

**Investigation into the death a man in December 2011  
while a prisoner at HMP Birmingham**

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

**January 2013**

This is the report of an investigation into the death of a man at HMP Birmingham, who died in John Taylor Hospice. A post mortem recorded the man's death as being due to a blockage of the arteries supplying blood to the intestines, caused by a blood clot and cancer. I extend my condolences to his family and friends.

The investigation was carried out by one of my investigators. A clinical reviewer was appointed to conduct a review of the clinical care the man received while in custody. Staff at Birmingham cooperated with the investigation. I apologise that the report has been delayed.

The man had been ill for some months but was not formally diagnosed with terminal lung cancer until 2 November 2011. He was admitted to hospital on 17 November and moved to the hospice in December a day before he died. The clinical reviewer found that the man's treatment for his cancer was complicated by an initial diagnosis of TB, but that he received appropriate treatment. The clinical reviewer noted that prison staff showed genuine concern for his care but there was a lack of an overarching strategy or formal end of life pathway to ensure that palliative care was properly co-ordinated.

The man remained in custody till the end of his life and was not released either temporarily or permanently on compassionate grounds. There were grounds to support these decisions, but there appears to have been a confused approach to the assessment of his risk which did not always focus sufficiently on the man's actual risk at the time, taking account of his medical condition. Nevertheless, I am pleased to note that, with regard to security issues in hospital and at the hospice, risk was appropriately and humanely managed.

The recommendations made in the draft report have been accepted by HMP Birmingham. I have included the prison's response to the recommendations at the end of this report.

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**

**January 2013**

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## SUMMARY

1. The man died in December 2011 at a local hospice. He died of natural causes as a consequence of mesenteric ischaemia<sup>1</sup> caused by thrombosis of the superior mesenteric artery (a blood clot in the artery supplying blood to the intestines) and widespread cancer (metastatic carcinoma). He had been diagnosed with terminal cancer on 2 November 2011.
2. The man was first remanded into custody at HMP Birmingham in 1967. On 1 April 1968, he was sentenced to life imprisonment and held at various prisons over the years before he returned to HMP Birmingham on 29 November 2007. He worked as a cleaner and in the laundry at the prison until he was too unwell to work.
3. The man was a smoker. He was offered and declined assistance to help him stop smoking on a number of occasions. When he was diagnosed with terminal lung cancer on 2 November 2011, he was offered the option of moving to the prison's healthcare centre but initially declined. On 17 November, the man agreed to move to the healthcare centre, but was so ill he was taken to outside hospital.
4. After the man's condition worsened he moved to a hospice where he died the next day. His partner of a number of years was at his bedside when he died.
5. The clinical reviewer, considered both the care provided for the man throughout his time in prison and when he transferred to hospital. In the clinical reviewer's view, the general standard of care given to the man was not equivalent to what is available in the community.
6. After the man died, his estranged family came forward. The man had made no will so they were recognised as next of kin. This led to a long and complicated process because the man also had a longstanding partner. As a result the man's funeral was delayed for a number of months.
7. We make three recommendations relating to end of life care, the use of dietary supplements and risk assessment for release on temporary licence.

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<sup>1</sup> The mesenteric arteries are the arteries that supply blood to the intestines. Ischemia occurs when blood cannot flow through the arteries as well as it should, and the intestines do not receive the necessary oxygen to perform normally. Mesenteric ischemia usually occurs when one or more of the mesenteric arteries narrows or becomes blocked. When this blockage occurs, the patient can experience severe abdominal pain.

## THE INVESTIGATION PROCESS

8. The Ombudsman's office was informed of the man's death in December 2011. The investigator issued notices to both staff and prisoners at HMP Birmingham to inform them of the investigation process and asking anyone with relevant information to contact him. No responses were received.
9. A clinical reviewer was commissioned to review the man's clinical care during his time in custody. The clinical reviewer's report was received on 27 April 2012.
10. The investigator visited HMP Birmingham on 12 December and spoke to staff involved in caring for the man. He examined the man's relevant prison records including his medical records. He returned to Birmingham on 17 January to interview First Line Manager, Head of Safer Custody, and Officer A. He also interviewed two prisoners; Nurse B was interviewed by the clinical reviewer.
11. On 17 January, the investigator gave initial feedback to the operational manager at Birmingham and later confirmed this in writing to the Director.
12. HM Coroner for Birmingham District was informed of the investigation and provided a copy of the post-mortem report. The Coroner will be sent a copy of this investigation report.
13. One of the Ombudsman's family liaison officers contacted the man's partner and his family. She explained the purpose of the investigation and offered the chance for them to raise any concerns about the man's care at Birmingham. The investigator and the family liaison officer met the man's partner. She had concerns about the man's healthcare while he was in custody and his sentence progression. We have attempted to address these issues in the report. The man's partner received a copy of the draft report and she raised further issues in light of the findings. She noted the recommendations made in relation to the use of dietary supplements and risk assessment for release on temporary licence. The man's partner felt that the diet provided by kitchen staff at Birmingham was particularly high in fat and salt and not suitable for someone with a heart condition. She agreed that estimating risk should be made on current rather than past behaviour and situations. The man's partner also mentioned the problems she encountered in relation to property not being returned to her. Although she spoke to both the police and staff at Birmingham, she was not provided with an opportunity to retrieve personal items before belongings were given to his family. The man's partner was also grateful for the compassion shown by some of the staff and prisoners interviewed during this investigation.
14. We apologise for the delay in issuing this draft report, due to work pressures in the Ombudsman's office.

## **HMP BIRMINGHAM**

15. HMP Birmingham is a large local prison serving the courts of Birmingham and much of the West Midlands. It holds up to 1,450 adult male prisoners, on remand and sentenced. Birmingham is the first public sector prison to be transferred to private sector management. G4S assumed responsibility for Birmingham on 1 October 2011 and will manage the contract for the next 15 years.
16. Healthcare is provided by NHS Birmingham and Solihull. The unit has 24 hour nursing cover staff, with an in-patient care unit in the healthcare centre.

## **HM Inspectorate of Prisons (HMIP)**

17. The last inspection of HMP Birmingham by HMIP was in January 2012. About healthcare the report noted:

“There was a good range of community-equivalent clinical services, but prisoners’ views about the quality of health services were relatively poor. Reasons for these perceptions needed examination but part of the problem was a flawed appointment system. Clinical staff were well qualified and primary care services were delivered professionally... Pharmacy services were generally good but night medication was issued very early. Inpatient facilities were impressive and backed up by good quality care....The management of external NHS appointments was very efficient and security did not hamper prisoner attendance at external appointments.”

## **Independent Monitoring Board**

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

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

## **Multi-Agency Protection Arrangements**

20. Multi-Agency Public Protection Arrangements (MAPPA) support the assessment and management of the most serious sexual and violent offenders. The aim of MAPPA is to ensure that a risk management plan is drawn up for the most serious offenders that benefits from the information, skills and resources provided by the individual agencies, including the police, co-ordinated through MAPPA. There are three levels of MAPPA which provide for

different levels of input from the various agencies. Level three is the level for those who present the highest risk. The man was assessed at MAPPA level three, for those who present the highest risk.

### **The Parole Board**

21. The Parole Board is an independent public body that works with criminal justice partners to protect the public by risk assessing prisoners to decide whether they can be safely released into the community.
22. In relation to life sentenced prisoners, the Parole Board advises when a life sentenced prisoner is suitable for transfer to an open prison in preparation for release and decides on suitability for release once the prisoner has served the minimum time to serve set by the courts.

### **Previous deaths at Birmingham**

23. Since 2009, the Ombudsman has investigated 10 deaths through natural causes at Birmingham, including that of the man. Although not related to the circumstances of the man's death, the clinical reviewer noted a lack of chronic disease management about which we have previously made recommendations at Birmingham. The clinical reviewer makes a further recommendation about this issue.

## KEY EVENTS

24. The man was born in Birmingham. He died in December 2011, at a local hospice.
25. On 20 December 1967, the man was remanded into custody at HMP Birmingham. On 1 April 1968, he was sentenced at Birmingham Crown Court to life imprisonment and sent to HMP Parkhurst.
26. In 1973, the man was involved with other prisoners in an unsuccessful escape attempt from Parkhurst by digging a tunnel. The man subsequently progressed through his sentence and transferred to HMP Lindholme open prison in 1994 as part of his preparation for release. In 1995, due to concerns raised about his behaviour the man was returned to a closed prison. He was later held at various prisons before he returned to HMP Birmingham on 29 November 2007.
27. On 18 August 2008, a Judge at Birmingham Crown Court decided that a further charge from 1961 should be stayed (deferred) as he felt the man could not receive a fair trial due to passage of time since the offence was committed.
28. On 9 June 2009, the Parole Board considered the man's suitability for release or for a move to an open prison. Although the man had undertaken some offending behaviour work, the Board was not satisfied that he was suitable for release on licence or transfer to open conditions and believed he still needed to complete certain offending behaviour programmes.
29. On 22 September 2010, the man's sentence was reviewed again. His offender supervisor did not consider he was ready for direct release into community but she supported a progressive move to an open prison.
30. The Parole Board considered the man's case and recommended on 4 February that he move to open conditions. On 10 February, the Public Protect Casework Section of the National Offender Management Service (NOMS) wrote to the man on behalf of the Secretary of State. The letter confirmed the Secretary of State agreed with the Parole Board's decision and that his case would be referred to the Board again in July 2012 for the following reasons:
  - A robust risk management and release plan needed to be developed.
  - As the man had been in custody for 43 years he would need a sufficient amount of time to adjust to life in an open prison and for his eventual release.
  - He also needed to engage in rehabilitation work to his address his sexual offending behaviour.
31. On 20 February 2011, Nurse B saw the man as officers were concerned that he was not eating. The nurse recorded that the man weighed 56 kilograms and was "possibly underweight for height". The man had been buying nutritional drinks and asked if they could be prescribed. A prescription was not issued at the time.

32. Dr A, a prison doctor, saw the man on 1 March and noted that he had finger clubbing (a phrase used to describe the changes in fingers and fingernails that sometime occur in people with heart or lung problems and some cancers). The doctor arranged a chest X-ray within two weeks as he was concerned about cancer. He also requested blood and stool tests. He prescribed a carton of Ensure Plus (a nutritional supplement drink). The man attended hospital for an X-ray on 8 March. The results showed suspected cancer and further investigations were recommended.
33. On 16 March, Dr A informed the man of the X-ray findings and the need for further tests. He recommended the use of regular nutritional supplement drinks and prescribed two cartons of Ensure Plus. On 27 March, Nurse B carried out a review of the man's capacity to undertake daily tasks and discussed the possible diagnosis of cancer with him. The man was offered a transfer to the healthcare centre but declined.
34. On 20 April, a computerised tomography (CT – a scan that uses detailed images to view the inside of the body) guided biopsy (where a small sample of tissue is taken) was abandoned by the hospital as preliminary scans showed that the suspicious area had become smaller. The man was asked to return to the hospital two months later for a repeat scan.
35. On 14 May, the man started work in the laundry on D wing. Previously he had worked as a cleaner in the visits hall. Three days later, on 17 May, he attended an appointment with Dr B and his weight was recorded as 60kg.
36. Prison Custody Officer (PCO) A told the investigator that because of his health issues, the man had signed a disclaimer postponing a move to an open prison for medical reasons. A potential transfer had been arranged but the man wanted to be able to attend his hospital appointments easily. PCO A said:

“He was unsure whether to sign the disclaimer at first because obviously he was desperate to go... to finally get his cat D but he knew that here he was guaranteed hospital appointments ...he wanted to think about it and asked her to come back on the Monday which she did and he signed it.”
37. On 19 July, the man attended a clinic appointment at the local hospital. It was recorded that his appetite was okay and his weight was steady. He was booked for a repeat CT scan. The scan showed that the suspicious area was smaller than the original scan but larger than seen on 20 April. The result of the scan was recorded as “suspicious of malignancy”. There were no entries in the medical records about how or whether the man was told.
38. On 9 August, the man attended a clinic appointment at the local hospital and was told he required a bronchoscopy (which allows a view of the airway and any abnormalities). This was carried out the following day.

39. On 11 August, the hospital informed healthcare staff at Birmingham that there was evidence the man had tuberculosis (TB), for which treatment started immediately. His weight was recorded as 60kg.
40. A week later, on 16 August, the man did not attend a clinic appointment at the local hospital. The reason for his non-attendance was not noted in his clinical records. His records at that stage indicate that it appeared he had TB and a possibility of cancer. The man's case was to be discussed by the respiratory team at the hospital.
41. Dr C, another prison doctor, saw the man on 20 September. He recorded his weight as 56kg and that he had shoulder pain and loss of appetite. He issued two cartons of Ensure Plus and prescribed tramadol (a strong painkiller) to be taken once a day. The next day, 21 September, the man attended outside hospital. Analysis suggested he did not have TB, but a consultant decided that the treatment for TB should continue and asked for a repeat CT scan in four weeks.
42. Dr C saw the man on 30 September. He prescribed a higher dose of tramadol as the man was still complaining of pain in his chest. On 17 October, the man saw Dr C again as he was experiencing breathing difficulties and pain. The man declined hospital admission for pain control and was prescribed morphine solution and zopiclone (a sleeping tablet). The following day, 18 October, the man attended a clinic appointment at the local hospital. It was recorded that he was still unwell and it was regarded as unlikely that he had TB, but the treatment would continue until the results of further tests.
43. On 21 October, the man was admitted to hospital for fluid to be drained from his lungs (a diagnostic pleural tap). Two days later, on 23 October, it was recorded that the man was in a lot of pain and was given oramorph (liquid morphine). He continued to resist being admitted to the healthcare centre.
44. On 25 October, the man was recorded as looking "frail and wasted". The next day, when Dr B saw him, the man complained of being in constant pain. The doctor suggested he move to the healthcare centre but he preferred to stay in his cell on D wing. At a review on 27 October, the doctor recorded that the man was using morphine solution regularly and changed the prescription to regular slow release morphine tablets. He also prescribed laxatives as the man had constipation.
45. On 31 October, Dr B again suggested a transfer to healthcare but the man said that he would only consider moving when he could no longer manage the stairs. The possibility of a Macmillan Nurse to support him was discussed. The doctor noted in the man's records: "Understands likely serious underlying diagnosis although not been discussed with him in so many words".
46. On 2 November, a mental health nurse, reviewed the man and noted that his "mental health appeared stable, no evidence to suggest low mood despite his physical health issues". Another assessment of his daily living capabilities was

undertaken and it was noted that he remained constipated. It was recorded that the local hospital was to be contacted for a Macmillan Nurse referral.

47. The same day, 2 November, the hospital telephoned to confirm a diagnosis of cancer and that the man's prognosis was very poor. It was estimated that he had no more than two months left to live. That afternoon, Dr B and Staff Nurse A saw the man and informed him of the diagnosis. It was recorded that the man was "happy that it had finally been diagnosed, understands it is a terminal condition". The man was offered the opportunity to move to the healthcare centre but again declined to move. The man agreed that because of his irreversible condition he should not be resuscitated in the event of cardio-respiratory arrest and this was recorded in his clinical record.
48. On 3 November, a meeting was held to agree a management plan for the man's care. The man still wanted to stay on D wing for as long as possible. Entries in the clinical record suggested he had increased pain. The plan of care included a daily review by the prison doctor and twice daily reviews by primary care nurses. The man said that he had no blood relatives and his next of kin was his partner. The Healthcare Manager informed the man's partner of his diagnosis and acted as the prison's family liaison officer throughout the rest of his illness.
49. Dr C made a referral to the palliative care service the next day. Three days later, on 7 November, the man declined to attend an oncology clinic appointment to discuss treatment options. A member of the Independent Monitoring Board visited him in his cell and noted "The man was seen and was resting and okay".
50. The possibility of release on temporary licence (ROTL)<sup>2</sup> was considered should the man need to stay in hospital. On 8 November, as part of a risk assessment for release on temporary licence Assistant Director A, Head of Community Engagement, wrote:

"Given the notoriety of the original case and the fact he has only recently gained Cat [Category] D through the Parole Board the risk for ROTL are too high. He is also a MAPPA 3 which would appear to exclude him from ROTL".
51. On 9 November, Deputy Controller refused ROTL for the man. She recorded in her assessment that there was a "high risk of harm to children and the public. Media interest in the case" and that the man was "untested without supervision even though he had been approved for a progressive move to open conditions".

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<sup>2</sup> Release on temporary licence (ROTL) enables prisoners to participate in necessary activities, outside of the prison establishment, that contribute to their resettlement into the community and their development of a purposeful, law-abiding life.

52. The Deputy Controller's decision was:

“ROTL refused – risk in relation to the public is too high to manage should he abscond and media interest would probably highlight that public confidence in a decision to ROTL the man would not be forthcoming. His current physical health is acknowledged but the risk is too high to manage.”

53. On the same day, an application was made for release on compassionate grounds. Under section 30 of the Crime (Sentences) Act 1997, the Secretary of State may, at any time, release a prisoner on licence if he or she is satisfied that exceptional circumstances exist which justify early release on compassionate grounds. One of the criteria for compassionate release is that the risk of re-offending (particularly sexual or violent nature) is minimal.

54. The Assistant Director wrote in support of the man's application for compassionate release saying that the man's behaviour did “not bring him into conflict with the prison system, which has been necessary to his long term survival in the custodial environment”. The Assistant Director drew attention to the recent Parole Board hearing where it was agreed that the man could be transferred to open conditions. The Assistant Director also discussed the man's prognosis with Dr C and stated in the letter of support that, although the man had been given two months to live, the doctor felt his deterioration was such that “he would not be surprised if he passed away as soon as the end of the week”. The Assistant Director said:

“It is with this in mind and his limited capacity to commit any further offence, even if he should wish to do so, that I would wholeheartedly recommend that you support this application”.

55. On 10 November, a doctor from the hospice visited the man to start planning his care.

56. On 17 November, the man moved from D wing to a single cell in the healthcare centre. At around 9.15pm the same day, the man had breathing problems and was taken to the Accident and Emergency (A&E) Department of the local hospital. He was not restrained, but was accompanied by two officers. At 10.00pm, he was taken for an X-ray and had a large volume of fluid drained from his lung. At around 12.20am on 18 November, the man was admitted to the Medical Assessment Unit (MAU) at the hospital. No restraints were used while the man was in hospital, although he remained accompanied by two officers.

57. On the morning of 18 November, the man's partner was contacted as she was due to visit him at the prison and was travelling from London. Arrangements were made for her to visit the man in hospital that afternoon. She was also able to visit him in hospital on 21 and 30 November and 3 December.

58. On 2 December, a letter was received from the Early Release and Recall Section of the National Offender Management Service rejecting the application for compassionate release. The letter referred to advice from the Parole Board and stated that the Secretary of State shared the Parole Board's concerns that there was little evidence of a reduction in the man's risk factors, despite his long time in custody. The reason for the refusal was because the man did not meet all the criteria for compassionate release and that he had been "assessed as still posing a risk to others, even with your [the man's] reduced physical capability".
59. Around midday on 5 December, the man moved to the local hospice. His partner visited him there that afternoon.
60. At around 9.10am on the day the man died, a hospice nurse visited the man and commented that his breathing had changed. It appeared to be quieter and slower. Shortly afterwards she went to get a doctor and at 9.23am, a doctor and Ward Manager confirmed that the man had died. The man's partner was with him when he died.

### **Following the man's death**

61. Prison staff told the other prisoners on D wing of the man's death later that morning. They also asked whether they required any support or wanted to speak to a Listener (prisoners selected and trained by the Samaritans to offer confidential emotional support to fellow prisoners in distress). All the prisoners on self-harm and suicide monitoring arrangements were reviewed.
62. The duty manager, held a hot debrief on the day the man died with the staff involved in the bedwatch to focus on reassurance, information sharing and how staff could support each other. No areas of concern were identified and staff were offered support from the prison's care team.
63. After the man died the operational manager at Birmingham took over from the healthcare manager as the prison's family liaison officer. After his death, the man's estranged family contacted the prison and the Coroner. Although they had not had any contact with the man for a number of years, and the man had a longstanding partner, his family were recognised as his legal next of kin. This resulted in a delay in arranging the man's funeral. The operational manager maintained contact with the man's partner and his family and assisted with the funeral arrangements. The prison offered financial assistance towards the costs of the man's funeral in line with national policy.

### **Post-mortem**

64. The post-mortem report records that the man's death was due to natural causes, as a consequence of mesenteric ischaemia (blockage in the arteries supplying the intestine) caused thrombosis of the superior mesenteric artery (a blood clot) and widespread cancer.

## ISSUES

### Clinical care

65. A review of the man's medical care was carried out by the clinical reviewer Murdoch on behalf of NHS Birmingham and Solihull. From the medical records, it was clear that the man was seen regularly by healthcare staff.
66. In his review, the clinical reviewer notes that both prison and healthcare staff were often concerned about the suitability of the man living on the wing, especially after his diagnosis. Each time the man was reviewed and received appropriate treatment. The man made it very clear that he did not want to move to the healthcare centre and wanted to remain on the wing. The clinical reviewer also notes that towards the end of his illness, the man clearly received frequent care and was located where he wished in his cell on D wing. There were a number of entries recorded in the man's records that refer to frank discussions with him about the severity of the potential diagnoses.
67. In his clinical review, the clinical reviewer noted that there appeared to be an absence of formal systematic management of the man's chronic diseases which included thyroid and benign prostrate disease. As this was not related to the circumstances of the man's death we do not comment further here but draw the Head of Healthcare's attention to the clinical review annexed to this report.
68. The clinical reviewer also finds that there was a confused approach to the use of dietary supplements which appear to have been used on an ad-hoc basis and not within their normal range of application. In addition, at no point was a dietician involved in the man's care. The clinical reviewer states the problems associated with the man's constipation should have been anticipated at the time of starting his opiate based medication as these are known side effects.

**The Head of Healthcare should ensure that dietary supplements are used in line with the recommendations of the local Sandwell and West Birmingham NHS Trust formulary.**

69. Palliative care is the active holistic care of patients with an advanced progressive illness, such as cancer. A palliative care or end of life pathway is used to help manage a patient's pain and any other symptoms that they may be experiencing. It also helps to provide psychological, social and spiritual support. Overall, it aims to provide the best quality of life for patients and their families. Although referral to a Macmillan Nurse is mentioned several times in the man's records there does not appear to have been any input from them. It also appears that there was a variable approach to his pain management. The clinical reviewer states that "regular usage of oral morphine solution should be used to help guide the dose of regular slow release morphine tablets which appears only to have been undertaken once. As a result [the man's] pain control was variable".

70. The clinical reviewer noted that the man was frequently asked if he wished to be admitted to healthcare and he always declined until he became very unwell. However, there was no documentation to support his capacity to make these decisions. The clinical reviewer finds that there did not appear to be an overarching strategy to managing the man's terminal illness within a framework as would be expected in a primary care setting.
71. In his review, the clinical reviewer states that, although the care provided by the local hospital was very complicated, it progressed in an appropriate way. There was a requirement for ongoing TB treatment "as the organism was not typical and therefore posed a potential risk of a multi-resistant TB which would have been a major issue in the prison environment". The clinical reviewer finds that each step was also communicated at clinic appointments with the man.
72. The man was reviewed several times before he complained of symptoms of his subsequently terminal illness. Clubbing of his fingers was first recorded on 1 March 2011. Although it is likely the clubbing was present for some time before this, examination of the hands is not a routine examination.
73. In his conclusion, the clinical reviewer finds that because of the lack of an active, specialist approach to his palliative care, the care provided to the man was not of the same standard as would be expected in the general community.
74. The NHS document 'The route to success in end of life care – achieving quality in prisons and for prisoners' sets out how an end of life care pathway might be implemented in prisons. Among the benefits of an end of life pathway are that it helps carers to plan when and how care will be delivered, and helps patients make choices about how they are cared for towards the end of their lives.
75. We believe that an end of life care pathway should have been introduced for the man. This would have ensured a structured good practice approach to his care in the final weeks of his life.

**The Head of Healthcare should ensure that a formal end of life pathway is implemented when a prisoner nears the end of life.**

#### **Liaison with the man's next of kin**

76. After the man's terminal diagnosis was made, Birmingham appointed a family liaison officer who kept in contact with the man's partner. Although he had been in a relationship with his partner for many years, and had nominated her as his next of kin, their relationship was not a legal one. After he died no will was found and, in the absence of a will, when his estranged family came forward the situation about the man's property and the arrangements for his funeral became quite complicated. Although Birmingham kept in contact with the man's partner, her lack of legal status caused some difficulty. Eventually, the man's partner was able to organise his funeral and she informed the investigator that she was grateful for the support from the prison.

77. In the case of a diagnosed terminal illness, it is good practice as part of a palliative care plan, to appoint a family liaison officer. Birmingham appropriately appointed a family liaison officer on 4 November following the man's terminal diagnosis.
78. The man had complex domestic relationships and we consider that some of the difficulties caused in this case could have been avoided by a more structured end of life pathway, referred to above which might have encouraged the man to discuss arrangements for after his death and put his affairs in order.

### **Risk assessments for release on temporary licence (ROTL) and Compassionate release**

79. The possibility of the man being released on temporary licence was considered but turned down on grounds of risk. The Assistant Director drew attention to the notoriety of the original case and the fact that, as the man "has only recently gained Cat [Category] D ... the risk for ROTL are too high". Deputy Controller Hayward, decided against ROTL on the grounds that the man still posed a high risk of harm to children and the public; the media interest in the case; and that he was untested without supervision even though he had been approved for a "progressive move to more open conditions".
80. The same day, 9 November, an application was made for compassionate release. This was supported by a letter from Assistant Director which also drew attention to the recent Parole Board hearing where it was accepted that the man could transfer to open conditions. A move to an open prison had been put on hold solely due to his medical condition. The Assistant Director also said that Dr C (the prison doctor) "would not be surprised if he passed away as soon as the end of the week" and went on to say "with this in mind and his limited capacity to commit any further offence, even if he should wish to do so". The Assistant Director recommended to the Controller that the application for compassionate release was supported.
81. The man's application for compassionate release was refused because he did not meet the criteria for release and was assessed as still posing a risk to others.
82. We are satisfied that an application for compassionate release was made as soon as practicable after the man's terminal diagnosis. However, leaving aside the other grounds on which both the application for compassionate release and ROTL was turned down, there appears to be some confusion about the assessment of the man's risk of escape and therefore risk of harm to the public. It had been agreed that the man was suitable for open conditions. We understand that being approved for transfer to open conditions does not necessarily mean that the prisoner is also suitable for temporary release. But it does mean that the Parole Board considered he would be likely to comply with the conditions of temporary release. Category D prisoners are defined by the Prison Service (PSI) 40/2011 as "Prisoners who present a low risk, can reasonably be trusted in open conditions for whom open conditions are appropriate".

83. When the man was taken to, and stayed, in hospital, no restraints were used. This meant that the prison had assessed him a low risk of escape and harm to the public.
84. Against this background it is difficult to see why the man was regarded as a high risk of harm to the public when it came to the decision about his ROTL assessment. It is particularly difficult to reconcile the Assistant Director's assessment in relation to ROTL that the risks were too high with his assessment at the same time, that he should be allowed compassionate release. It appears to us that the reasons for the prison supporting the compassionate release application were just as relevant to a ROTL application and was not a full consideration of the risks that the man posed at the time when he was very seriously ill and not mobile. We accept that it was appropriate for the prison and NOMS to consider the notoriety of his offence, victim issues and whether public confidence in the system might be undermined, but the approach to the assessment of risk was inconsistent.

**The Director should ensure that the actual risks a prisoner poses at the time are taken into account when considering whether to release on temporary licence.**

#### **Restraints and security**

85. When the man went to hospital he was risk assessed to determine the level of escort and what restraints, if any, were needed. The initial risk assessment concluded that the man was a low risk of escape and harm to the public and took into account his physical condition at the time. It was decided that restraints were not to be used but that two officers should remain with him. We are satisfied that this was an appropriate risk assessment which allowed the man to spend his last days in dignity and not chained to a prison officer as we often find. We commend the prison for this approach.
86. The investigator found that the notes of the escort officers in the accompanying log were concise with appropriate entries. When interviewed the officers spoke perceptively and compassionately about their relationship with the man. This reflects well on the support from prison staff during his time in custody.

## CONCLUSION

87. The man arrived at Birmingham on 29 November 2007. He had been in custody since 1967 after being sentenced to life imprisonment. On 2 November 2011, the man was diagnosed with terminal cancer and his prognosis was very poor. Just over two weeks later, on 17 November, when his condition worsened he was admitted to a local hospital. The man moved to a local hospice on 5 December where he died there the following day. His partner was with him when he died.
88. After the man was informed of his terminal diagnosis, Birmingham appointed a family liaison officer who liaised with his partner. After the man's death members of his estranged family made contact with the prison and were legally his next of kin. Birmingham continued to keep the man's partner informed but the issues relating to his estate delayed his funeral for over three months.
89. The clinical reviewer has indicated some areas for improvement at Birmingham, principally in relation to the management of end of life care. There is also a need for appropriate and consistent approach to assessment of risk for release on licence.

## RECOMMENDATIONS

At the draft report stage, the National Offender Management Service (NOMS) responded to the recommendations. That response is included in italics below the recommendation.

1. The Head of Healthcare should ensure that dietary supplements are used in line with the recommendations of the local Sandwell and West Birmingham NHS Trust formulary.

*Dietary supplements will be used in accordance with the Birmingham Community Health Trust policy, who are partners within the healthcare services at HMP Birmingham, the formulary of Sandwell and West Birmingham NHS Trust will be measured against this policy to ensure all areas are covered*

2. The Head of Healthcare should ensure that a formal end of life pathway is implemented when a prisoner nears the end of life.

*Palliative Care Nurse now is post, end of life pathway finalised, awaiting ratification through clinical governance and for formal implementation once end of life cell is in use.*

3. The Director should ensure that the actual risks a prisoner poses at the time are taken into account when considering whether to release on temporary licence.

*All issues surrounding the prisoner's length of sentence, type of offence, risk to public, and security information will be considered when assessing a prisoners risk.*