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A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

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**Investigation into the death of a prisoner at HMP  
Shrewsbury on 8 November 2012**

## ***Our Vision***

*'To be a leading, independent investigatory body,  
a model to others, that makes a significant contribution to  
safer, fairer custody and offender supervision'*

This is a report of the investigation into the death of a prisoner at HMP Shrewsbury on 8 November 2012. The man, who was 72 years old, died from widespread cancer. I offer my condolences to the man's family and friends.

The investigation was carried out by one of my investigators. A doctor reviewed the man's clinical care at the prison. Staff at Shrewsbury cooperated fully with this investigation.

The man transferred to HMP Shrewsbury from HMP Birmingham on 22 August 2012. On 29 October 2012, he was taken to hospital after becoming unwell and, a few days later, was diagnosed with cancer of the liver which had spread to the lungs. No treatment was possible. He returned to the prison on 6 November and was looked after in the prison's palliative care suite, where he was able to be visited by his family. His condition deteriorated very quickly and he died on the morning of 8 November 2012.

While aspects of the man's treatment at Birmingham were not satisfactory, the standard of care he received at Shrewsbury was commendable and at least equivalent to that which he could have expected to receive in the community. Although a more fully considered risk assessment for the use of restraints should have been made when the man first went to hospital, overall staff at Shrewsbury were professional and compassionate and helped the man die with dignity. The prison also provided good support to the man's family before and after his death.

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.

The 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.

**Nigel Newcomen CBE**  
**Prisons and Probation Ombudsman**

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## SUMMARY

1. The man was born in 1940. He was 72 years old when he died on 8 November 2012 at HMP Shrewsbury. On 8 June 2009, the man was sentenced to 12 years imprisonment and went to HMP Birmingham. The man had diabetes and was checked frequently by healthcare staff. Other than his diabetes, there were no significant healthcare issues in 2009 and 2010.
2. On 18 February 2011, the man was diagnosed with a soft-tissue injury to his back after a fall. Later that month, he was admitted to the inpatient unit at the prison because of concerns about his diabetes management and low blood pressure. During his time as an inpatient, he was prescribed pain relief for frequent back pain.
3. During March, the man had a number of blood tests which indicated a slightly high liver test and a low platelet count (part of the blood that contributes to clotting) and very slight reduction in the white cell count (the cells that fight infection). Further blood tests in April showed that the platelet count was still low and the white cell count was slightly below normal as was the haemoglobin (iron in the blood), but no further action was considered necessary.
4. On 20 April, a physiotherapist advised on exercise to help his movement and reduce pain. He appeared to improve and, on 25 May, the physiotherapist noted that the man had a good range of back movements and did not report pain. He was discharged from the inpatient unit on 28 May.
5. On 25 September, the man was prescribed further pain relief for long standing back pain. On 24 November, a doctor noted that the man “was riddled with osteoarthritis” and prescribed nefopram (a strong pain killer). The doctor noted that he was due a diabetic blood test in spring 2012.
6. In February 2012, another note was made in the man’s record stating that “he needs bloods for diabetes”. There is no record that blood tests were undertaken at that time.
7. On 22 August, the man transferred to HMP Shrewsbury. It was noted when he arrived that he was diabetic, had suffered some heart problems in the past and walked with the aid of a stick. On 5 September, the prison doctor saw the man and discussed further blood tests that showed abnormal liver results and a low platelet count, which suggested obstructive liver disease.
8. On 20 September, the man saw the doctor and complained of back pain after a fall during the night. There were no signs of injury and he was advised to take his pain relief regularly.
9. On 24 October, the man passed blood in his urine and the doctor noted that his blood results continued to show a low platelet and reduced white cell count. He also noted that the liver test results had worsened. The results were discussed with a consultant haematologist who advised that the liver test results should be investigated.

10. On 29 October, the man appeared unwell with stomach pain and was taken to outside hospital later that day. Initially he was restrained by an escort chain at the hospital (a long chain with a handcuff at either end, one attached to the prisoner and the other to an officer). These restraints were removed on 31 October. On 4 November, the man was diagnosed with cancer in his liver which had spread to his lungs.
11. On 6 November, the man was discharged from hospital and returned to HMP Shrewsbury's palliative care suite, where his daughter was able to visit and stay with him overnight. The man's health continued to deteriorate and he died at 9.45am on 8 November.
12. After his death, the prison family liaison officer maintained contact with the man's family. The family was offered support and help with the funeral expenses in line with national policy.
13. The Coroner decided a post-mortem examination was not necessary and indicated that the man had died of cancer of the liver which had spread to his lungs.
14. We are satisfied that the care and attention the man received at Shrewsbury was equivalent to that he could have expected to receive in the community. However, some aspects of the man's care at HMP Birmingham were not satisfactory. We do not consider that the use of restraints when the man first went to hospital was justified by a fully considered risk assessment. We make two recommendations about the management of clinical care at HMP Birmingham. A recommendation about risk assessments for the use of restraints has not been made as HMP Shrewsbury has now closed.

## THE INVESTIGATION PROCESS

15. The Ombudsman was informed of the man's death on 8 November 2012. Of the Ombudsman's investigators issued notices to staff and prisoners at Shrewsbury informing them of the investigation and asking anyone with relevant information to contact him. No one came forward. The investigator examined all the man's relevant prison records, including his medical records.
16. Shrewsbury County Primary Care Trust appointed a doctor to review the man's clinical care at Shrewsbury and Birmingham. He was provided with a copy of the man's medical records.
17. The investigator visited Shrewsbury on 12 November and spoke to the governor and the duty governor as well as the senior lead for prison health, the clinical nurse manager; and the resettlement manager. He also spoke to the Chair of the Independent Monitoring Board (IMB) and the man's cell mate. The investigator visited the man's cell on C wing and the palliative care suite where he died. He returned to Shrewsbury on 12 December to interview staff. Initial feedback was given to the safer custody and local information manager, on 15 January 2013, and subsequently confirmed in writing.
18. HM Coroner for Mid and North West Shropshire District was informed of the investigation. The Coroner decided that a post-mortem examination was not needed. The cause of death given by a doctor at HMP Shrewsbury was carcinomatosis (widespread cancer), hepatocellular carcinoma (liver cancer), cirrhosis of the liver (liver disease) and non-insulin dependent diabetes mellitus. The Coroner has been sent a copy of this investigation report.
19. One of the Ombudsman's family liaison officers contacted the man's family and explained the purpose of the investigation. The man's family were positive about his care at Shrewsbury and the support they received after his death. However, the family were concerned that the man might not have received appropriate care at HMP Birmingham, especially as he died soon after his move to HMP Shrewsbury. The man's family received a copy of the draft report. No further representations were made in response to the findings.
20. 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.

## **HMP SHREWSBURY**

21. At the time the man was there, HMP Shrewsbury held up to 340 prisoners. In January 2013, the Ministry of Justice announced the prison's closure by the end of March 2013. The last prisoners left at the end of February 2013.
22. Healthcare at Shrewsbury was commissioned by Shropshire County Primary Care Trust and provided by Shropshire Community Health NHS Trust, with a visiting mental health in-reach service provided by South Staffordshire and Shropshire Healthcare NHS Foundation Trust. There were no inpatient facilities, but a palliative care suite was opened and staffed 24 hours when needed. The man was the first prisoner to use the suite.

## **Her Majesty's Inspectorate of Prisons (HMIP)**

23. The last report published on Shrewsbury by HMIP followed an announced inspection in September 2011. The report noted:

“Health care provision was very good and delivered by an impressive number of high-quality staff. Prisoners were generally satisfied with the level of access to staff and clinics. Physical health care services were comprehensive and appropriate for the population. Pharmacy services were satisfactory, although some areas required attention. Dental services were good, with acceptable waiting times. Prisoners with mental health problems had access to good primary care mental health facilities and a comprehensive secondary mental health in-reach service.”

## **Independent Monitoring Board (IMB)**

24. 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 Shrewsbury covers the year to April 2012. The report noted that healthcare continued to deliver to a good standard and that a palliative care suite was now available.

## **Previous deaths at Shrewsbury**

25. Since 2009 there has been one other death at Shrewsbury where the prisoner had also been diagnosed with a terminal illness. After that prisoner's death, a palliative care suite opened at Shrewsbury.

## **HMP BIRMINGHAM**

26. 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. Birmingham is the first public sector prison to be transferred to private sector management. G4S assumed responsibility for Birmingham on 1 October 2011. Healthcare is provided by NHS Birmingham and Solihull. There is 24 hour nursing cover, with an inpatient care unit in the healthcare centre.

### **Her Majesty's Inspectorate of Prisons**

27. The last inspection of HMP Birmingham was in January 2012. 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**

28. The most recent IMB annual report for Birmingham covers the year to June 2012. The IMB commented that there had been fewer nursing staff shortages than previously. There had been some problems with the late dispensing of medication but the IMB noted that a programme of specific treatment times on various wings had been introduced. The IMB were concerned about hospital appointments being cancelled because of a shortage of escorting staff and that medication prescribed at hospital was taken from prisoners when they returned to the prison.

### **Previous deaths at Birmingham**

29. In a previous death in custody investigation in 2012, we made a recommendation to Birmingham about chronic disease management and a similar recommendation is made in this report

## ISSUES

### The diagnosis of the man's terminal illness

30. From February 2011, while at Birmingham, the man complained of considerable back pain. The clinical reviewer says that although back pain can be a sign of cancer, the man's pain arose from an injury following a fall. It appeared to settle and responded to physiotherapy.
31. The clinical reviewer notes that the response of the man's pain to physiotherapy would suggest that his back pain was musculoskeletal (muscle and joint related) rather than indicative of cancer. However, he notes that, despite complaining about daily back ache for almost two months while he was in the prison hospital inpatient unit at Birmingham, there was no evidence in the prison medical records of a formal assessment and examination of his back, except after the initial injury and when he was assessed by a physiotherapist. The clinical reviewer states that, as the pain responded to treatment with physiotherapy, there was no indication for further investigation and nothing to suggest that this was an early sign of his terminal illness
32. When the man was in the healthcare inpatient unit at Birmingham he was seen frequently by healthcare staff. Appropriate investigations were ordered and reviewed with plans to repeat when necessary. However, during this period there did not appear to be any overall management plan. The man was eventually discharged from the inpatient unit with a report that he could be seen again if necessary, but no formal follow-up appointment was made and no subsequent blood tests were ordered to check if there had been any deterioration.
33. When the man arrived at Shrewsbury in August 2012, blood tests were carried out which showed abnormal liver function, and a prison doctor noted that this was suggestive of obstructive liver disease. She was concerned that this was due to his diabetic medication and arranged for this to be reduced and for the tests to be repeated. The clinical reviewer states that such action appeared appropriate at that stage.
34. After seeing the man on 4 October, the doctor recorded: "Repeat bloods as problems don't seem to have been addressed from last time". The man was seen promptly during subsequent episodes of ill health by another prison doctor but blood tests were not repeated until 24 October when Dr Rees saw him again. These tests came back as abnormal and deteriorating. Dr Rees acted promptly to discuss the results with a specialist at the local hospital. The specialist advised that the blood test results should be investigated. The man was due to attend a hospital appointment for this the next week, but his health quickly became worse and he was admitted to hospital on 29 October. On 4 November, after tests in hospital the man was diagnosed with liver cancer which had spread to his lungs and could not be treated.

35. The clinical reviewer examined the man's records to ascertain whether his terminal condition could have been diagnosed sooner allowing the possibility of treatment. In his report he states:

“It does seem clear from the medical records that his condition rapidly deteriorated. This is apparent from the worsening blood test results and also from observations of non-clinicians including prison officers who noticed a marked change in his physical appearance and well-being over a short period of time during September and October 2012 ... It is clear that The man's health did deteriorate in early 2011, however the symptoms he presented with, along with the blood test results would not have specifically indicated liver disease. All the symptoms and results were non-specific signs of many possible causes including ageing. “

36. The man initially had abnormal blood test results while in the prison hospital inpatient unit at Birmingham. These tests were repeated on several occasions, but remained slightly abnormal. The clinical reviewer says that accurately determining a medical reason for these non-specific blood abnormalities could present challenges and possibly require specialist opinion. However, the man was discharged from the inpatient unit without any clear plan to monitor or to repeat or to investigate further, these abnormal results. The clinical reviewer refers to the difficulties in diagnosing liver cancer, and it is not possible to say whether further follow-up at this time would have made a difference to the outcome for the man. The clinical reviewer says:

“I do not feel that the diagnosis of hepatocellular cancer [liver cancer] could necessarily have been made at a treatable stage. Hepatocellular carcinoma is rare and is often diagnosed late due to the non-specific symptoms that it produces. In addition, blood test results may be normal in the early stages and abnormal blood test results could be due to many factors. In my opinion, the non-specific symptoms and the investigation results did not specifically indicate the cancer and it is not unreasonable to monitor and repeat blood tests in the event of minor changes or abnormalities.”

37. However, the clinical reviewer notes: “there is a possibility that cirrhosis of the liver, which was likely to be factor in the development of the hepatocellular carcinoma, could have been detected earlier”. We believe it is important that follow-up arrangements are made in the event of abnormal investigation or blood results.

**The Head of Healthcare at HMP Birmingham should ensure that there are robust follow-up and monitoring procedures to review, action and manage abnormal investigation or blood test results.**

### **Informing the man about his condition and treatment**

38. Once tests confirmed his diagnosis, a hospital doctor, informed the man of the outcome on the afternoon of 4 November. He was told the cancer was

inoperable and the only possible treatment was palliative<sup>1</sup>. The doctor explained he had very little time left to live. The prison doctor also spoke to the man's family about his condition and prognosis. After discussion with the man, the hospital completed a DNAR (do not attempt resuscitation) form indicating that the man did not wish to be resuscitated in the event of a cardiac or respiratory arrest. After discussion of his terminal prognosis arrangements were made for the man to return to prison. The sensitive and professional approach of the staff at Shrewsbury, and the hospital, ensured that the man was kept fully informed about his condition and that no active treatment was possible.

### **The man's medical appointments and treatment**

39. While not related to his death, the clinical reviewer had some concerns about how well the man's long term conditions were managed at HMP Birmingham. The man had diabetes, hypertension and possible heart disease. In the community, he would have expected to have been invited for a review at least annually to monitor these long-term conditions.
40. As a diabetic, the man would normally have had annual blood tests to review the control of his diabetes. His records suggest that he had a blood test in 2009 but these were not repeated until his period of ill health in 2011. Although later comments in his records suggested the need for diabetes blood tests, there is no evidence that this was done.

### **The Head of Healthcare at HMP Birmingham should ensure that prisoners with long term conditions (chronic diseases) are reviewed regularly at least in line with arrangements in the community.**

41. After his diagnosis of cancer on 4 November, prison healthcare staff liaised with hospital staff to ensure the man received continuity of care. Due to his terminal diagnosis there were no plans for any further active treatment after his discharge from hospital on 6 November
42. In his report the clinical reviewer states: "Following a sudden deterioration in his health, the man was urgently admitted to hospital. Healthcare staff kept in touch with the hospital regarding the man's care, investigations and subsequent diagnosis".

### **The man's pain relief and medication**

43. After the man's terminal diagnosis, he received diamorphine by injection then later by syringe driver when he needed continual pain relief. Diamorphine is a powerful opioid pain relief which is often used in preference to morphine for patients who are terminally ill because it is considered less likely to cause nausea or lower blood pressure and can be injected in smaller volumes. Hyoscine butylbromide was also used to clear respiratory secretions (this is an

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<sup>1</sup> 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.

antispasmodic medication most usually used for stomach cramps, but sometimes used to reduce secretions in the lung). In his report, the clinical reviewer states:

“The man died peacefully in no obvious pain or distress with full care and maintenance of his dignity at all times. Both the planning and the care were exemplary and equivalent to the best practice that he would have expected to have received in the community.”

We are satisfied that the man was offered appropriate medication and pain relief.

### **Palliative care plans**

44. 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.
45. The man was fully consulted on palliative care and end of life plans to ensure his wishes were complied with. The hospital and the prison worked well together to ensure an effective end of life care plan was in place for both the man’s time in hospital and for his return to the prison. After a meeting on 6 November the following information was recorded: “The man has a terminal illness in the end stages of life, outcome poor”. It was agreed that 24 hour care was to be provided by healthcare staff on his return to Shrewsbury. Healthcare staff were also to implement all relevant care plans alongside the Liverpool Care Pathway<sup>2</sup>.
46. The man was aware of his condition and prognosis when he returned to Shrewsbury. The records show that he was involved in and informed of his care plans. The plans were followed and he was reviewed regularly. The clinical review says that all of the man’s care needs appear to have been met and palliative medication was prescribed as required. On his return to Shrewsbury, he was located in the palliative care suite and was nursed by two members of healthcare staff. Healthcare staff completed the appropriate ‘do not resuscitate’ forms with the man’s involvement and informed consent.
47. We consider Shrewsbury’s sensitive handling of the man’s end of life care was commendable.

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<sup>2</sup> The Liverpool Care Pathway for the Dying Patient (LCP) is a model of care which enables healthcare professionals to focus on care in the last hours or days of life when a death is expected. It is tailored to the person’s individual needs and includes consideration of their physical, social, spiritual and psychological needs.

## **Liaison with The man's family**

48. The man, hospital staff, as well as prison and healthcare staff from Shrewsbury, kept his family well informed about his condition.
49. Shrewsbury appointed a family liaison officer as soon as it was clear that the man was seriously ill. He ensured that the man's family was informed and kept updated about his condition. His family were able to visit him in the palliative care suite at Shrewsbury after he was discharged from hospital and his daughter was able to stay with him overnight on one occasion. After the man's death, the prison's family liaison officer visited the man's family to offer support. He maintained contact with the man's family to provide continuing support and, in line with national policy, offered financial assistance towards funeral expenses. The family were very positive about the help provided by the prison's family liaison officer and also by the prison chaplain.

## **The man's location**

50. After his transfer to Shrewsbury the man was allocated a shared cell on C wing. Healthcare staff maintained regular contact with the man to monitor his condition and health needs. The cell was on the ground floor, quite near to the wing office. A prisoner carer was appointed to help the man with tasks such as keeping his cell clean and collecting his meals when he felt unwell.
51. When he returned from hospital on 6 November, the man went straight to the palliative care suite on A wing which was specially equipped to provide 24 hour care for the dying. The cell he was nursed in was a spacious, purpose designed suite suitable for end of life care. During the last few days of his life the suite was left unlocked to ensure easy access.
52. In his report the clinical reviewer says:

"Both the hospital and the man were keen that he return to HMP Shrewsbury. Healthcare did everything expected to ensure a quick but safe return, allowing the man to be comfortably settled and managed in the specialist palliative care suite. They also ensured that all the appropriate support was in place prior to his return."

53. We are satisfied that the man's location was always appropriate for his needs, and that in his final days the palliative care suite at Shrewsbury provided good accommodation.

## **Early release on compassionate grounds**

54. Early release on compassionate grounds is a means by which prisoners who are seriously ill can be permanently released from custody before their sentence has finished. In order to be released on compassionate grounds, a prisoner must have a terminal illness and there must be an indication that death is likely to occur imminently (usually within three months). A number of reports are required which have to be considered by the National Offender

Management Service nationally. All such releases have to be approved by the Secretary of State.

55. Although the man was unwell for some time, the terminal nature of his illness was not confirmed until 4 November, just four days before his death. Due to the very rapid deterioration in the man's condition, the prison did not progress an application for early release on compassionate grounds. For the same reason an application for release on temporary licence was considered but not progressed as this would have required wide consultation to take into account, among other considerations, his family and victim issues.

### **Restraints, security and bedwatch**

56. The Prison Service has a duty to protect the public when escorting prisoners to hospital, and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes into account factors such as the prisoner's health and mobility.
57. When the man went to hospital, on 29 October, an initial risk assessment concluded that he was a "normal" risk of escape (the risk assessment form has three levels of risk: low/normal/high) and harm to the public. This risk assessment did not appear to fully take into account his physical condition at the time. It was decided that he should be handcuffed while travelling to and from hospital and then restrained by an escort chain when he was in hospital. Two officers were to remain with him. The risk assessment was revised on 31 October, and the restraints were removed. After his terminal diagnosis on 4 November, the level of escort was reduced to one officer.
58. Although the man was convicted of serious offences, the most relevant factors to consider at the time he was taken to hospital on 29 October were his likelihood of escape and his risk to the public should he do so. At the time he was taken to hospital, the man was a very ill, 72 year old man who had restricted mobility. There was no evidence that he was a risk of escape and the presence of two prison officers should have been an adequate security precaution. The medical condition and mobility of a prisoner needs to be fully considered as part of the decision making process and levels of restraint must be proportionate to actual security risks, balanced by considerations of care and decency. We make no recommendation about this as HMP Shrewsbury has now closed.

## 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 at HMP Birmingham should ensure that there are robust follow-up and monitoring procedures to review, action and manage abnormal investigation or blood test results.

*Accepted: A formal monitoring system is in place for ensuring appropriate follow up for both abnormal investigations and blood results. This is currently being reviewed, the following is our suggested process to be implemented: Abnormal Investigations - All correspondence from external appointments is immediately logged on patient clinical record. A copy of the letter is also given to the relevant medic for direct discussion with patient. Following consultation the medic or nominated deputy will make an entry in the clinical note of the outcome of the discussion. Abnormal blood results - The result is received back from the local hospital via an IT link, which goes directly to the GP to review. The results are attached to the patient record and the GP or their nominated deputy will feedback the results to the patient on a face to face basis.*

2. The Head of Healthcare at HMP Birmingham should ensure that prisoners with long term conditions (chronic diseases) are reviewed regularly at least in line with arrangements in the community.

*Accepted: Following the appointment of a long term condition specialist nurse. All prisoners with a long term condition as identified within NHS Quality Outcomes Framework (QOF) are registered and are being monitored against agreed standards, as detailed with NICE guidance. With formal reviews being undertaken as diarised and within the period of time suggested.*