at hospital, while he was a prisoner at HMP Birmingham. He died in August 2011 of cancer of the liver. He was 33 years old. I offer my condolences to his family and others affected by his death.

The investigation was carried out by an investigator. The local Primary Care Trust appointed a clinical reviewer to carry out a review into the man's clinical care. HMP Birmingham fully co-operated with the investigation. I apologise for the delay in issuing this report.

The man suffered from a rare and aggressive tumour, which was too advanced for treatment by the time it was diagnosed. After a stay of some weeks in hospital, he was discharged back to the prison, despite the concerns of prison staff that they would not be able to provide him with the palliative care he needed. Clearly, it is preferable that a terminally ill prisoner should be cared for in a hospice, but a bed could not be found. The decision to discharge him from hospital is a matter for the hospital authorities, but I am concerned that the prison did not feel equipped to manage a dying prisoner and did not complete an appropriate end of life care plan. I also consider that communication with the family could have been better and suffered from a lack of trained family liaison staff at Birmingham, a matter this office has raised before.

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

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Prisons and Probation Ombudsman

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SUMMARY

1. The man was sent to HMP Birmingham on 10 February 2011 following his arrest for failing to surrender to the police. On 29 June, after suffering abdominal pains, he was sent to hospital. He was diagnosed with an angiosarcoma of the liver¹ which had spread to other parts of his body, including his lungs. His condition was not treatable.
2. While in hospital, consideration was given to moving the man to a local hospice. At that stage he did not meet the hospice criteria for palliative care and he returned to the prison's in patients unit on 26 July.
3. During the early hours of 27 July the man fell out of his bed and was very unwell. Because a suitable bed in a hospice could not be found, he returned to hospital where he remained until he died in August.
4. The possibility of release on temporary licence (ROTL) was considered on 19 June. It was decided that the man was not suitable due to the nature of his offence and the perceived risk to his victim. When his health deteriorated this was considered again on 27 July. He was released on a special purpose licence² to hospital on the same day.
5. The clinical reviewer comments that the decision to return the man to prison on 26 July was not appropriate and that he should have remained in hospital until a bed in a hospice was found. He notes that an operational manager at the prison expressed concern that the prison was not staffed to provide the palliative care that he required.
6. There is no record of an end of life pathway in the man's medical notes or any entry which suggests that an end of life care plan was being prepared. This report therefore includes a recommendation about the importance of completing a formal end of life care plan.
7. The man's family were not offered appropriate support from the prison's family liaison officer (FLO) (who had not undertaken any formal training before she was given the role). At the time of the man's death, Birmingham only had one trained FLO who was unavailable due to the number of previous deaths at the prison. This report includes a recommendation about ensuring that there are a sufficient number of trained FLOs.

¹ An angiosarcoma of the liver is a rare type of cancer that starts in the lining of blood vessels in the liver. It is generally an aggressive tumour which often spreads to other parts of the body.

² A special purpose licence might be granted for prisoners to attend medical out-patient appointments, or in patient requirements.

THE INVESTIGATION PROCESS

8. The investigation was undertaken by an investigator. The investigation was opened by one of our family liaison officers (FLO) on 5 August 2011. She was given access to the man's prison records and saw the healthcare unit where he lived during his time at the prison.
9. During this initial visit, the FLO met a member of the Independent Monitoring Board (IMB)³. The IMB did not have any specific issues to raise. She also ensured notices to staff and prisoners were displayed at the prison to inform them of the investigation and to invite them to contact the investigator if they wanted to provide information relevant to the investigation. No one came forward in response to the notices.
10. The local Primary Care Trust (PCT) commissioned a clinical review of the care that the man received while he was in custody at Birmingham. The clinical review was undertaken by a clinical reviewer on behalf of the PCT.
11. The investigator and FLO met the man's family on 20 September 2011 to explain the purpose of the investigation and to invite them to ask any questions or raise any issues for consideration. They wanted to know why:
 - He was not considered for release on temporary licence when his terminal illness was diagnosed.
 - He did not receive his prescribed medication after 10.00pm on 26 July 2011.
 - An ambulance was not called until midday on 27 July 2011, despite the rapid deterioration in his condition.
 - They were not told when he was taken to hospital.
 - He was handcuffed in hospital.
 - His trainers were not returned to them by the prison's family liaison officer in time for his funeral.
12. The family received the draft report as part of the consultation period and did not raise any concerns.
13. The investigation has assessed the main issues involved in the man's care including his diagnosis and treatment, liaison with his family, his location and security arrangements, whether compassionate release was considered and whether appropriate palliative care was provided.
14. This report has been delayed in part by the length of time taken to complete the clinical review into the man's clinical care. The report was received from the Primary Care Trust on 31 January 2012. This delay was then further compounded by workload pressures within the Ombudsman's office.

³ Each prison has an Independent Monitoring Board. IMB members are unpaid and monitor day-to-day life in the prison to ensure that proper standards of care and decency are maintained. The IMB produces an annual report of its work.

15. The National Offender Management Service responded to the draft report. They identified no factual inaccuracies and we include their response to the recommendations at the end of the report.

HMP BIRMINGHAM

16. HMP Birmingham is a large local prison serving the courts of Birmingham and much of the West Midlands. It holds up to 1,450 remand and sentenced adult male prisoners. Since 1 October 2011, the prison has been managed by G4S Care and Justice Services.

Her Majesty's Inspectorate of Prisons

17. The report of the most recent inspection of Birmingham in January 2012 is not yet published. At an unannounced full follow up inspection in December 2009, inspectors found that healthcare provision at the prison was generally satisfactory. It was largely delivered from a modern purpose built unit by three distinct groups of staff working in primary care, in-patient care and visiting specialists. Relationships between healthcare staff and prisoners were identified as good, particularly on the in-patient wards.

Independent Monitoring Board

18. The most recent annual report published by the Birmingham IMB covers the period 1 July 2010 to 30 June 2011. The Board wrote that "all cells have been redecorated and one has been designated for 'end of life' care with funding from the King's Fund". They noted that there had been problems with prisoners missing healthcare appointments but external appointments functioned well. Overall the IMB said they had observed a good level of care being provided.

Previous deaths in custody at Birmingham

19. The man's death was one of 27 deaths to have occurred at Birmingham since April 2004, when this office began investigating all deaths in prison custody in England and Wales. Twenty two of these deaths were due to natural causes. We have had cause to comment on the lack of trained family liaison officers at Birmingham and repeat a recommendation in this investigation.

ISSUES

The diagnosis of the man's terminal illness

20. The man first arrived at HMP Birmingham on 3 December 2010. His medical record shows that he was seen on the wing by a nurse after complaining about pains in his chest. He was prescribed paracetamol and ibuprofen. He was released on licence from Birmingham on 16 February 2011.
21. On 26 March 2011, he was recalled to prison. The same day a nurse carried out a medical assessment on him. The nurse noted that there were no concerns about his physical health and he had not seen a doctor in the community during his short period of release from prison. He was considered to be fit for allocation to a general wing and work.
22. The man had a further health assessment on the same day with a prison doctor. He noted that the man was suffering from symptoms associated with drug withdrawal. Because his urine tested positive for diazepam⁴ but negative for buprenorphine,⁵ he was started on a four week detoxification programme and prescribed medication to relieve his withdrawal symptoms. The medical record shows that prison doctors regularly reviewed his detoxification programme.
23. On 5 April 2011, a locum⁶ prison doctor saw the man, who told the doctor that he took iron tablets as he was anaemic. The doctor noted that his last blood test was in July 2010, the results of which had not shown any sign of anaemia, so decided that a further blood test should be arranged. His medical record shows that the blood test took place on 26 April. However, there is no evidence in his medical record that the results were received or recorded.
24. The clinical reviewer notes that this indicates either the test did not take place or the results are missing. He considers that this should have been investigated by healthcare staff to determine if the blood test took place as arranged. In his opinion, the missing blood test results "suggest a lack of governance over clinical follow-up of blood tests. This is a patient safety issue".

The Head of Healthcare should ensure that healthcare staff follow up the results of blood tests and include these in prisoners' medical records.

25. A nurse saw the man in his cell on 14 June as he had complained about abdominal pain in his left side. He said his pain was worse when he breathed in, and he was unable to lie down or bend over. The following day, another nurse saw him. He said his abdominal pain had settled, but he wanted to see

⁴ Diazepam is used for the short-term relief of symptoms related to anxiety disorders.

⁵ Buprenorphine is a prescription medication for people addicted to heroin or other opiates that acts by relieving the symptoms of opiate withdrawal such as agitation, nausea and insomnia.

⁶ A locum doctor is a doctor who works in the place of the regular doctor when that doctor is absent, or when a hospital/practice is short-staffed.

a doctor. An appointment was made for 20 June. The records show that he did not attend this appointment. On 24 June, he went to healthcare complaining of pain in his kidney area. A nurse noted that his skin was tinged with yellow and made an urgent referral to the doctor. The locum doctor saw him on the same day and referred him for urgent blood tests.

26. On 28 June, the man was reviewed in his cell by a prison doctor. The doctor noted that his abdomen was distended and swollen and decided he should be sent to hospital for further investigation.
27. The following day, the man was admitted to hospital. On 1 July, he underwent a CT scan⁷ of his abdominal area. The results showed that he was suffering from cancer of the liver which had spread to several parts of the body, including his lungs. He was told of his condition on 4 July. This was confirmed by the results of a biopsy taken on 13 July which showed that he was suffering from hepatocellular carcinoma⁸ which had spread to his lungs.
28. The clinical reviewer raised a further area of concern. He notes that on two occasions the man complained of pain which required an urgent medical assessment. On 6 February 2011, he complained of chest pain and, on 14 June, he complained of abdominal pain. Each time he was offered a doctor's appointment one week later which he failed to attend. The clinical reviewer writes:

“It is normal practice for chest pain and acute abdominal pain to be assessed on the same day or at the very latest the following day. The precise nature of the abdominal pain is not clear but this is a potential patient safety issue”.

The Head of Healthcare should ensure that prisoners who require urgent appointments are seen by a doctor within twenty four hours.

29. Despite these issues, the clinical reviewer has commented that the man's condition was diagnosed two weeks after he first displayed symptoms. The clinical reviewer notes that this was within the two week urgent referral window for suspected cancer. He writes that it is doubtful that his condition could have been detected earlier, although with hindsight the blood test in April could have shown early signs of abnormality.

Informing the man about his condition and treatment

30. Following the results of the CT scan, the man was told on 4 July by a consultant physician and gastroenterologist at hospital that he had cancer in his liver and lung. A biopsy was taken on 13 July which showed that he had primary liver cancer which had already spread to other organs.

⁷ A CT (computerised tomography) scanner is a special kind of X-ray machine. Instead of sending out a single X-ray through your body as with ordinary X-rays, several beams are sent simultaneously from different angles.

⁸ Hepatocellular carcinoma (HCC) is the most common type of primary liver cancer.

31. On 15 July, a meeting took place between the man, his family and a Macmillan clinical nurse specialist. A nurse also attended from the prison healthcare department. The Macmillan nurse explained the results of the biopsy to him, and said it was unlikely that his condition would be improved by chemotherapy treatment. However, she planned to discuss this further with a consultant oncologist. His medical record reveals that he was upset by the news of his condition and did not wish to be told any further information about his prognosis.
32. His medical records show that he was informed of his diagnosis by staff at the hospital. His family attended a meeting with a Macmillan nurse which offered them the opportunity to raise any questions regarding his prognosis. Although it appears that he did not wish to know details of his condition, we agree with the clinical reviewer that he was told of his condition in an appropriate manner.

The man's medical appointments and treatment

33. Following a review by a doctor, the man was admitted to hospital on 29 June, where he remained before he returned to prison on 26 July. During this time he was diagnosed with liver cancer. His records show that he was regularly reviewed by the doctor and visited by prison healthcare staff.
34. A multi-disciplinary team (MDT) meeting took place on 7 July to determine the man's treatment. It was decided that he would undergo a liver biopsy and be referred to a consultant oncologist⁹ at another hospital. On 14 July, the consultant physician and gastroenterologist wrote to the consultant oncologist noting that the man was aware that his condition was incurable, but asking if he could be seen in his clinic to investigate whether his condition would be suitable for palliative chemotherapy. He was not able to be seen by the consultant oncologist before he died.
35. On 15 July, the Macmillan nurse told the man the outcome of the MDT meeting and that his condition might be suitable for palliative chemotherapy. However, she noted that it was possible that his deteriorating health could mean that he was unable to tolerate the treatment. In the event he did not receive any treatment, other than palliative care.
36. The man returned to prison on 26 July but following a rapid deterioration in his condition he went back to hospital the following day. He remained in hospital until he died in August.
37. The clinical reviewer has not raised any concerns about the man's medical appointments or treatment following his diagnosis. We agree that his treatment was appropriate.

⁹ An oncologist is a doctor who specialises in the treatment of cancer.

The man's pain relief and medication

38. On his return to prison from hospital on 26 July, the discharge letter from the consultant physician and gastroenterologist said that he had been prescribed morphine for pain relief and dexamethasone¹⁰ to relieve the symptoms of his condition. He was also given fortisips¹¹ to aid nutrition. The consultant said he should continue with the prescribed medication in prison.
39. The man's medication was reviewed by a prison doctor and was advised to inform healthcare staff if he had any concerns about his pain management. The doctor noted in his medical records that he did not raise any concerns at this time.
40. The man's family have asked why he did not receive medication after 10.00pm on 26 July. The Head of Primary Care at Birmingham explained that medication is routinely given to prisoners twice a day. The clinical record shows that he was given his evening medication on 26 July at 7.51pm by a nurse. Although night staff entered his cell at 3.30am because he had fallen out of bed, he did not tell healthcare staff that he was in pain or request any additional medication.
41. At 9.00am on 27 July, a nurse went to his cell to administer his morning medication of zomorph, morphine sulphate, cyclizine and dexamethasone. He was lying in bed and, while he was able to respond to her voice, he required a 'mild shake to his shoulder' to remain awake. The nurse was unable to give him his medication as he would not open his mouth. She sought advice from the doctor who advised her to concentrate on making him comfortable. He was given a full bed bath and his bed sheets were changed. The Head of Primary Care said the nurse acted appropriately in seeking advice from the doctor when he declined his medication on 27 July. We are satisfied this was the correct action.
42. The clinical reviewer commented that the man received his evening medication as prescribed on 26 July and would only have received additional medication on request. He raised no concerns and we are satisfied that his pain relief and medication was managed appropriately.

Liaison with the man's family

43. The family consider that the communication with them by the prison had been poor. They told the investigator and the FLO that they were concerned that they had not been informed when he was admitted to hospital on 29 June. They said they had been told by the prison that there was a requirement to wait thirty six hours before informing the family.

¹⁰ Dexamethasone is a type of medicine known as a corticosteroid. Corticosteroid medicines are derivatives of the corticosteroid hormones cortisol and aldosterone that are produced naturally by the adrenal glands. They are often simply called steroids

¹¹ Fortisip is a therapeutic food manufactured by Nutricia. It is a ready-made milkshake style drink meant for consumption by people who cannot consume enough solid food to maintain a balanced diet; when appetite is poor and nutritional requirements are not being met through ordinary food.

44. Prison Rule 22 requires governors to inform the prisoner's spouse or next of kin when a prisoner 'becomes seriously ill'. However, on 29 June the man's condition was not known and he was admitted to hospital for tests. Arguably, any unknown condition which requires hospital in-patient admission is likely to be serious, and in the event it was. However, he was allowed to telephone his family the next day. In the circumstances, we do not consider that there was an unreasonable delay in his family being informed.
45. An operational manager at Birmingham said she met the man's family at hospital on 27 July, when she was completing a management check of the escort arrangements. She spoke to his sister in law and exchanged contact details, but could not recall if she had told them that she would be acting as the prison's family liaison officer (FLO) at that stage. She said she met his family again on 3 August at the hospital, and they had not raised any concerns with her.
46. The day after the man died, the FLO telephoned the man's brother and mother and arranged to visit his mother on 9 August. At the meeting with her, she explained that the prison would contribute to funeral expenses. The man's mother said some items of his property were missing, in particular a pair of trainers, which she wished him to be buried wearing. The FLO made a note that the trainers needed to be returned.
47. An entry in the FLO log on 10 August indicated that she believed she had successfully tracked down the man's trainers and intended to return them to his family before his funeral which took place on 24 August. This was not done and she explained to the investigator that she had mistakenly believed they had been found on 10 August. She apologised for any distress that this might have caused the family. The family explained to the investigator when they met on 20 September 2011 that they had not received them and they were unhappy that the prison FLO had not contacted them about this. We understand that his property has now been returned after we raised this with the prison.
48. We do not consider that the family received the standard of communication and support we would expect. This is not a direct criticism of the individual member of staff acting in the FLO role, who had been asked to do so without having received family liaison officer training. We understand that at the time of the man's death Birmingham only had one trained FLO. We have been told that other suitable members of staff have since been identified for the role and are waiting for FLO training.

The Director of Birmingham should ensure that the prison has sufficient trained family liaison officers.

The man's location

49. The man was a patient at hospital from 29 June where he was diagnosed with liver and lung cancer on 4 July.

50. Following his diagnosis, two Birmingham hospices were identified as suitable locations for him. The man's first choice of hospice was one close to his family. On 19 July, the Macmillan nurse was told by the hospice manager at that hospice that a suitable bed could not be found. On 20 July, a Macmillan nurse at the hospital informed the prison that he was not yet suitable for a move to a hospice. The same day a Governor spoke to a doctor at another hospice. The doctor explained that the man might not be suitable for a hospice environment as his life expectancy was longer than two weeks at that stage.
51. On 20 July, hospital staff informed the Head of Offender Health at Birmingham that, as the man was not receiving any medical treatment, there was a possibility that he would be discharged to the prison. He stated that he wanted to return to K wing where he shared a cell with a relative, rather than to the healthcare unit. He was worried that he would be harmed by other prisoners in the unit who were suffering from mental health problems, and he did not want to be in a single cell. The Operational Manager told him that he would go to the physical health ward in the inpatient unit rather than the mental health ward.
52. On 26 July, he returned to prison as an inpatient on the healthcare unit. The clinical reviewer considers that his return to prison from the hospital on 26 July was not appropriate. He notes that one of the prison managers stated on several occasions that the prison was not staffed to provide the appropriate palliative care that he required. The clinical reviewer writes:
- “It is highly probable that the hospital staff were aware that he would have limited life expectancy. It is my opinion that it was not safe, suitable or respectful to the patient's wishes to return to die in prison and he should have remained in hospital until a suitable hospice or nursing home bed became available. “
53. We agree with the clinical reviewer that ideally he should have remained in hospital on 26 July until a hospice bed became available, but the decision of the hospital is outside the remit of this office. However, we are concerned that a prison with such a large in-patient unit as Birmingham should apparently not have the facilities to provide appropriate end of life care. We make the make the following recommendation:
- The Director and Head of Healthcare should ensure that prisoners who need end of life care should be supported in appropriate facilities, preferably in the community, but in the prison where necessary.**
54. Following the man's fall out of bed on 27 July prison healthcare staff informed both hospices that his condition had deteriorated. At this point, it became apparent that his name had been removed from the waiting list at one hospice and there were no available beds at the other. The decision was made to return him to hospital.

55. The man's family asked why an ambulance was not called until midday on 27 July, despite the deterioration in his condition. The Head of Primary Care explained that when he fell out of bed at 3.30am on 27 July, healthcare staff noted an obvious deterioration in his condition. However, they did not consider that he should return to hospital immediately because at that time it was likely he would have been temporarily held in the accident and emergency department for some hours before he was admitted to a ward. She also believed that he might have been restrained and in her opinion this would have been undignified.
56. In the clinical reviewer's opinion, the man's fall out of bed would not have required immediate readmission to hospital. He shares the Head of Primary Care's view that a transfer during the night might have led to an undignified wait on a hospital trolley in the accident and emergency department. He returned to hospital the next morning at 11.45am, and we consider this was reasonable in the circumstances.

Compassionate/temporary release

57. Prison Service Order (PSO) 6300 sets out the policies and required actions that the Prison Service must undertake when considering an application for release on temporary licence (ROTL). Any release on temporary licence will only take place once the prisoner has satisfied a stringent risk assessment carried out by a designated ROTL Board at the prison. Prison Governors have an overriding duty, when considering any release, to ensure that both public safety and public confidence in the system are maintained. There is no automatic right of entitlement for release on temporary licence to be granted.
58. The man's application for ROTL was first considered on 19 July 2011 by an operational manager at the prison. This was four days after his initial diagnosis when he was still fully mobile. The manager noted that he was a licence recall prisoner who was originally sentenced for threats to harm and harassment of his ex-partner. He was described as very high risk to his victim and high risk to children. The manager did not support his application for ROTL because of these risk factors. He noted that the decision to refuse ROTL would be reviewed if there was a deterioration in his health. On 27 July, his application for ROTL was reconsidered, and he was released on a special purpose licence¹² to hospital.
59. Prisoners who are diagnosed with a terminal illness can also be considered for early release on compassionate grounds. Prison Service Order 6000 (Parole release and recall) explains that the principles underlying the approach for early release on compassionate grounds are:
- The release of the prisoner will not put the safety of the public at risk.
 - A decision to approve release would not normally be made on the basis of facts which the sentencing or appeal court was aware.

¹² A special purpose licence might be granted for prisoners to attend medical out-patient appointments, or in patient requirements.

- There is some specific purpose to be served by early release.
60. Early release might be considered on medical grounds where a prisoner is suffering from a terminal illness and death is likely to occur soon. The decision to release a prisoner on compassionate grounds is made by the Secretary of State, taking into account information provided by Prison Service staff and medical opinions. There are no set time limits but three months is considered to be an appropriate period. A clear medical opinion on life expectancy is required. The Secretary of State will also need to be satisfied that the risk of re-offending is past and that there are adequate arrangements for the prisoner's care and treatment outside prison. There is also a requirement that the early release of a prisoner will bring some significant benefit to the prisoner or his family.
 61. On 21 July, the consultant physician and gastroenterologist wrote to the prison to support his application for early release. He said the man was terminally ill with a predicted life expectancy of two to three months.
 62. A prison manager explained the process of applying for early release on compassionate grounds to the man on 26 July when he returned to the prison. The manager said that he would start the process, but because he was released on temporary licence the next day, his application for early release on compassionate grounds was not progressed.
 63. This investigation has found that the man was considered for ROTL following his diagnosis. The initial decision to refuse his application was appropriately based on the risks factors associated with his offending history. When his condition deteriorated his application was reconsidered. We consider it appropriate that he was released on a special purpose licence at this time. While release on compassionate grounds would have been preferable, it is unlikely this could have been considered in time.

Palliative care plans

64. The man was supported by a Macmillan clinical nurse specialist at the hospital. On 12 July, he was visited by her and given advice about eating a high calorie diet. She attended the multi disciplinary team (MDT) meeting with his family on 15 July and provided information on his diagnosis and possible treatment options.
65. There is no record of an end of life pathway in his medical notes or any entry which suggests that an end of life care plan was being prepared. The National End of Life Pathway Programme promotes a high standard of care for all prisoners regardless of diagnosis at the end of life. This is achieved by improving the quality of care offered and enhancing dignity and choice for serving prisoners approaching the end of life. The core principles for the delivery of end of life care are :
 - Treat individuals with dignity and respect
 - Identify and respect people's preferences

- Provide information and support to families and carers
- Recognise and respect and individual's spiritual and religious needs
- Provide effective pain and symptom management
- Provide care after death
- Ensure care is patient-centred and integrated
- Provide a safe environment for care

66. The man was diagnosed with his condition on 4 July 2011. Prison healthcare staff were kept informed of his diagnosis, and that he would not be receiving any treatment. While we consider he received appropriate care, and many elements of the pathway were fulfilled, we believe that at the point of diagnosis healthcare staff should have started the process of developing a formal end of life care plan for him. This would have helped to ensure that his needs and preferences were fully considered and coordinated by all involved.
67. On 27 July, a locum prison doctor noted in the man's medical record that he had been advised by healthcare staff that he was 'still for active resuscitation'. The doctor noted that given his significantly poor prognosis this was inappropriate and, in the event of a cardio respiratory arrest¹³, he should not be resuscitated. There is no evidence in his medical record that a discussion was held with him about his resuscitation status or that a Do Not Resuscitate (DNR)¹⁴ was completed. Had an end of life care plan been completed this would have helped ensure he was consulted.

The Head of Healthcare should ensure an end of life care plan is completed and implemented for prisoners who have been diagnosed with a terminal illness.

Restraints, security and bedwatch

68. When the man was first taken to hospital on 29 June, he was double handcuffed and escorted by two members of staff on the journey there. The risk assessment said that he was regarded as a medium risk of escaping from custody and a high risk to staff and the public.
69. A medical assessment was completed in the accident and emergency department which said that there were no medical objections to restraints being used. His medical condition did not restrict his ability to escape and the treatment he required would not require the removal of the restraints. Later that day he was moved to a main ward. His handcuffs were removed and he was placed on an escort chain¹⁵. The risk assessment for restraints did not change during his time in hospital.

¹³ A cardiorespiratory arrest (also known as a cardiac arrest) is the cessation of normal circulation of the blood due to failure of the heart to contract effectively

¹⁴ A 'do not resuscitate' form is a legal order written either in the hospital or on a legal form to respect the wishes of a patient to not undergo CPR or advanced cardiac life support if their heart were to stop or they were to stop breathing. This request is usually made by the patient or health care power of attorney and allows the medical teams taking care of them to respect their wishes.

¹⁵ An escort chain allows a prisoner officer to maintain discreet control of a prisoner.

70. The following day, the risk assessment was reviewed because the man had been moved to a side ward. He was then authorised to make telephone calls to his family and receive visits.
71. His family asked why these measures were used in hospital given his medical condition. When he was in hospital between 29 June and 26 July, the escort (bedwatch) records show that he was mobile and able to use the hospital facilities, such as the shower, independently. He also went for walks around the hospital, escorted by prison staff. He was still mobile when he left the hospital. We are satisfied that, on the basis of the assessed risk, an escort chain was appropriate.
72. On 27 July, the man returned to hospital following a sudden and significant deterioration in his health. The risk assessment completed on 27 July describes him as a “semi conscious, deteriorating patient”. For this reason he was not restrained and escorted by two prison officers. He was released on temporary licence later that day.

CONCLUSION

73. When prison doctors became concerned about the man's distended abdomen he was sent to hospital where he was found to be suffering from a rare malignant tumour in his liver. The clinical reviewer has concluded that his condition was diagnosed within the two week urgent referral period for suspected cancer.
74. He was returned to prison on 26 July 2011, when a bed could not be found at one of the two local hospices. Following a rapid deterioration in his condition, he was readmitted to hospital the following day. The clinical reviewer considers that it was not appropriate to return him to prison because it was unable to offer the level of palliative care that he needed. We consider the prison should be able to provide such support.
75. His family were not offered appropriate support by a trained family liaison officer due to a shortage of suitably trained staff.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that healthcare staff follow up the results of blood tests and include these in prisoners' medical records.

The National Offender Management Service accepted this recommendation:

"The Head of Primary Care will review the current service provision and develop a new system of monitoring, which is in accordance with this recommendation"

2. The Head of Healthcare should ensure that prisoners who require urgent appointments are seen by a doctor within twenty four hours."

The National Offender Management Service partially accepted this recommendation:

"All prisoners who request an urgent appointment are seen by a Doctor that day if clinically indicated following nurse triage."

3. The Head of Healthcare should ensure an end of life care plan is completed and implemented for prisoners who have been diagnosed with a terminal illness.

The National Offender Management Service accepted this recommendation:

"A palliative care/chronic disease nurse has been appointed from June 2012 and is developing an end of life policy which will include care planning, in conjunction with the local hospice with whom the prison negotiate appropriate respite and end of life care, as appropriate."

4. The Director of Birmingham should ensure that the prison has sufficient trained family liaison officers.

The National Offender Management Service accepted this recommendation:

"The Number of Family Liaison Officers currently in post at HMP Birmingham has been increased to 4. A further 2 members of staff are currently waiting for a FLO course to become available."

5. The Director and Head of Healthcare should ensure that prisoners who need end of life care should be supported in appropriate facilities, preferably in the community, but in the prison where necessary. .

The National Offender Management Service accepted this recommendation:

"There is a dedicated cell on the physical health ward currently being upgraded for end of life care. This should be decorated and finished by the end of August 2012. As detailed in the response to recommendation 3

(above), this will be used in conjunction with an end of life care plan and supported by the local hospice.”