

**Prisons &
Probation**

Ombudsman
Independent Investigations

Investigation into the death of Mr Anthony Harris, a prisoner at HMP Birmingham, on 8 July 2015

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Anthony Harris died of lung and colon cancer in hospital on 8 July 2015, while a prisoner at HMP Birmingham. He was 54 years old. I offer my condolences to Mr Harris' family and friends.

Mr Harris died very quickly after first reporting a cough on 22 June. There was a very slight delay in a nurse assessing him and a more urgent referral to a GP could have been considered, but neither of these matters would have prevented Mr Harris' death, which was very sudden and unexpected. I am satisfied that Mr Harris received a good standard of care at the prison, which was equivalent to that he could have expected to receive in the community.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

January 2016

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Summary

Events

1. Mr Anthony Harris was remanded to HMP Birmingham on 7 April 2015. Mr Harris smoked cigarettes, was alcohol dependant and had a history of panic attacks and depression. Doctors prescribed medication to manage alcohol withdrawal symptoms and depression. Mr Harris did not want help from the substance misuse team but healthcare staff continued to monitor him, including for high blood pressure. On 13 May, Mr Harris was sentenced to 14 months in prison
2. On 22 June, Mr Harris reported having a dry cough and kidney pain. A nurse arranged to assess him on his wing on 23 June, but officers said that because of staffing difficulties they were unable to facilitate a visit on the wing. Another appointment was arranged for the next day. On 24 June, a nurse assessed Mr Harris, who said he had lower back pain, and had had a cough for three weeks. His appetite was poor and he was short of breath at night. The nurse referred him to the GP who arranged a standard chest review for 7 July. On 1 July, Mr Harris told a nurse on his wing that he had been coughing for over two weeks. She noted that his cough was not productive and that he had stopped smoking two weeks before. As he already had an appointment arranged for 7 July, she advised Mr Harris to tell the GP about this.
3. On 5,00pm on 5 July, an officer asked a nurse to see Mr Harris, as he appeared unwell. The nurse noted the he was short of breath and his pulse and breathing rates had increased. She gave him oxygen but this had little effect, so she asked for an ambulance. At 5.50pm, paramedics arrived and, at 6.15pm, took Mr Harris to hospital where he was admitted as an inpatient.
4. On 6 July, after an X-ray and CT scan, doctors told Mr Harris he had lymphangitis cancer of the lung and a sigmoid colonic mass. His prognosis was poor and no active treatment was possible. Mr Harris's condition deteriorated very quickly and he died in hospital on 8 July. Members of his family were with him at the time.

Findings

5. Although Mr Harris missed a planned nurse assessment on 23 June, this matter was quickly rectified and a nurse saw him the next day. Mr Harris was taken to hospital on 5 July, before a planned GP assessment on 7 July. While an earlier GP assessment should have been considered on 1 July, when Mr Harris reported a continuing cough, the clinical reviewer noted that this would not have altered the outcome for Mr Harris, who died very quickly, two days after his cancer had been diagnosed on 6 July. We are satisfied that Mr Harris received a good standard of care at Birmingham, equivalent to that he could have expected to receive in the community.

The Investigation Process

6. The investigator issued notices to staff and prisoners at HMP Birmingham informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
7. The investigator obtained copies of relevant extracts from Mr Harris' prison and medical records.
8. NHS England commissioned a clinical reviewer to review Mr Harris' clinical care at the prison. The clinical reviewer has made two recommendations in his review about nurses' access to patients and about waiting times to see a GP, which the Head of Healthcare will need to address. We do not repeat them in this report as the issues did not affect the outcome for Mr Harris.
9. We informed HM Coroner for Birmingham and Solihull district of the investigation who gave us the cause of death. We have sent the coroner a copy of this report.
10. One of the Ombudsman's family liaison officers contacted Mr Harris' sister, who acted as his next of kin, to explain the investigation. His sister did not have any specific matters she wanted the investigation to consider.
11. Mr Harris' sister received a copy of the initial report. She made no comments.
12. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.
13. The investigation has assessed the main issues involved in Mr Harris' care, including his diagnosis and treatment, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.

Background Information

HMP Birmingham

14. HMP Birmingham is a local prison, principally serving the West Midlands courts, and holds up to 1,450 men. It is managed by G4S Care and Justice Services. Birmingham and Solihull Mental Health Foundation Trust provides 24-hour health services at the prison and sub-contract Birmingham Community Healthcare NHS Trust to provide primary care services.

HM Inspectorate of Prisons

15. 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 and waiting times to see the doctor were less than 48 hours.

Independent Monitoring Board

16. 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, with a locum service for evening and weekend cover. Prisoners could usually see a GP within a week and almost immediately if urgent.

Previous deaths at HMP Birmingham

17. Mr Harris was the sixth prisoner to die from natural causes at HMP Birmingham since October 2012. There were no significant similarities with the circumstances of the other deaths.

Findings

The diagnosis of Mr Harris' terminal illness and informing him of his condition

18. Mr Harris arrived at Birmingham on remand on 7 April 2015. (He was subsequently sentenced in May to fourteen months in prison for assault.) At his initial health screen, a nurse noted he was a long-term cigarette smoker and dependent on alcohol. He said he had suffered from panic attacks since 2003, had a history of depression and high blood pressure. A prison GP prescribed medication to manage alcohol withdrawal symptoms and for depression.
19. On 8 April, a prison GP assessed Mr Harris and noted that he had no alcohol withdrawal symptoms and did not want any help from the substance misuse team. Nurses continued to monitor Mr Harris' blood pressure and for any signs of alcohol withdrawal.
20. On 22 June, Mr Harris told a nurse at the wing medication hatch, that he had a dry cough and kidney pain. The nurse arranged for a nurse to review him the next day. On 23 June, a nurse went to the wing to assess Mr Harris, but officers said she could not see him on the wing as they had insufficient staff on duty. The nurse raised her concerns about the lack of access with senior managers and the assessment was rearranged for the next day. We are satisfied that this issue was appropriately resolved.
21. On 24 June, a nurse saw Mr Harris in his cell. Mr Harris reported lower backache and said he had been suffering with a cough for three weeks. The nurse noted that the cough was not productive and he had no cyanosis (Cyanosis is the appearance of a blue or purple coloration of the skin due to the tissues near the skin surface having low oxygen saturation). Mr Harris said he was unable to eat a full meal. The nurse asked for a GP appointment. A prison GP responded the same day and arranged a standard chest review for the next available slot on 7 July.
22. On 30 June, a nurse took Mr Harris's clinical observations and noted his blood pressure had increased since 24 June but all other observations remained the same. Mr Harris said that his father had suffered from lung cancer. The nurse advised him to discuss his concerns with the doctor at his forthcoming GP appointment and ask to see a nurse, if his symptoms got worse in the meantime.
23. On 1 July, a nurse was visiting another prisoner on the wing when Mr Harris told her that he had had a cough for over two weeks. She noted that the cough was not productive and that he had stopped smoking two weeks before. She told him to tell the prison doctor at his appointment on 7 July.
24. At 5.00pm on 5 July, an officer asked a nurse to examine Mr Harris, who looked unwell. Mr Harris was short of breath and his pulse and breathing rates had increased. The nurse gave him oxygen but this had limited effect and the nurse requested an ambulance. At 5.30pm, the nurse repeated the observations. She noted Mr Harris was alert and answering questions but his oxygen saturation had fallen to 90%. At 5.50pm, paramedics arrived and at 6.15pm, took Mr Harris to outside hospital.

- The hospital admitted Mr Harris as an inpatient and doctors gave him intravenous fluids and antibiotics. The next day, 6 July, doctors diagnosed he had lymphangitis cancer of the lung and a sigmoid colonic mass (cancer in the colon) after a chest X-ray and CT scan. Hospital staff told Mr Harris about his diagnosis and explained his prognosis was poor.
25. The clinical reviewer noted that Mr Harris was assessed quickly by prison healthcare staff and was taken to hospital promptly. While some consideration could have been given to arranging an earlier GP appointment when Mr Harris reported ongoing symptoms while waiting for his appointment scheduled for 7 July, this did not affect the outcome for Mr Harris. It is unlikely that an earlier GP review would have led to an earlier diagnosis. The clinical reviewer considered the standard of health care received by Mr Harris was equivalent to that he could have expected to receive in the community.

Mr Harris' medical treatment

26. At the time of his diagnosis, doctors explained to Mr Harris that he had little time left to live. No active treatment was possible and he received palliative care. Mr Harris' health declined very quickly in hospital. On 7 July, hospital staff used a syringe driver to administer continuous pain relief. On 8 July, Mr Harris died. Members of his family were with him at the time.

Mr Harris' location

27. Mr Harris had a shared cell on a standard prison wing. He did not have any mobility issues and did not need any adjustments to his cell. As soon as his symptoms were recognised on 5 July, he was taken to hospital. The possibility of a move to a hospice was considered, but a hospital consultant said that Mr Harris was too ill to move. Mr Harris remained in hospital until he died just three days later. We are satisfied that Mr Harris was appropriately located during his time at Birmingham.

Restraints, security and escorts

28. When prisoners have to travel outside prison such as to a hospital or hospice, a risk assessment is conducted to determine the nature and level of any security arrangements, including any restraints.
29. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. The level of restraints used should be necessary in the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which takes account of factors such as the prisoner's health and mobility.
30. On 5 July, when Mr Harris went to hospital, he was unwell and short of breath but he was alert and mobile. Healthcare staff assessed that his condition did not affect his risk of escape. The prison security manager decided that officers should use handcuffs to restrain him on the way to hospital. When Mr Harris arrived at the hospital, the prison security manager reviewed the risk assessment and, because of Mr Harris' declining health, decided that he should not be restrained.

31. A manager reviewed and approved the removal of restraints quickly after Mr Harris arrived at the hospital. We are satisfied that there was a comprehensive and considered risk assessment, which clearly took into account how Mr Harris' condition affected his risk of escape.

Liaison with Mr Harris' family

32. On 6 July, a nurse visited Mr Harris in hospital and informed the Head of Safer Custody of the seriousness of his condition. Mr Harris' listed next of kin was his mother. The head of safer custody telephoned Mr Harris' mother but there was no reply. She then telephoned his sister, who explained that Mr Harris' mother was in hospital. She arranged for his sister and other family members to visit Mr Harris in hospital.
33. A prison manager acted as the family liaison officer. He arranged to meet members of Mr Harris' family at the hospital and supported them on the day that Mr Harris died.
34. The prison manager remained in contact with Mr Harris' sister. Mr Harris' funeral was on 28 July and the prison contributed towards the cost in line with national policy.

Compassionate release

35. Prisoners can be released before their sentence has expired on compassionate grounds for medical reasons. Mr Harris' condition deteriorated very quickly and he died just two days after his diagnosis. There was therefore insufficient time to consider or progress and application for compassionate release.

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