Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ian Clark a prisoner at HMP Birmingham on 31 August 2016

A report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

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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*

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 Ian Clark died of bowel cancer at St Mary's Hospice on 31 August 2016, while a prisoner at HMP Birmingham. He was 69 years old. I offer my condolences to Mr Clark's family and friends.

Mr Clark received a high standard of clinical care at Birmingham where healthcare staff monitored his condition and reviewed him frequently. Staff treated Mr Clark with respect and agreed an appropriate end of life care plan, which allowed him to die in line with his wishes. I am satisfied that Mr Clark received care equivalent to that he could have expected to receive in the community.

However, I am concerned that the use of restraints when Mr Clark was taken to hospital, the level of those restraints and the use of full searching was not always justified by suitably informed risk assessments. I have raised similar issues about the use of restraints in previous investigations at HMP Birmingham and am disappointed to have to do so again.

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 2017**

Contents

Summary 1
The Investigation Process 3
Background Information 4
Findings 5

Summary

Events

1. On 30 June 2015, Mr Ian Clark received a five year prison sentence for sexual offences and was sent to HMP Birmingham.

2. At an initial reception screen, Mr Clark told a nurse that he had bowel cancer and she booked him a GP appointment. Two days later, a prison GP reviewed Mr Clark and recorded that he had an upcoming oncology appointment. On 14 July, a consultant oncologist confirmed that Mr Clark's bowel cancer had spread to his liver and that he had six to nine months to live. The consultant suggested palliative chemotherapy, which Mr Clark declined.

3. On 16 July, Mr Clark reported mild constipation to a prison GP, who advised regular monitoring due to his increased risk of a bowel obstruction. Mr Clark continued to suffer from constipation and the same doctor admitted him to the prison's healthcare unit for further monitoring on 23 July.

4. On 24 July, a nurse noted that Mr Clark could no longer tolerate food or fluids and sent him to hospital as an emergency. Hospital staff subsequently transferred him to another hospital, where he had an operation to relieve a bowel obstruction. While recovering from surgery, Mr Clark decided that he wanted palliative chemotherapy, which started on 22 September.

5. Over the next 11 months, prison staff facilitated Mr Clark's chemotherapy appointments and healthcare staff monitored and reviewed his condition frequently. Nurses created care plans and liaised with palliative care nurses regarding a hospice transfer. Doctors prescribed appropriate medication along with nutritional drinks for weight loss.

6. On 22 August 2016, a nurse recorded that Mr Clark's health and mobility had declined significantly. An urgent multi-disciplinary meeting took place and he was transferred to a hospice the next day. Mr Clark died there on 31 August.

Findings

7. The clinical reviewer found that Mr Clark received a high standard of clinical care at Birmingham. Healthcare staff followed specialist advice, reviewed him frequently and treated his conditions appropriately. Liaison with the hospice was good and Mr Clark was appropriately involved in decisions about his care. We are satisfied that the care he received was equivalent to that he could have expected to receive in the community.

8. We are concerned that Mr Clark was restrained by double handcuffs when he was taken to hospital in January 2016. This level of restraint was not justified by his security category or an objective assessment of risk. We are also concerned that an escort chain was used to restrain Mr Clark during chemotherapy treatment.

9. We are also concerned that Mr Clark was subject to full searches (also known as a strip search) on returning to the prison from hospital, with no evidence of a risk assessment to justify the procedure.

Recommendations

- The Director and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of the prisoner and are based on the actual risk the prisoner presents at the time.
- The Director should ensure that full searches on return from hospital escorts are only undertaken following an appropriate risk assessment, and when there is sufficient intelligence to justify their use.

The Investigation Process

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

11. The investigator obtained copies of the relevant extracts from Mr Clark's prison and medical records. He interviewed one member of staff at Birmingham on 27 October 2016 and another by telephone on 14 November.

12. NHS England commissioned a clinical reviewer to review Mr Clark's clinical care at the prison.

13. 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.

14. One of the Ombudsman's family liaison officers contacted Mr Clark's cousin to explain the investigation and identify any matters she wanted the investigation to consider. His cousin was concerned that Mr Clark suffered from constipation shortly after he arrived at HMP Birmingham and she wanted to know more about the care he received for this. She was concerned about the use of restraints for hospital escorts and asked why he was strip searched in January 2016.

15. The investigation has assessed the main issues involved in Mr Clark'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.

16. Mr Clark's family received a copy of the initial report. They did not make any comments.

17. The initial report was shared with the Prison Service. The Prison Service pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Birmingham

18. 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, which includes a healthcare unit with two 15 bed wards.

HM Inspectorate of Prisons

19. 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

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to June 2016, the IMB reported that healthcare staff sickness levels had had a negative impact on the department, particularly when multiple unlock was required. However, there continued to be a high level of prisoner satisfaction with the service provided by the healthcare department. The IMB also reported that a small number of prisoners had been double handcuffed for external appointments, which caused difficulties taking blood and receiving chemotherapy.

Previous deaths at HMP Birmingham

21. Mr Clark was the fifth prisoner to die of natural causes at Birmingham since January 2015. There have been three subsequent deaths. We have previously raised the need for appropriate risk assessments to justify the use of restraints.

Findings

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

22. On 30 June 2015, Mr Ian Clark received a five year prison sentence for sexual offences and was sent to HMP Birmingham. At an initial reception screen, Mr Clark told a nurse that he had recently been diagnosed with bowel cancer and secondary liver cancer and she booked him a GP appointment. Later the same day, a prison GP requested Mr Clark's community medical record and prescribed omeprazole (a medication to reduce the amount of acid produced in the stomach). The GP did not see him in person.

23. A prison GP reviewed Mr Clark on 2 July and noted that he had an upcoming oncology appointment. On 14 July, a consultant oncologist saw Mr Clark at the hospital and confirmed that his bowel cancer had spread to his liver. The consultant suggested palliative chemotherapy but Mr Clark declined this treatment as it would not cure him and agreed to treatment of symptoms only.

24. Healthcare staff acted promptly after Mr Clark disclosed that he had bowel cancer. They requested his community medical record and facilitated his oncology appointment. We are satisfied that healthcare staff acted appropriately and without delay.

Mr Clark's clinical care

25. On 16 July, Mr Clark informed a prison GP that he had a diagnosis of terminal cancer with a life expectancy of six to nine months. He reported mild constipation and that he had had a stent fitted inside his bowel, before entering the prison, to alleviate any obstructive symptoms. The GP recorded that Mr Clark was at risk of a bowel obstruction, identified a need for close monitoring and requested formal confirmation of his cancer diagnosis.

26. On 21 July, Mr Clark told a nurse about his terminal diagnosis and indicated that he would prefer to die in a hospice. He reported ongoing constipation and she booked him a GP appointment. Later that day, another nurse reviewed Mr Clark with a prison GP, who advised to continue with daily monitoring. The GP prescribed Lactulose (a laxative) but did not see him in person.

27. On 23 July, Mr Clark reported mild abdominal pain and a decrease in his appetite to a prison GP, who conducted an examination and noted that he did not report any vomiting or difficulty passing wind. The GP recorded that Mr Clark had an abdominal X-ray arranged for later that day and admitted him to the prison's healthcare unit for further monitoring. A nurse received formal conformation of Mr Clark's diagnosis from the hospital and attended a multi-disciplinary meeting to plan his ongoing care.

28. The next day, the nurse noted that Mr Clark could no longer tolerate food or fluids and sent him to hospital as an emergency. Hospital staff later transferred him to another hospital, where he had an operation to relieve a bowel obstruction that resulted in the formation of an ileostomy (where the small intestine is diverted through an opening in the stomach, known as a stoma). While in hospital, Mr Clark decided that he wanted to receive palliative chemotherapy and

staff made an oncology referral. On 3 August, Mr Clark returned to the prison's inpatient unit and a nurse saw him for a review.

29. A consultant oncologist reviewed Mr Clark at hospital on 8 September. Two weeks later, with the support of a nurse, he started his first cycle of chemotherapy. Over the next four months, healthcare and prison staff facilitated Mr Clark's hospital appointments and attended regular multi-disciplinary review meetings. Nurses created care plans and doctors prescribed appropriate medication, as indicated by hospital specialists.

30. On 4 May 2016, Mr Clark told a nurse and a prison GP that he did not want anyone to resuscitate him if his heart or breathing stopped. He signed an order to that affect and the nurse notified his next of kin. Over the next two months, healthcare staff created an end of life care plan and monitored Mr Clark's general presentation and dietary intake daily. They facilitated outside hospital appointments and liaised with specialist palliative care nurses regarding a hospice transfer as his health deteriorated. Doctors prescribed appropriate medication and high energy drinks for weight loss.

31. On 21 July, a prison GP examined Mr Clark and recorded that his overall health had declined. He had lost weight, had a reduced appetite, and developed an increased swelling around his stoma site. The GP sent Mr Clark to hospital, where staff admitted and treated him for ascites (a build up of fluid in the abdomen) and sepsis (a life-threatening condition that arises when the body's response to infection injures its own tissues and organs). On 28 July, Mr Clark returned to the prison and a nurse saw him for a review.

32. A specialist nurse from a hospice visited Mr Clark on 10 August to discuss his end of life wishes and to explain what he should expect at the hospice. Two days later, the same nurse told Mr Clark that they would not be arranging his immediate transfer to the hospice as he was due to have another cycle of chemotherapy. The nurse noted that the hospice could only admit Mr Clark for four to six weeks and they wanted to avoid a situation whereby he would have to return to the prison should his condition improve.

33. On 22 August, a nurse issued Mr Clark with his morning medication and recorded that his mobility had declined rapidly. She noticed pressure sores on his back and arranged for the delivery of an airbed. Another nurse called an urgent multi-disciplinary meeting and a prison manager agreed to leave his cell door unlocked so that nurses could access him promptly. The next day, Mr Clark deteriorated further and was transferred to the hospice for end of life care. Prison healthcare staff kept in frequent touch with the hospice for updates. Mr Clark died at the hospice on 31 August.

34. The clinical reviewer considered that Mr Clark received a high standard of care at Birmingham. Healthcare staff managed his condition well and followed instructions from specialists in relation to his chemotherapy treatment and end of life care. Staff put in place care plans, prescribed appropriate medication and involved Mr Clark in decisions about his ongoing treatment. We are satisfied that the care Mr Clark received was equivalent to that he could have expected to receive in the community.

Mr Clark's location

35. Mr Clark sent the majority of his time at Birmingham in the prison's healthcare unit after moving there on 23 July 2015. A nurse told the investigator that he had good mobility and did not necessarily need to be there, but he had made friends and the prison could facilitate him remaining there.

36. On 10 June 2016, Mr Clark moved to the older prisoners' wing, as he wanted to associate with prisoners of a similar age and have access to the prison gardens. However, his condition deteriorated and he returned to the healthcare unit a month later.

37. Mr Clark indicated that he wanted to go to a hospice for end of life care. A nurse liaised with prison managers and staff at the hospice to arrange a move. We are satisfied that Mr Clark's location was appropriate throughout his time in custody and that the prison took full account of his wishes.

Restraints, security and escorts

38. 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 a 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 judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

39. Mr Clark went to hospital on a number of occasions and those escort risk assessments provided by the prison indicated that he presented a low risk of escape and harm to others. Generally, his risk assessments recommended that officers restrain Mr Clark with single handcuffs and medical staff did not indicate any objections. Evidence shows that staff reviewed the same risk assessment each time Mr Clark went to hospital and adjusted the level of restraint according to his physical presentation and ability to mobilise. A nurse told us that Mr Clark's mobility was good until his death and despite having a fall in July he refused to use walking sticks or a Zimmer frame. Although evidence suggests that medical input regarding his mobility and the use of restraints was discussed in weekly bed management meetings with prison staff, the risk assessment does not appear to have been updated.

40. When Mr Clark went to hospital for chemotherapy on 5 January 2016, a prison manager decided that staff should use double handcuffs to restrain him instead of single handcuffs. Double cuffing entails the prisoner having his hands handcuffed in front of him and then having one wrist attached to a prison officer by an additional set of handcuffs. This is usually required for moving category A or category B prisoners in good health. When, exceptionally, double handcuffs are used for a category C prisoner, like Mr Clark, the Prison Service requires that the reasons should be recorded in writing. This was not done and we can see no

reason why it would be justified. Prior to Mr Clark starting his chemotherapy treatment, escort officers obtained permission to reduce the level of restraint to an escort chain. (An escort chain is a long chain with a handcuff at each end, one of which is attached to a prison officer.) This disregards the 2007 High Court Judgment, which held that restraints should not be used during life saving treatment such as chemotherapy, except when justified by security considerations. The prison manager told the investigator that he took account of Mr Clark's offence, mobility, and knowledge obtained from previous escorts when making his decision.

41. Evidence shows that prison staff used single handcuffs to restrain Mr Clark for hospital escorts until 12 April. At this point, his health deteriorated and prison managers downgraded the level of restraint to an escort chain. When he went to the hospice on 23 August, a prison manager authorised two officers to escort him but not to use any restraints as his condition had deteriorated. Mr Clark was not restrained again.

42. While we are satisfied that the prison reduced Mr Clark's level of restraint as his condition deteriorated and that they appropriately decided not to use restraints following his transfer to a hospice, we are concerned about the decision to use double handcuffs. The risk assessment appears to have been based primarily on Mr Clark's offence, with little consideration of his actual risk or how his health affected this risk, as the 2007 High Court judgment requires. We are also concerned that an escort chain was used to restrain Mr Clark during chemotherapy treatment. Whenever restraints are used, the risk assessments must accurately reflect the risk posed at that time to ensure proportionality and to maintain human dignity. We make the following recommendation:

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

43. A prison manager authorised a full search (otherwise known as a strip search) on Mr Clark's return to prison on 5 January 2016. He told us that he did not recall any specific threat but considered regular escorts to be an increased risk. Escort risk assessments from 12 April and 12 July, indicate that Mr Clark be subject to a full search on returning to prison. An escort record from 21 July indicates that prison staff conducted a full search of Mr Clark, with no evidence of a heightened risk. It would appear that despite restraints remaining in place throughout his hospital treatment, Mr Clark was still subject to full searches on returning to prison.

44. Prison Service Instruction (PSI) 07/2016, Searching of the Person, does not require the prison to automatically perform a full search of a prisoner returning from a hospital escort. Instead, it states that each prison must carry out risk assessments to assess the security risks and to put in place appropriate screening as a response. Despite repeated requests it has not been possible to obtain a copy of Birmingham's local searching policy. There is no intelligence to suggest an increase in the risk Mr Clark presented and no record of a risk

assessment that assessed his security risk for any of the full searches that staff performed on Mr Clark. We can see no reason why they would be justified.

45. Full searches are inherently demeaning and can be unpleasant for both staff and prisoners. Where they are not properly authorised and conducted they might also constitute an assault. For these reasons, it is vital that any full searches conducted on prisoners returning from hospital escorts are supported by a risk assessment that accurately reflects any security concerns and the risks posed. This will also help to ensure proportionality and to maintain human dignity. We make the following recommendation:

The Director should ensure that full searches on return from hospital escorts are only undertaken following an appropriate risk assessment, and when there is sufficient intelligence to justify their use.

Liaison with Mr Clark's family

46. In July 2015, the prison appointed a prison manager as a family liaison officer. She made immediate contact with Mr Clark's cousin to update her on his deteriorating condition and to offer ongoing support. She maintained contact with Mr Clark's cousin until he started to respond to treatment in October.

47. On 23 March 2016, the prison manager resumed contact with Mr Clark's cousin. Over the next five months, she kept in contact with Mr Clark's cousin and helped facilitate visits to the prison and to the hospice.

48. At 1.25pm on 31 August, a member of staff from the hospice informed the prison manager that Mr Clark had died. At 1.40pm, she telephoned Mr Clark's cousin to break the news as previously agreed, but the hospice had already notified her. She offered her condolences and provided ongoing support until Mr Clark's funeral on 16 September. The prison did not contribute to the costs of the funeral because Mr Clark had a pre-paid funeral plan.

49. We are satisfied that there was appropriate liaison with Mr Clark's family.

Compassionate release and release on temporary licence

50. 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.

51. Release on temporary licence (ROTL) can be granted for precisely defined and specific activities which cannot be provided in the prison. A risk assessment is completed to ensure that the prisoner's temporary release does not present unacceptable risks. A National Offender Management Service (NOMS) manager working within a private sector prison is able to grant the temporary licence and will decide on whether the prisoner is to be accompanied by staff.

52. In July 2015, Mr Clark received a prognosis of six to nine months. After exceeding this prognosis, hospital consultants did not offer another prognosis. As a result, the prison could not apply for compassionate release. We are

satisfied with this decision because Birmingham considered ROTL as an alternative.

53. On 23 August 2016, a prison manager and an offender supervisor completed a ROTL risk assessment. This indicated that one member of staff should accompany Mr Clark at the hospice due to the nature of his offences. The same day, a NOMS manager reviewed the assessment and authorised Mr Clark's temporary release for end of life care. Mr Clark signed a copy of his licence and prison staff kept the risk assessment under frequent review. We are satisfied that ROTL was appropriate for Mr Clark in the circumstances.

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