PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in October 2014, while a prisoner at HMP Birmingham

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 the investigation report into the death of a man, from widespread cancer, in October 2014, while a prisoner at HMP Birmingham. He was 71 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received at Birmingham was undertaken. The prison cooperated fully with the investigation.

The man had been in prison since 2005 and had spent most of his time at Birmingham. He had several chronic conditions, including diabetes, high blood pressure and heart disease. He had a diagnosed personality disorder and had developed dementia in prison. Healthcare staff saw him frequently, but he usually refused to allow them to monitor his conditions or take his prescribed medication. Healthcare staff and forensic psychiatrists assessed that he had the capacity to make decisions about his treatment.

In June 2014, healthcare staff became concerned that the man appeared to be losing weight, but a hospital health check in July showed no major concerns. He continued to refuse medication and medical observations and his health deteriorated further. In October, he agreed to go to hospital and tests showed that he had widespread cancer. Hospital doctors predicted he had up to six months to live. When he returned to the prison on 17 October, healthcare staff provided palliative care, in consultation with the hospital and a local hospice. From their observations and knowledge of him, healthcare staff believed that the initial prognosis was unrealistic and suspected that he had only days or weeks to live. On 22 October, a nurse arranged for him to be transferred to an end of life care unit in the community. He died shortly afterwards.

I agree with the clinical reviewer's findings that, in spite of the man's challenging behaviour and refusal to cooperate with medical advice, healthcare staff at Birmingham provided a very good standard of care. When they noticed a deterioration in his condition, they promptly referred him for further investigation and provided appropriate palliative care, in partnership with specialists. However, I am concerned that restraints were used when he was in hospital, in early October, without a fully considered risk assessment. This is an issue I have raised with the prison before and the Director needs to ensure that all staff completing risk assessments for the use of restraints fully understand the legal position.

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.

Nigel Newcomen CBE **June 2015**
Prisons and Probation Ombudsman

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SUMMARY

1. The man was remanded to prison on 1 October 2005. In February 2006 he received an indeterminate sentence for arson. When he arrived at Birmingham in April 2009, he had diabetes, hypertension and cardiovascular disease and a history of strokes. Doctors prescribed medication for these conditions and he had appropriate care plans. However, he was not compliant with his medication and refused to allow healthcare staff to take necessary clinical observations.

2. The man had a personality disorder and was often unpleasant and occasionally aggressive to staff. He neglected himself, but healthcare staff and forensic psychiatrists assessed that he had the mental capacity to refuse medication and medical advice. In 2013, doctors diagnosed vascular dementia (a condition that can include memory loss and difficulties with thinking, problem solving or language, caused when the brain is damaged due to problems with its supply of blood). The prison unsuccessfully applied for him to be transferred to a secure hospital.

3. In June 2014, healthcare staff noticed that the man was losing weight. He continued to refuse medication or allow staff to take medical observations, but on 4 July, he had a full health check at hospital including a chest X-ray. A doctor found no evidence of cancer. Healthcare staff believed that his weight loss was the result of his diabetes, but he continued to refuse to take his diabetic medication.

4. In October, the man's health deteriorated further and he was taken to hospital. Despite his poor health and immobility, he was restrained by an escort chain. A CT scan revealed that he had widespread cancer and doctors said he had up to six months to live. The hospital discharged him a few days later and prison healthcare staff looked after him in the prison's palliative care suite. A specialist nurse implemented an end of life care plan, which included pain relief and support. His health deteriorated very quickly and healthcare staff arranged for him a transfer to the Sheldon Unit, an end of life care facility in the community, as he did not want to die in prison. He died soon afterwards.

5. The clinical reviewer noted that the man's refusal to allow staff to take observations made diagnosis difficult and considered it was reasonable to attribute his weight loss from July 2014 to his uncontrolled diabetes. She concluded that he received a high standard of care and we agree. Once prison staff realised the seriousness of his condition, they began efforts to identify his next of kin and to complete an application for compassionate release. Sadly, his health deteriorated rapidly, so they were unable to locate his family or progress the application before he died. We are concerned that the use of restraints, when he went to hospital in October, was not fully justified. We make one recommendation about this.

THE INVESTIGATION PROCESS

6. The investigator issued notices to staff and prisoners at HMP Birmingham, informing them of the investigation and inviting anyone with relevant information to contact him. No one responded.

7. NHS England commissioned a clinical reviewer to review the man's clinical care in prison.

8. The investigator obtained copies of the man's medical records and relevant extracts from his prison record. He and the clinical reviewer interviewed five members of staff on 11 and 12 December 2014.

9. We informed HM Coroner for Birmingham of the investigation, who provided the cause of death and a copy of the post-mortem report. We have sent the Coroner a copy of this investigation report. The Coroner held an inquest on 28 November 2014 and found that the man died from carcinomatosis (a widespread cancer) and pancreatic cancer.

10. One of the Ombudsman's family liaison officers contacted one of the man's sons to explain the investigation process. His son had no specific issues for the investigation to cover.

11. The investigation has assessed the main issues involved in the man's care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.

12. The man's family was informed the draft report was available, but did not wish to receive a copy or make any comment.

13. The draft report was shared with the Prison Service. They pointed out some factual inaccuracies and this report has been amended accordingly. The action plan has been added to the end of this report.

HMP BIRMINGHAM

14. HMP Birmingham is a local prison, principally serving the West Midlands courts, which holds up to 1,450 men. G4S Care and Justice Services have managed the prison since October 2011.

15. Birmingham and Solihull Mental Health Foundation Trust provide 24-hour health services at the prison and subcontract Birmingham Community Healthcare NHS Trust to provide primary care services.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Birmingham was in March 2014. Inspectors noted that health services were generally very good and valued by most prisoners. Patients with complex acute or chronic needs had access to well-organised inpatient units staffed by caring nurses and officers. External health appointments were rarely cancelled for security reasons. Inspectors noted that the healthcare centre had a new palliative care room.

Independent Monitoring Board

17. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that prisoners are treated fairly and decently. In its most recently published report for the year to June 2013, the IMB noted that healthcare provision was available in the prison 24 hours a day. Doctors were on site every weekday and a locum service provided evening and weekend cover. Prisoners could usually see a GP within a week and almost immediately if urgent.

Previous deaths at HMP Birmingham

18. The man was the fourth prisoner to die from natural causes at HMP Birmingham since October 2012. We have previously made recommendations about the use of restraints for elderly and infirm prisoners.

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ISSUES

The diagnosis of the man's terminal illness and informing him of his condition

19. The man was remanded to HMP Hewell on 1 October 2005, charged with arson. On 28 February 2006, he received an indeterminate sentence, with a minimum period to serve of 18 months. He had been at HMP Birmingham since 20 April 2009.

20. The man had a number or physical and mental health conditions, including type 2 diabetes, hypertension (high blood pressure) and cardiovascular (heart) disease, which had caused several strokes. This had limited his mobility. Nurses drew up care plans and he had an electric wheelchair and a pressure-relieving mattress. Medical and prison records show that he had a diagnosed personality disorder and was a challenging prisoner. There was a suggestion that he had exaggerated his mobility difficulties. He did not follow medical advice and often refused medication or to allow nurses to monitor his conditions.

21. On 8 October 2013, a prison GP diagnosed vascular dementia. On 21 October 2013, a consultant in old age psychiatry assessed the man and found that he had the capacity to make decisions about his treatment and care.

22. From March 2014, the prison held monthly multidisciplinary team (MDT) meetings to discuss the man's care. Psychiatrists saw him frequently to assess his mental health and on each occasion recorded that he retained the capacity to refuse treatment. Between August and October, healthcare staff observed that his capacity appeared to fluctuate. During 2014, he continued to refuse medication and clinical observations. An application for a place in a secure hospital was rejected.

23. In June, nurses noticed that the man appeared to be losing weight, although he refused to allow nurses to weigh him. A nurse suspected this was due to him refusing to take medication to treat his diabetes. On 20 June, the Head of Healthcare and a consultant forensic psychiatrist assessed him. The psychiatrist noted that he appeared emaciated, particularly around his legs and face and his voice seemed less full and forceful.

24. On 4 July, the man had a health check at hospital. A chest X-ray showed a small foreign body, such as a thin wire-like clip in his chest. A consultant geriatrician reviewed the test results and suggested the object might have been there for some time. He found no evidence of cancer and no other health reason for his weight loss.

25. The man continued to lose weight and, on 14 August, a nurse began a food diary to monitor his intake. The records show that he was eating normally and that diet was not a cause of the weight loss. Nurses continued to monitor him daily.

26. At a multidisciplinary team meeting on 10 October, healthcare staff were concerned about the man's poor health. He had become unusually quiet and compliant and had refused food for a few days. A nurse and a doctor advised that he should be sent to hospital urgently for further assessment. After the meeting, he told the doctor that he felt unwell and wanted to go to hospital. The doctor noted he was not aggressive as he had previously been and was very frail. He was surprised, as the man had previously rejected medical advice and interventions.

27. The man was admitted to hospital later that day. On 14 October, a CT scan of his chest, abdomen and pelvis revealed that he had terminal widespread cancer, primarily of the lung and pancreas. Doctors explained the results to him the next day and initially advised that he had a life expectancy of up to six months. On 15 October, two nurses visited him in hospital to support him. He told the nurses that he knew he was going to die.

28. The hospital discharged the man on 17 October 2014. The discharge summary indicated that they had tried to explain his diagnosis to him, but he did not fully understand due to vascular dementia. Nurses at the prison continued to support and explain his diagnosis. From his presentation, they believed his life expectancy was much shorter than the hospital had predicted and considered it was likely to be weeks or days.

29. The clinical reviewer found that healthcare staff at the prison appropriately investigated, referred, and treated both his cognitive and physical conditions. It had been impossible to perform clinical observations regularly, as he would not cooperate. Healthcare staff promptly investigated the man's weight loss. A prison GP referred him to hospital for a health check up in July, which did not identify any signs of cancer. We are satisfied that there was no delay in seeking a diagnosis and that healthcare staff fully explained his condition and prognosis to him.

The man's clinical care

30. A nurse, the prison's chronic disease and palliative care lead, was the man's case manager. After he returned to the prison, healthcare staff implemented a palliative care plan. He had agreed in hospital that he did not want to be resuscitated if his heart or lungs stopped working. Plans included frequent observations, pain relief and measures to ensure his comfort and safety. Hospital doctors had given him oramorph (an opioid) and codeine as pain relief. A prison doctor reviewed him and prescribed fentanyl patches and tramadol until the patches were available, two days later.

31. The prison continued to liaise with the hospital and consulted Macmillan nurses for specialist advice. A palliative care team from a hospice visited on 21 October and contributed to his care plan.

32. Subsequently, the man became more compliant with medication and medical care. Nurses monitored his condition daily and gave him additional pain relief when he asked for it. At a multidisciplinary meeting on 20 October, prison

security staff agreed his cell should be left open at all times to allow healthcare staff easy access to care for him.

33. On 22 October, the man moved to the Sheldon Unit (an end of life care facility in Birmingham). The unit provides respite and palliative care for patients with complex needs. His breathing was difficult and the nurses at the Sheldon Unit gave him some pain relief. His breathing deteriorated further and he later died.

34. A post-mortem examination found that the cause of the man's death was widespread cancer and pancreatic cancer.

35. We agree with the clinical reviewer that the man's condition was well-managed at HMP Birmingham. There were appropriate care plans in place and prison healthcare staff worked well with hospital staff and Macmillan nurses.

The man's location

36. During his time at Birmingham the man had spent time in ward two (a mental health unit in the healthcare centre of the prison) and J wing (a social care unit). He had been admitted to the healthcare centre's inpatient unit several times.

37. While the man was in hospital in October, he told a nurse that he did not want to go back to the prison. She discussed with a hospital palliative care nurse, whether it would be possible to refer him immediately to either the Sheldon Unit or a hospice. However, because of his life expectancy at the time, the nurse advised that a referral to a hospice was not urgent.

38. On 21 October, the man said that he would like to go either to the Sheldon Unit or a hospice, as he did not want to die in prison. The next morning, the Sheldon Unit told the prison that they had a bed available. The nurse accompanied him there by ambulance later that day.

39. The clinical reviewer commented that the collaboration between the prison and hospice ensured the man was transferred to the Sheldon Unit to die peacefully and in comfort in a community setting. We agree that it was appropriate to transfer him and we are satisfied that the prison took reasonable steps to ensure his location was appropriate throughout his illness

Restraints, security and escorts

40. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. 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 takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between the prisoner's risk of

escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgement indicated that prison staff must take into account medical opinion about the prisoner's ability to escape and keep this under review as circumstances change.

41. On 10 October, the man went to hospital by ambulance. A risk assessment indicated that he was normal risk to the public, to hospital staff and of escape. The document stated that he had threatened prison staff in the past and had demonstrated poor behaviour. The medical input section of the risk assessment (section one) noted that he used a wheelchair and was not mobilising – although also indicated that his medical condition did not restrict his ability to escape. There was no medical objection to the use of restraints.

42. The authorising manager noted, "I have considered the need to remove cuffs due to TWS [the man's] age and presentation. Risk Assessment highlights still a potential risk to the public – and has the ability to stand/walk if he feels motivated to do so". However, this opinion of his medical condition is not consistent with the information in medical records for this period. On 30 September, a member of staff from Partnerships in Care Ltd. UK, assessed his suitability for a transfer to a psychiatric hospice care unit and found he was "totally bed bound, frail and unable to stand". The assessment noted that he was emaciated and had suffered gross weight loss and muscle wasting. Almost two weeks later, on the day he went to hospital, a doctor recorded in the medical records he was "very frail".

43. The risk assessment document showed he should have three escort officers and be restrained by an escort chain. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.)

44. On 15 October, two nurses visited the man. She noted in the medical records, "His right wrist where handcuff is situated is very red and sore as cuff is so heavy". She explained her concerns to the escort officer, who telephoned a security manager at the prison to ask whether his restraints could be removed. An hour later, the security manager and Head of Safer Custody visited him and agreed to the removal of the restraints due to his very limited mobility, improved behaviour and diagnosis.

45. When the man transferred to the Sheldon Unit on 22 October, no restraints were used.

46. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances, which must be fully considered, taken into account and balanced against the security risks. The man was a wheelchair user with a number of chronic medical conditions. Although there was a suggestion that he had tended to exaggerate his mobility difficulties, that was some time in the past. On the day he went to hospital, he was very frail and immobile. We are not satisfied that the use of restraints was justified by fully considered risk assessments that took into account his risk and

condition at the time, in line with the 2007 High Court judgement. We are pleased to note that he was not restrained when taken to the hospice on 22 October.

47. Ultimately, it is the Director's responsibility to ensure that the risk assessment process is managed properly. However, the Head of Healthcare also needs to ensure that healthcare staff understand their responsibilities, and have appropriate and considered input into the risk assessment process. We make the following recommendation:

The Director and the Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

Liaison with the man's family

48. While the man was in hospital after his diagnosis of terminal cancer, a nurse asked him whether he wanted to contact his next of kin. He told the nurse that he would like to inform his two sons, but he had not been in contact with them for many years. However, he had no contact details and none were listed on his records.

49. At a multidisciplinary meeting on the 20 October, healthcare and prison staff asked whether anyone had any further information about the man's sons. The prison appointed a designated family liaison officer. The Head of Security contacted the police to make enquiries but, on 21 October, they replied that they could not find any recent addresses. The man's offender supervisor then contacted his solicitors and his probation officer.

50. After his death the police contacted the prison again and gave them the telephone number and address of the man's ex-partner, the mother of his sons. The family liaison officer completed a risk assessment, with input from the Head of Safer Custody, which proposed making contact and instructed that this should be directly with his ex-partner and with sensitivity as the police had indicated potential victim issues.

51. On 3 November, the Director telephoned the man's ex-partner. He informed her that the man had died and asked if she could give any contact details for his sons. She agreed to let his sons know. On 5 November, the family liaison officer telephoned his ex-partner again and she gave her a telephone number for his eldest son.

52. The next day, the family liaison officer telephoned the man's elder son and offered condolences. He told her that he did not want to be involved in organising the funeral, but that he would speak to his brother. He explained that his brother worked at night, so it would be easier to contact him by email.

53. The man's younger son emailed the family liaison officer on 12 November with a telephone number for her to contact him. She emailed on 20 November, offered support, and gave information about the inquest and funeral arrangements. Between 22 and 28 November, they exchanged various emails. He said he was not sure whether he wanted to be involved and did not fully understand the process. She offered a face-to-face meeting or telephone discussion. In his last email on 28 November, he said that he had decided that he did not want to be involved, as he had not seen his father for twenty years. The prison liaised with social services to organise and pay for the funeral, which was held on 3 February 2015.

54. We are satisfied that prison staff made appropriate efforts to trace and contact the man's sons.

Compassionate release

55. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months.

56. At the multidisciplinary meeting on 20 October, healthcare and prison staff commented that the man's initial life expectancy prognosis of 6 months was not realistic and suggested he might only live for another six weeks. On 22 October, a doctor completed his medical assessment of the man and stated that he did not believe he was capable of re-offending due to his poor health. He died before the application could be submitted.

RECOMMENDATION

The Director and the Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and Function Responsible
1	The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.	Accepted	Staff have been reminded that information should be shared between prison and healthcare staff and in line with the 2007 High Court judgement all staff both clinical and operational who are involved in completing escort risk assessments will be reminded to examine the current presented risk with due consideration for medical circumstances in conjunction with the indicative risk generated through existing mandatory processes	Head of Safer Custody/Head of Healthcare April 2015