Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Marco Brooks a prisoner at HMP Birmingham on 12 August 2017

A report by the Prisons and Probation Ombudsman

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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.

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

Mr Marco Brooks died on 12 August 2017 of cancer of the spleen, bone marrow and liver, while a prisoner at HMP Birmingham. He was 25 years old. We offer our condolences to his family and friends.

Mr Brooks received a good standard of care at Birmingham, equivalent to that which he could have expected to receive in the community.

However, we note that there was scope to improve the quality of communication between healthcare staff at the prison and the hospital overseeing Mr Brooks' care. We are also concerned that Mr Brooks was unnecessarily restrained on his last admission to hospital.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman **February 2018**

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Summary

Events

1. On 20 January 2017, Mr Marco Brooks was convicted of conspiracy to supply drugs and was sent to HMP Birmingham.

2. During his initial healthcare induction, Mr Brooks told a nurse that he had asthma and depression, and that he had been diagnosed with a rare lymphoma (cancer) in 2015.

3. A nurse contacted his community specialist who explained that Mr Brooks had been in remission, but had not been attending his appointments. An ultrasound scan was booked to check the progression of his illness. The ultrasound confirmed that there was widespread disease, including to the cranial nerve.

4. On 21 February, Mr Brooks was admitted to hospital due to a decline in his health, believed to be due to lower spinal cord compression. He remained in hospital until 20 March, declining all options for treatment.

5. Mr Brooks then agreed to start treatment and on 24 March, he began chemotherapy. In late March, Mr Brooks was given a prognosis of six months, and all palliative options were discussed with him. Mr Brooks continued not to comply with his treatment, and was therefore not offered any further chemotherapy after 19 April.

6. In early July, a doctor raised concerns about Mr Brooks' blood count levels and recorded that he looked unwell and that his legs were swollen with cellulitis. Despite this, Mr Brooks refused treatment. On 3 July, Mr Brooks was unable to move at all and he was admitted to hospital, restrained by a single cuff.

7. On admission, Mr Brooks was given a prognosis of three months and the hospital facilitated end of life care. He was given extended visits so that his family could be with him. He remained in hospital and died on 12 August with his family by his side.

Findings

8. We are satisfied that Mr Brooks' care at Birmingham was equivalent to that which he could have expected to receive in the community. Mr Brooks came into prison with an incurable form of cancer, and healthcare staff referred him promptly to hospital when his condition deteriorated. His care was considerate and well managed, particularly as Mr Brooks did not comply with his treatment plan.

9. There was however an instance of poor communication between the prison healthcare department and the hospital, resulting in a delay of arranging an outpatient appointment.

10. When Mr Brooks was admitted to hospital on 3 July, the prison correctly appointed a family liaison officer who maintained regular contact with Mr Brooks' mother. The process for compassionate release was also started as soon as Mr Brooks was given a prognosis of three months.

11. We are, however, concerned that on his last admission to hospital he was unnecessarily restrained.

Recommendations

- The Head of Healthcare should ensure that there is effective communication between the prison healthcare department and the hospital so that necessary appointments are attended.
- 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 are proportionate, fully take into account a prisoner's health, and are based on the actual risk a prisoner presents at the time.

The Investigation Process

12. 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.

13. The investigator obtained copies of relevant extracts from Mr Brooks' prison and medical records.

14. NHS England commissioned a clinical reviewer to review Mr Brooks' clinical care at the prison.

15. We informed HM Coroner for Birmingham and Solihull of the investigation who provided us with the cause of death. We have sent the Coroner a copy of this report.

16. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

17. Our investigation assessed Mr Brooks' 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.

Background Information

HMP Birmingham

18. HMP Birmingham is a local prison, 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, including a 15-bed healthcare unit.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Birmingham was in February 2017. Inspectors noted that the health interactions were good. Clinical records and care planning were mostly good, and patients were involved in decision making as evidenced by mental health records (but not always in other documents).

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 2017, the IMB reported that waiting times to see a GP were comparable to those in the community.

Previous deaths at HMP Birmingham

21. Mr Brooks was the ninth prisoner to die of natural causes at Birmingham since January 2016. We have made previous recommendations about the inappropriate use of restraints.

Findings

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

22. On 11 January 2017, Mr Marco Brooks was remanded to HMP Birmingham. He was convicted of conspiracy to supply drugs on 20 January, and was returned to Birmingham.

23. On arrival, Mr Brooks told a nurse that he had asthma and depression and that he had been diagnosed with hepatosplenic t-cell lymphoma (a rare form of cancer, with a poor prognosis) in 2015. The nurse contacted an oncologist at a hospital in Birmingham and told them that Mr Brooks was under the care of HMP Birmingham. She asked for information about his diagnosis and the hospital scheduled an appointment for 31 January for Mr Brooks to see an oncologist (a cancer specialist). She referred Mr Brooks to a prison doctor for the second stage of his health screening.

24. A prison GP saw him on the afternoon of 20. He assessed Mr Brooks as suitable for in-possession medication, and gave him pain relief.

25. On 23 January, a consultant haematologist wrote to the prison and outlined Mr Brooks' diagnosis and care needs. He noted that Mr Brooks had not attended a number of appointments in the community, and while tests showed that he was in remission in July 2016, there was a high probability, given the type of cancer, that he would relapse at some point. The haematologist made an appointment for Mr Brooks to have an ultrasound scan on 20 January to assess the progression of his illness. This showed that Mr Brooks was no longer in remission and on 23 February, a nurse noted that there was widespread disease, including to the cranial nerve.

26. On 13 March, a hospital consultant told prison healthcare staff that Mr Brooks had six months to live. A nurse saw Mr Brooks that day, and they discussed his prognosis. She recorded that Mr Brooks was aware that his treatment options were limited and he had not attended appointments in the community. She explained all palliative options to him, and he was clear about his future.

27. Mr Brooks' health declined in early July. After he was admitted to hospital on 3 July, Mr Brooks received a prognosis of a maximum of three months.

28. Mr Brooks arrived in prison with an incurable form of cancer. The clinical reviewer felt that he received a good standard of care in the healthcare department at Birmingham. While Mr Brooks was sometimes a challenging patient to manage, there is evidence in his medical records that healthcare staff consistently tried to work with him, they kept him informed at all times and involved him in decisions about his care.

Mr Brooks' clinical care

Background

29. In 2015, Mr Brooks had a course of ICE chemotherapy (one of the chemotherapy regimens, used to treat relapsed or refractory lymphoma), followed by three courses of SMILE chemotherapy (a chemotherapy regime to treat stage four lymphoma). This resulted in the remission of Mr Brooks' cancer in 2015. In 2016, he had a relapse of meningeal disease (the cancer spread to the membranes around the brain and spinal cord). Mr Brooks was then given a further cycle of both chemotherapies but, as he did not comply consistently with his management plan, his oncologist said that he might not have had enough treatment for it to be effective.

HMP Birmingham

30. When Mr Brooks returned to HMP Birmingham on 20 January, a healthcare administrator, contacted a hospital to rearrange his existing appointments and was told that an appointment had been made for 31 January. She noted that on 23 January, she telephoned the hospital oncology team who told her that they had no record that Mr Brooks received treatment in their department and that a new referral was needed. Prison healthcare staff referred Mr Brooks again on 24 January, and he subsequently received an appointment for 7 February.

31. On 16 February, Mr Brooks was unable to walk to the medication hatch due to back pain. A nurse created a physical mobility care plan for him, which included a pain review and falls prevention management.

32. On 21 February, Mr Brooks was due to attend an appointment at the hospital for a lumbar puncture and intrathecal chemotherapy (a procedure where a needle is inserted into the lower part of the spine to test for conditions affecting the brain, spinal cord or other parts of the nervous system). However, he said that he felt too unwell to go. A nurse insisted that he should attend but when he arrived at hospital, the staff there assessed that he was too unwell to receive treatment and required further assessment in hospital.

33. Mr Brooks remained in hospital until 20 March when he was returned to the prison hospital wing. He told nursing staff at the prison that he had not been offered any treatment or therapy in hospital. However, when a nurse contacted the hospital a specialist told her that Mr Brooks had declined all of his treatment and therapy options. The nurse noted that Mr Brooks appeared to have full mental capacity.

34. The next day, a prison GP prescribed Mr Brooks with anti-viral medication and pain relief.

35. On 24 March, Mr Brooks attended a further course of chemotherapy at the hospital. He then refused to attend an appointment with the oncologist on 31 March. The prison did not contact the hospital to inform them of this. He next attended hospital for chemotherapy on 19 April, after which no further appointments were made due to his non-compliance.

36. On 2 May, Mr Brooks' consultant haematologist wrote to the prison healthcare team outlining his missed outpatient appointments and highlighting the importance of him attending, or they would consider the need to discharge him.

37. On 26 May, a nurse noted that Mr Brooks had facial paralysis. Mr Brooks told her that it became worse when he had chemotherapy. A prison GP, saw him that day and noted that it should be monitored but that the paralysis was likely related to his cancer and would settle naturally.

38. On 26 June, Mr Brooks told a nurse that he had trouble sitting up and had swelling to his legs. She booked an appointment for him to see a doctor.

39. On 1 July, a prison GP saw Mr Brooks, and recorded that his legs were very swollen with cellulitis. He noted his concern that Mr Brooks was refusing anticoagulant injections. He tested Mr Brooks' blood. The blood test results came back on 2 July and indicated concern about his blood count levels. A Sister contacted the haematologist at hospital who advised her that a review of the results could wait until his hospital appointment the next day.

40. On 3 July, Mr Brooks was unable to move and his hospital appointment that day was cancelled. A clinical team manager contacted the hospital and was advised that he should be brought to hospital that evening. Mr Brooks was taken to hospital X as it was nearer than hospital Y, and after he stabilised, he was transferred to Hospital Y on 7 July.

41. As it became apparent that Mr Brooks was nearing the end of his life, a decision was made for him to remain in hospital. The hospital facilitated end of life care, with open visits so that his family could be with him. On 28 July, Mr Brooks said that he did not want anyone to resuscitate him if his heart or breathing stopped and he signed an order to that effect.

42. Mr Brooks' health continued to decline, and at 9.38pm on 12 August, a doctor confirmed his death.

43. We agree with the clinical reviewer that Mr Brooks' condition was well managed at Birmingham, and was equivalent to the care that he could have expected to receive in the community.

44. However, the clinical reviewer said that, while he could not say whether or not it would have changed the outcome for Mr Brooks because of his poor prognosis and lack of compliance with his treatment, communication between HMP Birmingham and a hospital was sometimes poor, and had resulted in a delayed appointment. We agree, and we make the following recommendation:

The Head of Healthcare should ensure that there is effective communication between the prison healthcare department and the hospital so that necessary appointments are attended.

Mr Brooks' location

45. When Mr Brooks arrived at Birmingham on 20 January 2017, he was placed on C Wing. On 13 February, after Mr Brooks complained of back pain, a prison GP suggested that Mr Brooks should be transferred to a ward in the healthcare department. Mr Brooks refused as he was a smoker, and knew that he could not smoke there.

46. Mr Brooks remained on C Wing and members of the healthcare team regularly assessed him to check that this did not affect him adversely. On 15 February, Mr Brooks asked to be moved to the healthcare department as he was becoming increasingly unwell. The next day, Mr Brooks signed a refusal for medical treatment and discharged himself from the ward against the advice of healthcare staff's advice.

47. On 20 March, after being discharged from hospital, Mr Brooks asked to be returned to C Wing. There were no cells available so he remained in the healthcare department. On 21 March, Mr Brooks said that he had changed his mind and wanted to remain on the ward. He was given a wheelchair as he was unable to walk. The Director approved that nursing staff could unlock Mr Brooks' cell at night if needed - during night patrol state, only the night orderly officer can usually open cells - and that an officer could be asked to help move him if necessary.

48. Mr Brooks remained on the hospital ward until 10 May 2017 when he discharged himself again and signed a disclaimer to that effect. Mr Brooks refused to be returned to the healthcare ward and remained on C Wing until his final admission to hospital on 3 July.

49. We agree with the clinical reviewer that Mr Brooks' location was appropriate and did not affect his clinical care. There are several examples of good practice where prison and healthcare staff worked well together to make sure that Mr Brooks' wishes were taken into account without his healthcare being compromised.

Restraints, security and escorts

50. When prisoners have to travel outside of the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk, taking into account factors such as the prisoner's health and mobility.

51. A risk assessment was completed for all Mr Brooks' transfers to hospital, with clear medical input and decision making. On each occasion, Mr Brooks was assessed as a low risk of hostage taking and risk to staff, and a medium risk of potential escape, external assistance, to staff and the general public. On each of these occasions, Mr Brooks was still fully mobile and was restrained with a single cuff, which was appropriately removed during any treatment that he received. We considered that these decisions were reasonable in the circumstances.

52. When Mr Brooks was taken to hospital on 3 July, he was restrained by a single cuff. The decision to do so was reviewed after 24 hours by the Director. Although Mr Brooks was initially immobile, he was soon able to move, the Director noted that Mr Brooks should remain restrained, but he lowered the level of his restraints to an escort chain. After he was stabilised, Mr Brooks was transferred from Hospital X to Hospital Y on 7 July, restrained with an escort chain. Mr Brooks' risk continued to be reviewed, and on 11 July after a decline in his health, the Director authorised the removal of Mr Brooks' restraints for reasons of decency. Mr Brooks was unrestrained for the remainder of his time in hospital.

53. We are pleased that HMP Birmingham completed thorough risk assessments when Mr Brooks was receiving treatment, and considered the risk that he posed at that time.

54. However, when Mr Brooks was admitted to hospital, he was clearly a very ill man. Although staff completed a timely review of his risk after 24 hours and reduced the level of restraint, given his physical condition, it is hard to see that he posed a realistic risk of escape, to the extent that mechanical restraints were necessary in addition to the two escorting officers. 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 are proportionate, fully take into account a prisoner's health, and are based on the actual risk a prisoner presents at the time.

Liaison with Mr Brooks' family

55. On 4 July, after Mr Brooks was admitted to hospital, a training manager was appointed as the family liaison officer. On 5 July, the training manager and the Director visited Mr Brooks who confirmed that his mother was his nominated next of kin and that he was happy for the training manager to share information with her about his condition. She contacted Mr Brooks' mother, and remained in regular contact with her, advising her of developments in Mr Brooks' condition and offering support. An entry in Mr Brooks' medical records indicated that his family were given open visitation from 12 July.

56. Mr Brooks' mother remained at his bedside for the following month and was with him when he died on 13 August. The training manager contacted his mother that day but she was unable to speak to her. She eventually managed to speak to her on 16 August and arranged to visit her two days later. She remained in contact with Mr Brooks' family until after the funeral.

57. Four members of prison staff attended Mr Brooks' funeral which was held on 11 September 2017. The prison contributed towards for Mr Brooks' funeral in line with national instructions.

Compassionate release

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

59. When he was admitted to hospital on 3 July, Mr Brooks received a prognosis of three months or less. The Offender Management Unit (OMU) appropriately started the process for compassionate release on 6 July. This was a lengthy administrative process which involved collating information about Mr Brooks' condition, evidence of his current risk to the public should he be released and the arrangements for care within the community. The OMU appropriately passed this information to the Director who approved the application and sent it to HM Prisons and Probation Service (HMPPS) for a final decision. HMPPS considered Mr Brooks as eligible for compassionate release at a review on 1 August but he died before the process was completed.

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