Investigation into the circumstances surrounding the death of a man at hospital in September 2010, while in the custody of HMP Birmingham

Report by the Prisons and Probation Ombudsman for England and Wales

October 2011

This is a report of an investigation into the circumstances surrounding the death of a prisoner at HMP Birmingham. He died in September 2010, shortly after being diagnosed with cancer of the lungs and bowel. He was 58 years old. I offer my condolences to his family and friends for their loss.

The investigation was undertaken by an investigator. The local Primary Care Trust commissioned a clinical review of the healthcare provided to the man and I am grateful to the clinical reviewer for his review. I would also like to express my thanks to the Governor of Birmingham and his staff for their co-operation and assistance. In particular, I would like to thank the liaison officer whose liaison with my investigator was excellent.

The man was in his second year of a twelve year sentence when he developed abdominal and back pain, as well as other symptoms. He became very unwell and was referred to hospital for a chest x-ray and scan. Doctors subsequently diagnosed cancer of the lungs and bowel, although the primary site of the cancer was unclear. On 28 August, around five weeks after he became unwell, he transferred from the healthcare inpatients ward at the prison to hospital, where he died five days later. His wife was at the hospital visiting him at the time.

I am satisfied that during the relatively short period between the onset of the man's symptoms and his admission to hospital, staff took appropriate steps to obtain a firm diagnosis and provided a good standard of care for him. However, I make a recommendation regarding the need for the Governor to consider notifying relatives scheduled to visit the prison when a prisoner has been admitted to hospital.

In this instance, prison managers considered it unnecessary to apply restraints to the man during his journey to and stay in hospital. I am pleased that this allowed him dignity in his last days. Prison staff also considered release on temporary licence. Unfortunately, on this occasion it was not appropriate.

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.

Thea Walton
Acting Deputy Prisons and Probation Ombudsman **October 2011**

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SUMMARY

The man was born in September 1951 and died in September 2010 at hospital. He was 58 years old. He was suffering from cancer of the bowel and lungs.

The man was remanded to HMP Birmingham on 27 June 2009 and was subsequently sentenced to 12 years imprisonment in October of the same year. At his first healthscreen he was considered to be fit and well but was being prescribed medication for high cholesterol and high blood pressure. During his time at Birmingham his health was not a major issue until October 2009, when he complained of a cough and shoulder pain. He was treated with antibiotics and anti-inflammatory tablets. In March 2010, he had a pain in his mouth and right ear. It was noted that he had poor dental hygiene and he was again given antibiotics.

In July, he reported pain around his stomach and lower back area, which he believed to be linked to constipation. Over the next few weeks, he went to the healthcare centre on a number of occasions with concern about loss of appetite, weight loss, stomach and chest problems. He was subsequently referred for a chest x-ray, which was found to be abnormal.

On 22 August, the man was taken to hospital when he became dizzy and nauseous, with extreme pain in his lower abdomen. He was discharged later the same day and diagnosed with a viral illness. The hospital staff do not appear to have been aware of his abnormal x-ray results at that time.

Two days later, on 24 August, the man complained of chest pain and vomiting. He was admitted to the inpatients' wing at Birmingham and it was noted in his records that there was a high likelihood that he had cancer. Over the next few days, he found it difficult to swallow and had severe abdominal pain with further vomiting. He was admitted to hospital on 28 August, as prison healthcare staff discovered internal bleeding in his stomach.

After his admission to hospital, he rapidly deteriorated. His consultant advised that no further procedures should take place as he was not well enough to go through them. He was given a life expectancy of a few days at this time. In September he died. His wife was visiting him at the time of his death and was given support by prison managers. The escort staff were also offered support.

I make one recommendation in respect of informing families when a prisoner has been taken into hospital with a critical diagnosis. I concur with the clinical reviewer's conclusion that the man's diagnosis was timely and his clinical care appropriate. I also draw attention to the reasons for non-attendance for healthcare appointments to be recorded.

THE INVESTIGATION PROCESS

1. My investigator opened the investigation on 14 September, when she visited HMP Birmingham. She met the family liaison officer, a representative for the Prison Officers' Association (POA), a member of the Independent Monitoring Board (IMB) and visited the cell where the man lived before he died. She received copies of all his prison and health records. She subsequently returned to the prison on 18 January 2011 to carry out interviews with staff.

2. HMP Birmingham issued notices to staff and prisoners, informing them of the investigation and inviting anyone who had any relevant information to contact my investigator. Nobody came forward in response to the notices.

3. A clinical review of the healthcare provided to the man was commissioned. Unfortunately, there was a delay in providing this. A clinical reviewer was not allocated until 22 November and the final report was not received until 24 February 2011. I am grateful to the clinical reviewer for his review.

4. One of my family liaison officers spoke to the man's family to ask if they had any concerns that they wanted to be addressed in the investigation. They raised a number of issues relating to his health and clinical care during the last few months of his life:

    - He had mentioned to them previously that he had a chest and kidney infection but later said in a letter that he had got over his illness. The family were concerned that his illnesses might have been symptoms of cancer which had not been picked up sooner.

    - His wife visited the prison on a regular visit only to be told that he was in hospital. She was concerned that she had not been told that he had been admitted to hospital before her visit.

    I have considered these issues in my report and I hope the family gains a better understanding of his illness and care before he died.

HMP Birmingham

5. HMP Birmingham is a local prison serving the Crown Courts of Birmingham, Stafford and Wolverhampton, in addition to several local Magistrates Courts. The prison consists of 11 accommodation units which include the original Victorian wings and additional accommodation built in 2002. This provides space for a further 450 prisoners. The prison can hold a maximum number of 1450 prisoners.

6. The Heart of Birmingham Teaching Primary Care Trust (PCT) provides general healthcare at the prison. Key services include general health assessment, dental, GP and therapy services, chronic disease management, general and specialist nursing service. There is an inpatient facility with two wards. One is mainly for prisoners with mental health needs and the other is for more general, physical illnesses. The PCT has a partnership agreement with Birmingham and Solihull Mental Health Trust to provide mental health care.

7. At the time of the man's death there had been 32 deaths at Birmingham, since the Ombudsman started investigating deaths in custody, in 2004. There have been another two since then. In November 2008, the Ombudsman made a recommendation in respect of informing the next of kin, when a prisoner was taken into hospital. I repeat the recommendation in this report.

Independent Monitoring Board (IMB)

8. The IMB are a body of people appointed to each prison by the Secretary of State for Justice to be independent watchdogs of the public interest. They are not members of the Prison Service nor are they part of the management team. They are required to produce an annual report to the Secretary of State on the prison, highlighting good practice and flagging up areas of concern.

9. The most recent IMB Annual Report July 2009 to June 2010 states:

    "During the transition to the new contract healthcare suffered severe staff shortages and problems in recruitment. These were exacerbated by delays in obtaining the CRB clearance of new staff. The shortages caused operational difficulties in areas such as the daily distribution of medication before prisoners move from their wings to labour and activities. There was also a reduction in the range of nurse led and specialised clinics available; prisoners were triaged by nursing staff who were only minimally trained for this work; appointment slips were not consistently being delivered the evening before a clinic. Progress has been made in addressing all of these problems, although missed appointments do remain a concern to the Board. Efficient operation of the system requires not only timely notification of the arrangements, but also availability of staff as escorts and a readiness on the prisoner part to keep the appointments.

    "Overall, however, the Board finds prisoners well informed about the Health Care services open to them, how they may be called upon and how a complaint may be registered. (The one significant reservation in this respect

concerns prisoners whose understanding of English is poor). Outside hospital appointments are managed well. The waiting times are well within the national NHS targets."

Her Majesty's Inspectorate of Prison's Report

10. The last inspection of Birmingham was in December 2009. The Chief Inspector concluded:

"This full follow-up inspection found that, while some progress had been made, there was still a considerable amount to do to ensure a safe, decent and effective prison. Only two of our 10 main recommendations at the previous inspection had been fully achieved, and we needed to make nine new main recommendations in areas that had not previously been matters for serious concern. While we have not changed our assessment, these included some important aspects of safety.

"Health services were well managed, and mental health provision, including day care, had greatly improved, but the shortage of nurses impacted on primary and inpatient care."

Release on Temporary Licence (ROTL)

11. In certain circumstances, a prisoner will be allowed to leave prison on a temporary licence. The purpose of this is either for compassionate reasons or to help the prisoner improve their chances of resettlement after their release. The system of release on temporary licence (ROTL) is designed to ensure that suitable prisoners are released for precisely defined and specific activities, which cannot be provided in Prison Service establishments. In order to ensure public safety and maintain public confidence in the system, prisoners are only released on temporary licence after they have been rigorously assessed and approved for ROTL by an authorised senior manager.

12. Prisoners can only be released for three purposes:
    - Facility licence - for attendance at work experience, interviews or other training which cannot be provided within the prison;
    - Compassionate licence - for urgent personal crises such as family funerals, near death of relatives, urgent hospital treatment;
    - Resettlement licence - for prisoners to re-establish themselves in the community prior to release.

KEY EVENTS

13. The man was a bus driver who lived in Wolverhampton before he was convicted and sentenced to 12 years imprisonment. He was married, with three daughters and two sons.

14. The man was remanded to HMP Birmingham on 27 June 2009, where he remained after he was sentenced on 23 October 2009. This was his first time in prison. All prisoners go to the healthcare department for a healthscreen on arrival at a prison. Prison records show that at his healthscreen, he told staff that he had been prescribed medication for high blood pressure and high cholesterol but that he didn't take it because he couldn't swallow the tablets. He did not report any other physical or mental health problems at that time.

15. The man's most recent health problems seem to have started in October 2009, when he went to see one of the prison doctors. He had a wheezy chest and cough and had lost weight, although it is noted in the medical records that he had always been of slim build. The doctor diagnosed a respiratory infection. He prescribed doxycycline hyclate, an antibiotic and a note was made that he had been a smoker all of his life and that he currently smoked between 20 and 39 cigarettes a day. He also told the doctor about pain in his shoulder. He said that he had not injured it but that it had been painful for about four months. The doctor advised that he should have an x-ray on his left shoulder and prescribed painkillers. It is not clear from the notes whether he attended for an x ray of his shoulder.

16. The man did not return to healthcare until 1 March 2010, when he complained of pain in the right side of his mouth, a sore throat and ear and problems swallowing. A doctor examined him and noted that his tonsils were clear but that was some pus in his throat and he had poor dental hygiene. He prescribed him some antibiotic medication and ear drops.

17. On 17 July, the man was reported to have constipation and pain around his kidney area. On the same day, officers asked healthcare staff to examine him as he had told them he had stomach and back pain. Staff thought this might have been musculo skeletal (relating to muscles) because he had said he jumped off the top bunk when he got out of bed. His other clinical observations were noted as all within the normal range. He was subsequently prescribed paracetamol and ibuprofen (anti inflammatory painkiller) and a note made that he should attend for urinalysis. (Urinalysis is a number of tests performed on urine to help diagnose certain conditions.)

18. On the same day, there was another call from staff when the man complained of further pain in the lower right side of his back. He felt better after about ten minutes and was referred to see the general practitioner (GP). There was another episode of similar pain on 19 July and urine tests were ordered. The results returned the following day and it was noted that there was blood in his urine. Prison Doctor A who attended to him that day, told my investigator that anyone of his age who had blood in his urine should be tested further as this could be an indication of cancer. His symptoms could also have been

attributable to diabetes or thyroid problems. He wanted to refer him to hospital but he could not do so without first making an appointment with him and checking that he agreed to this. He booked an appointment for him two days later, but he did not attend this or a further appointment on 29 July. Although in interview the doctor said that the man went to work, the clinical records state that he did not work on either of the above dates. My investigator has been unable to find out why he did not attend these appointments.

19. A further appointment was made for 11 August, which the man attended. Prison Doctor B examined him. He told the doctor that he had lost a lot of weight over the previous few months but that his appetite was alright. In response to the doctor's questions, he said that he had not felt sick or vomited, had no chest pain, night sweats, nor did he have a cough at that time. He was still constipated and told the doctor that his father had died of lung cancer when he was 66 years old. Prison Doctor A said that Prison Doctor B's notes of the appointment in August did not point to anything obvious as cancer, except possibly his change in bowel habits. Prison Doctor B did not find any masses which would indicate stomach cancer and subsequently arranged blood tests to assess his liver and kidneys, a urine test to check for diabetes and a chest x-ray.

20. Approximately one week later, the man was examined by another doctor at the prison. Prison Doctor C noted that he was now losing his appetite and had started to feel sick on occasions. It is noted in his medical record that there was a high chance of cancer in the bowel or urinary tract. The notes also reflect an abnormal result following a chest x-ray on 18 August. The x-ray showed a 1.5cm mass and another of 1.62cm on his lungs. Prison Doctor A explained to my investigator that more than one mass would indicate that the cancer had spread from another part of the body. The hospital consultant considered that the masses on the man's lungs were secondary cancer and that a full computed tomography (CT) scan would be necessary to find the site of the primary cancer. (A CT scan is a type of x-ray which gives a three dimensional view of the organs and body.)

21. The man was taken to hospital on 22 August when he complained of feeling dizzy and nauseous with lower stomach pain. He was discharged later that night. Hospital staff diagnosed a viral illness and advised that prison healthcare staff should monitor it. He remained unwell and on 23 August, Prison Doctor B noted the abnormal chest x-ray again. He also wrote in the man's notes that there was a "high likelihood of cancer" and that he had already been referred for a CT scan. This was planned to take place on 31 August. Once the outcome of the tests was known, the intention was to refer him to a specialist under the National Health Service (NHS) arrangements for referring patients with symptoms of cancer.

22. The next day, the man reported chest pain on the right side of his chest. He was admitted to the healthcare inpatient ward at the prison. A Registered Mental Nurse (RMN) examined him. He told the nurse that he had been suffering from stomach problems for five weeks, that he had not been eating, vomited after taking his medication and also had difficulty passing urine.

23. The man remained in the inpatients' unit until 28 August. The medical notes show that during this time, he was told that he had cancer. He considered that the hospital had not explained anything to him. However, as explained by Prison Doctor A, at that time the primary site of the cancer was unknown but there was a possibility that it could be in his lungs, bowels, pancreas, liver or adrenal glands.

24. My investigator asked what support would have been available to the man after such a diagnosis. The doctor replied that the man would have had 24 hour access to the nurses and doctors whilst he was resident on the ward at Birmingham, where he could discuss his health and what the hospital had told him. Healthcare staff could also check on his pain and discomfort levels, discuss his eating, drinking and bowel habits and they would ensure that he was calm and as comfortable as possible.

25. On 28 August, the man vomited a dark brown liquid. Prison Doctor A made an urgent referral for him to be taken to hospital by ambulance as he suspected internal bleeding in his stomach, a serious condition. He was admitted to hospital. No handcuffs or restraints were used at this time. The CT scan which took place on 31 August confirmed the spread of cancer to his chest and abdomen.

26. The man had previously made arrangements for his wife to visit him in prison on 31 August. However, when she arrived at the prison she was told that he was in hospital. She was not given any other information. She subsequently went to visit him at the hospital that afternoon and she was told of his diagnosis by the nursing staff.

27. Prison staff contacted the hospital on 2 September by telephone and was told that the consultant had decided that he was too poorly to undergo any further treatment and said that he "was unlikely to survive the week". He subsequently arranged palliative care (treatment to relieve his symptoms) and Macmillan nurses. At this stage, the primary site of the cancer was still unclear and, unfortunately, this was not confirmed before he died in September.

28. On 1 September an assessment was made to see if the man was eligible to be released on temporary licence. Probation staff and police objected to his release on the grounds that he still posed a risk of harm to the public and that there may be adverse media attention and a risk of harm to himself. The prison added that because he had only completed a short period of his sentence and was still a category B prisoner, he remained ineligible for compassionate release at this time. (Prisoners are risk assessed when they come into prison and given a category based on their offence and the risk that they pose to the public should they escape. There are four levels of category: A, B, C and D, with category A prisoners being the most dangerous. Category B prisoners are those for whom the highest security conditions are not necessary but for whom escape must be made very difficult.)

29. On 3 September, the man's wife visited him just after 4.00pm. The escort officers told my investigator that during that time he appeared to spend most of the time sleeping and was unable to respond to his wife when she tried to make

conversation with him. Hospital staff asked her to leave his bedside when the evening meal was served. She returned at about 6.00pm.

30. After a short time, one of the officers became concerned about the man's breathing. He went to get a nurse who then confirmed that he had died. The officer said that he did not think that the man's wife was aware of this at the time as she did not have a good view of his face from her position at the side of his bed. The nursing staff subsequently told her that her husband had died.

31. Prison managers attended the hospital. The prison family liaison officer subsequently met with the man's wife and other members of his family and arranged financial assistance for his funeral. The staff care team offered support to the staff who were with him when he died and a hot debrief was arranged. (A hot debrief is a meeting for staff to discuss issues and any lessons learned following serious events such as deaths in custody, hostage situation or escape attempt. The meeting should focus on reassurance, information sharing and how staff can support each other.) The officers said that they had been supported by prison managers.

32. Both escort staff were concerned that nursing staff did not take the man's wife into a private room to grieve and mentioned this during the debrief. In their interviews with my investigator, they also expressed concern that hospital staff had not disclosed to her the full extent of his condition. The clinical reviewer considered that the family were told of the man's condition at the earliest opportunity.

Issues

Clinical care

33. The man reported minor symptoms of illness a few months after he went into prison, which were treated by antibiotics and painkillers. In July 2010, a nurse noticed urine in his blood following a test. Further symptoms developed and in August, healthcare staff arranged a number of tests, which indicated the possibility of cancer. He was admitted to hospital on 28 August and remained there until he died in September.

34. After the initial observation of urine in his blood, on 20 July, the man was advised to attend follow up appointments with a prison doctor, but failed to do so on 22 and 29 July. He was next reviewed on 11 August. There is no indication as to why he missed these appointments. However, Prison Doctor A offered a possible explanation. He said that they had been short notice emergency appointments in which a notification should have been slipped under his door the previous evening. It was therefore possible that he had not received sufficient notice, particularly as he had attended work on at least one of the appointment dates. A period of three weeks elapsed before he was eventually seen.

35. The clinical review gives no indication of any negative impact of the missed appointments on the man's subsequent health and treatment and healthcare staff were proactive and timely in re-arranging them. Therefore I make no recommendation on this matter. However, the Head of Healthcare will wish to remind staff of the need to record the reasons for missed appointments, where they are known.

36. After the man had received the results of an abnormal x-ray, whilst he was still in the inpatients' unit at Birmingham, he seemed unsure of his diagnosis and did not appear to be given any specific support. My investigator asked Prison Doctor A whether staff were available should he need to discuss his illness. He explained that he personally discussed his illness with him but at the time there was no clear diagnosis. It was still not known where the primary cancer site was and where any secondary cancers might be as they were still waiting for the CT scan, which would clarify this. He added that during the time he was in the inpatients' unit the man would have had the opportunity to speak to staff during the day and night.

37. In his clinical review, the clinical reviewer concludes that the man received treatment in prison comparable to that which he would have expected to receive in a community setting. He considered that his referral was made within the correct timescales for a suspected cancer diagnosis and that he was given full information about his condition and treatment as early as possible. Prison and hospital staff liaised appropriately and a palliative care plan was followed. He makes no recommendations in respect of the man's clinical care at Birmingham.

Family visit

38. The man had arranged for his wife to visit him in prison on 31 August before he was taken to hospital. She therefore travelled to Birmingham expecting to see her husband. However, when she arrived at the prison she was told that he was in hospital. She then went to the hospital and asked the prison officers what his illness was. They directed her to the nursing staff, who told her what the diagnosis was. The policy at Birmingham regarding notifying family members of a prisoner's admission to hospital was subject to a recommendation in the Ombudsman's report in November 2008. The prison accepted the recommendation and agreed in the action plan that:

    > "Next of kin can be informed when condition is diagnosed as critical with the approval of the Governor/Duty Governor as per the Local Security Strategy. This information/instruction will be included in the bedwatch packs that accompany the prisoner to hospital for staff to use."

    Although he did not have a definitive diagnosis at this stage, healthcare staff were aware that he had cancer when he was admitted to hospital. It is unacceptable that his wife, who was his listed next of kin, was not told about this before she visited the prison and I am disappointed that I have to repeat my previous recommendation here.

    The Governor and Head of Healthcare should ensure that staff inform the next of kin at the earliest opportunity if a prisoner is admitted to hospital in a critical condition.

Restraints and consideration of ROTL

39. When the man was transferred to hospital on 28 August, no handcuffs or other restraints were used. According to the bedwatch notes this remained the case throughout his time in hospital until his death. However, a member of his family stated that when she visited him on 2 September he was restrained by a single escort chain. As there are differing accounts and no clarification in the bedwatch notes why restraints were used on this occasion I can only comment that it would not seem appropriate for him to be restrained at this point. I therefore suggest to the Governor that bedwatch notes clearly state when and why the use of restraints is reconsidered.

40. Prison managers considered ROTL as soon as they were aware that the man had a very short life expectancy. The consideration of ROTL demonstrates that prison staff treated him with dignity and respect, while observing the need for the security and protection of the public.

CONCLUSION

41. The man's symptoms became apparent in the first few months of a lengthy sentence. The investigation has found that when prison healthcare staff suspected that he might have cancer or another serious condition, they took timely and appropriate steps to obtain a firm diagnosis. Unfortunately, he deteriorated rapidly and, within a few weeks, he had to be admitted to hospital. Again, his referral to hospital was swift when his symptoms worsened. He died six days later.

42. I concur with the clinical reviewer's view that the clinical care given to the man was comparable to what he could have expected in the community. I am also very pleased to note that in the light of his serious condition and consequential incapacity, discretion was exercised in avoiding the use of restraints and allowing him a measure of dignity in his final days.

43. I make one formal recommendation in this report and it refers to the need to advise relatives intending to visit the prison that a prisoner, with a critical diagnosis, is in hospital. The Head of Healthcare will also wish to remind staff of the need to record the reasons for missed appointments.

Recommendation

The Governor and Head of Healthcare should ensure that staff inform the next of kin at the earliest opportunity if a prisoner is admitted to hospital, in a critical condition.

Accepted – The Governor replied, "Next of kin can be informed when a condition is diagnosed as critical with the approval of the Governor/Duty Governor as per the Local Security Strategy. This information/instruction will be included in the bedwatch packs that accompany the prisoner to hospital for staff to use."

Feedback to the draft report from the man's family

The man's family made a number of points in regard to the findings of this investigation and they expressed their disagreement with the views of the clinical reviewer. They felt that there were "many missed opportunities for urgent referral for suspected cancer" and they note a number of times where they believe this to be the case. They conclude that in their view his care was not comparable with that which he would have received in the community and do not feel that his wife was offered sufficient support.

In addition to the family's response above, they refute that restraints were not used. In particular a member of the family visited him in hospital on 2 September and she said that he was restrained by an escorting chain around one of his wrists. She spoke to the officer but was told that the chain was being used for security reasons. I have been unable to find any mention of restraints in the bedwatch log and have commented on this in the draft report. However, I have noted the family's information and have slightly amended my comments, with a view to including their concern.