# INVESTIGATION INTO THE DEATH OF A MAN WHO DIED IN A HOSPICE WHILST A PRISONER AT HMP BIRMINGHAM

**REPORT BY THE PRISONS AND PROBATION OMBUDSMAN FOR ENGLAND AND WALES**

**July 2006**

This is the report of an investigation into the circumstances of the death of a man who died, according to his family, aged 45 years in a hospice in Birmingham. At the time of his death the man was a sentenced prisoner in HMP Birmingham. The cause of death given by the pathologist on 17 January 2006 at the post mortem was:

1a Bronchopneumonia
b Carcinoma of Bronchus
2 Metastasis of lung & lymph nodes

This investigation was carried out by two of my investigators. A doctor from the West Midlands Postgraduate Medical and Dental Deanery carried out a clinical review of the man's medical care and treatment for which I am most grateful.

I extend my condolences to the man's family on their loss.

I would like to thank the Governor of HMP Birmingham for making the necessary facilities available to my investigators, and thanks also to the liaison officer for his invaluable help and support

The Inquest into the man's death was held on Wednesday 21 June. The verdict of the jury was that the man died of natural causes.

**Emma Bradley**
**Deputy Prisons & Probation Ombudsman** **July 2006**

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## Summary

The man was 45 years old when he died. He was received into HMP Birmingham in January 2005 as a licence recall. At Birmingham, he completed a detoxification programme for his substance misuse. The man was transferred to HMP Featherstone on 20 May 2005.

On 30 October at Featherstone the man suffered a stroke and was admitted into the New Cross Hospital (stroke unit). This stroke left him physically impaired and unable to cope without 24 hour nursing care. On his discharge from the hospital on 30 November, the man was taken to HMP Birmingham.

Whilst in Birmingham the man stayed within the Healthcare Centre. During this period of time he complained of pain, difficulties in breathing and generally feeling unwell.

During December medical tests were arranged by two prison doctors. These revealed that the man probably had cancer with bony metastasis. The man was therefore placed on the pain relief medication Morphine. He was kept as comfortable as possible. The man's family were contacted by the prison doctor who informed them of the sad news. The family visited the man on the ward in the Healthcare Centre.

Staff were supportive of the man and his needs. A fellow prisoner befriended the man and for a while they shared a cell together.

It became clear that the man was terminally ill and as his health continued to fail, procedures were put in place to release him on temporary licence to a hospice.

On 12 January 2006, the man was transferred to a hospice in Birmingham where his palliative care continued until his death on 15 January.

In this report a total of six recommendations are made regarding clinical care.

## Investigation Process

My practice in apparent deaths from natural causes is to conduct an initial review to determine the extent of the investigation required. My investigators visited Birmingham on 19 January 2006, and spoke to the appointed liaison who outlined the facts relating to the man's stay in Birmingham and his transfer to the hospice. My investigators were given access to the man's records, including his medical record. Notices to staff and prisoners were issued announcing the investigation and providing them the opportunity to contribute to it.

A family liaison officer from my office contacted the family of the man. Both he and my investigator met the family on 6 February and explained the purposes of the investigation and its process. They also listened to the concerns of the family.

The clinical reviewer, an Associate Dean at West Midlands Postgraduate Medical and Dental Deanery, carried out a clinical review of the management of the man's health needs whilst he was at Birmingham on behalf of Heart of Birmingham Primary Care Trust.

My investigators interviewed several members of staff at Birmingham in relation to the man's health care.

The interviews took place over two days, and Birmingham kindly provided facilities to enable my investigators to work uninterrupted.

Her Majesty's Coroner for Birmingham was contacted to inform him of the nature and scope of the investigation. A copy of the post mortem report was also requested. My report was sent to the Coroner to assist with the Inquest which was held on 21 June.

## HMP Birmingham

Birmingham is a local Victorian prison built in 1849. It is a category B prison serving two Crown Courts and numerous Magistrates Courts in the West Midlands area. It is a prison that holds adult males on remand and those sentenced.

Birmingham has recently undergone a multi million pound investment programme. This includes a new Healthcare Centre.

The healthcare is provided by the Primary Care Trust (PCT) Heart of Birmingham, although the PCT commissions Birmingham and Solihull Mental Health Trust to provide the staff in the Healthcare Centre. The Healthcare Centre is able to hold 34 patients, 17 on each ward. Most cells are single occupancy although there are two doubles on each ward.

## The Man

The man was born and brought up in Birmingham. He had a happy childhood and went to a mainstream school. The man left school at the age of 16 with a number of formal qualifications. As a child and adult he had a good relationship with his family. and had five children, four of whom are grown up and his youngest, a son, lives in Ireland with relatives.

The man had a prolific offending history and had been in prison many times. It is thought his addiction to heroin was the catalyst for these convictions.

The man was recalled to prison in January 2005 after breaching his early release conditions from a previous period of imprisonment.

When my investigator visited the man's sister, she expressed frustration at not knowing why her brother's licence was revoked.

The revocation of his licence was due to the fact he breached conditions 5(iii) and 5(vi):

"5(iii) Failed to live where reasonably approved by your supervising officer and notify him or her in advance of any proposed change of address".

"5(vi) Failed to be of good behaviour, not to commit any offence and not to take any action which would jeopardise the objectives of your supervision namely to protect the public, prevent you from re-offending and secure your successful re-integration into the community".

On 28 February the man appeared before Birmingham Crown Court and was sentenced to 3 ½ years imprisonment for a further offence, committed whilst on licence. For the breach of his licence he also had to serve the remaining time of 18 months.

## Events leading up to the man' death

The man began his recall period on 24 January 2005, at HMP Birmingham. He was transferred to Featherstone on 20 May 2005 and returned to Birmingham on 30 November 2005.

During his stay at Birmingham the man commenced a 12 day detoxification programme for his drug abuse. He completed this programme successfully.

There are a few other entries within the medical record. These relate to back pain, which the man explained resulted from a fall five years previously. Other complaints include cough, cold and toothache.

The most significant entry related to the man being admitted to hospital from Featherstone on 30 October following a collapse and suspected overdose of five Tramadol tablets. An ambulance was called and he was taken to New Cross Hospital (stroke unit) before being transferred to West Park Rehabilitation Centre in Wolverhampton. Whilst in New Cross Hospital it was confirmed that he had suffered a stroke to the right side of his brain resulting in left sided weakness. This diagnosis was confirmed by a CT scan. He was discharged from hospital to Birmingham prison, as Featherstone prison did not provide the 24 hour nursing care that he required.

He was discharged on the following medications; Aspirin, Simvastatin (lipid reducing drug) Co-codamol, Folic Acid, Citalopram, Tramadol, Dihydrocodeine, Zopiclone and Temazepam.

At Birmingham the man was located in the Healthcare Centre. He had poor mobility of his left arm, left sided facial weakness and slurred speech.

On 1 December, the man was seen by a doctor who reviewed his medication. The doctor changed the Co-codamol to Paracetamol and stopped the DF118 (pain killer) and Temazepam. The consultation was recorded in the prisoner's medical record.

On 2 December, the man saw the first doctor who was very involved in his care and during this consultation he complained of pain. The man also told the doctor that he was not eating. The possibility of the man receiving Fortisips (food supplement drinks) was raised, although they were not thought to be appropriate at that stage. The immediate plan was for nurses to commence a food and weight chart. This would monitor the man's food intake and also monitor his weight. The consultation was concluded by the doctor writing "R/V (review) next week"

The following day, 3 December at 7am the man complained of feeling sick during the nurses' medication rounds. The man requested another painkiller from the nurse, as he thought that there would be none in his system due to his vomiting. This nurse did not give it to him, on the basis that there was no evidence of vomiting and she would not want to risk an overdose of medication. She advised him not to eat or drink until he felt better. The nurse's entries are recorded in the Multi-disciplinary Clinical Notes.

During the afternoon of 3 December, the man was seen by another registered general nurse (RGN). She said that he appeared tired, and had not been eating due

to lack of appetite. She made an entry in the medical record for the doctor to see the man on Monday (5 December).

The following day the man continued to complain of generalised pain and his appetite remained poor. The man remained in his cell and declined the offer of association (a period of time when prisoners mix with one another outside of their cells).

The man continued to suffer pain throughout December with only occasional days where he was reportedly pain free. His general well-being was varied. On occasions he enjoyed association and mixed well, but on others he remained in his cell.

On 10 December, the man was seen again by a nurse, she recorded in the clinical notes that "The man has been feeling better today. No complaints of pain raised in between medication. Utilised association time without any problems, spent time in cells 1 and 4. Eating and drinking well".

It should be noted that on 8/9/10 December entries do appear in the clinical notes whereby the man requested more paracetamol but staff declined to give it, for fear of exceeding maximum dosage.

However, on 12 December an entry recorded in the clinical notes by another nurse said "The man complained that he continues to be in a great deal of pain. Also informs me that he has vomited a small amount of blood, which has happened before. He generally looks unwell, gaunt and pale in appearance, for doctor's attention today".

The same day, after a consultation with the doctor it is recorded in the medical record that "he is still in pain not eating well and coughed up blood. Suffering with SOB (shortness of breath). On examination widespread crackles in lungs heard". The doctor prescribed the antibiotic Amoxicillin and a Salbutomol Inhaler to help with the man's breathing. She also requested a sputum culture from him and arranged for a number of blood tests to be carried out.

On 20 December the same doctor telephoned for the blood test results. On receipt of these she informed the man that they suggested a possible bone abnormality and that a further test had been arranged for the next day. At this point his pain killer Ibuprofen was changed to Diclofenac, a stronger painkiller.

At about 4.45pm the man was seen by a nurse. The man was worried about his health, and wanted to know the results of his blood tests. During this one to one chat the man asked to speak to the modern matron. A further entry at 6.55pm stated that the modern matron was unable to visit the man that day, but would visit the following day.

My investigators spoke to the modern matron to ask what it was the man wanted to talk to her about. Unfortunately she was not able to recall this, although she suspected it was about his pain control, which was addressed by the doctors.

On 21 December, the man went to New Cross Hospital in Wolverhampton for a bone scan. He returned to the prison about 3pm. On his return he felt tired and in pain. He remained in his cell over the association period and requested pain relief.

On 23 December, the probable diagnosis was made that the man had lung cancer with bony secondaries and it was planned to start him on a sliding scale of Morphine.

This was explained to the man by the doctor who had arranged his tests. She faxed an urgent request to the local oncology department. An appointment came through on 5 January, but the man was too unwell to attend. The same day, the man was due to have a chest x-ray, however he refused to go as he was struggling to breathe and felt he would have found it too much of an ordeal. His first dose of Morphine was administered at 4.25pm, when the man described his pain as slight. His next dose was at 8pm. At 9.40pm the man requested additional Morphine. An extra 10mgs was administered.

Over the next few days the man continued to be in pain, despite having received his Morphine. His mood was variable, some days were better than others. He interacted with other prisoners when he felt well enough to do so.

On 26 December, The man was reported to be "pain free at the present time". His spirits were recorded as good, and he was settled in mood. This note was written by a RMN in the clinical notes.

On 27 December at 7.30pm a male nurse wrote "We have rang Badger Doctors to recommend a safer dose 60mgs appears too much as the patient is frail and not having the necessary observations for Morphine patients". In the same entry he continued with "I have declined to give him 10mgs more since he had 60mgs at 17:00hrs".

The second doctor involved with the man's medical care wrote in the medical record the following day.

"If nursing staff feel unhappy about giving high doses of opiates at night when they are unable to monitor his condition. Discussed nature of illness and the requirement for effective pain relief.

Plan: nursing staff feel unable to give 60mgs at night they should give 40mgs but be willing to give as many additional 10mg doses as he asks for.

Once requirements worked out slow release meds need to be prescribed.

Currently appears fairly stable. Cough white sputum looks better than last week. Awaiting outcome of request for compassionate discharge".

The first doctor repeated this instruction by making an entry on the prescription charts so there was no doubt. She wrote "He can have top up doses of Oromorph as frequently as required. He does not have to wait 4 hours. Please ensure it is given at night when asked for. * DO NOT DENY HIM HIS PAIN RELIEF*".

On 28 December an entry by a nurse expressed concern by the nursing staff regarding the prison environment not being conducive for palliative care. These concerns were raised with the clinical service manager and modern matron

The man's health continued to deteriorate. Entries in the clinical record indicate that staff appeared attentive to the man's needs throughout a difficult time. On consultation with the second doctor on 4 January a plan was put in place for a member of staff from a hospice to visit. The man also requested at that point that his family be informed of his ill health so a visit from them could be arranged. The same day, the man's father and sister were both contacted by the doctor.

On 5 January, a hospice worker visited the man. A note was made in the clinical notes by another nurse "Worker from hospice visited today, will visit again on a weekly basis but if need in between times can be contacted and will come in".

On 6 January, this nurse discussed with the man the option of having a member of the clergy visit. The man did not feel like a visit from a vicar at that time, but said he would ask when he felt ready.

During 6 and 7 January, it would appear that the man had little sleep and complained of a great deal of pain. He received a visit from his family which took place in the group room in the healthcare centre.

It is also recorded that during that weekend the man asked to move cell, he requested to share with a fellow prisoner he had befriended who offered him a great deal of support. The sharing of the cell was arranged temporarily depending on what the doctor thought. She had no objections. However, this cell sharing did not last long due to the man's failing health. My investigators spoke to the cell mate who confirmed that he and the man were friends and shared a cell briefly He was unable to add information that was relevant to this investigation.

On 12 January, an entry in the medical record made by the doctor states "Rapid deterioration, unable to swallow seen by member of hospice, prognosis less than 48 hours, needs syringe driver. Urgent referral to hospice. Urgent ROTL (release on temporary licence) meeting 4.45pm".

A governor grade chaired the ROTL board, also in attendance were two other governor grades, the doctor and a member of staff from the National Probation Service. The board was in favour of the ROTL application and following the authorisation of the governing governor, the man was discharged from Birmingham prison to the hospice. He arrived at the hospice later that evening.

He was accompanied by a nurse in the ambulance for reassurance. It is the prison's policy to visit a prisoner after a ROTL, this is a visit that occurs after a prisoner has been away from the establishment for 3 days. Sadly, due to the man's rapid death, no visit took place.

The hospice updated Birmingham prison's healthcare staff for the few days that the man was there and the clinical notes reflect this.

During 14 and 15 January the man was extremely poorly. He was unable to eat and was placed on constant oxygen. His family attended his bedside and were present when he passed away. The man died on 15 January at 2.30pm.

The family received a letter of condolence from the prison after the man's death and they were also offered assistance with the funeral expenses.

## Issues

The man’s sister raised a number of issues with my liaison officer and investigator during the visit they made to her.

Her issues were the following.

1. The exact date of the man’s diagnosis is not known to the family.

2. The family feel that, given the man’ difficulty in swallowing, he should have been placed on a special diet.

3. The family experienced a long delay at the prison when visiting to collect the man’s personal belongings.

4. The family feel that the man was not being assisted with personal hygiene, for example, shaving and washing.

5. The family feel that the man should have been released to a hospice sooner.

I sympathise with the family over their loss and understand their concerns. I believe I have attempted to address the concerns in a fair and independent manner.

Also during the course of the investigation other matters became of concern to my investigators. These, too have been explored.

6. The issue of nurses questioning the doctors about the amount of Morphine prescribed to the man, and indeed refusing to give extra to him on one occasion.

7. There appears to be inadequate staffing levels in Healthcare.

8. I feel it is an issue that the Healthcare Centre is staffed by psychiatric nurses rather than a multi-disciplinary team.

9. There appears to be confusion between ROTL and Release on Compassionate Grounds. It appears that medical staff are unsure how to initiate these processes and who to approach regarding them.

**Consideration of Issues**

1 **Exact date of diagnosis being unknown**. The investigation has concluded that the man was informed of his cancer on 23 December. The medical record shows that it was not until 4 January that he requested that his family be notified. As the man was of sound mind it was appropriately left in his hands as to when his family should be told of his diagnosis. This is entirely consistent with medical confidentiality. The diagnosis was made on a highly likely basis after a series of tests had been carried out. These were blood tests, bone scans and x-rays. All of these results were indicative of cancer. On receipt of this information on 23 December, the man was spoken to by a doctor where he had the diagnosis of cancer explained to him and was then prescribed Morphine to aid pain relief. For a confirmed diagnosis the man would have required a tissue biopsy. It was felt that, given his condition and the fact that this was an invasive procedure, the man would have been too unwell to cope with it.

2 **The man not having received a special diet**. Whilst the possibility of Fortisips (food supplement) drinks was discussed on his initial consultation on 2 December, the doctor did not feel it appropriate at that stage, as the man was an adequate weight of 62Kg. A food and weight chart was commenced in order for staff to monitor the man's weight and food intake. However, as the man's health continued to deteriorate and he found it difficult to eat, the decision was made to give him the Fortisips. These were dispensed from the chemist on 5 January as instructed by the other doctor caring for the man. The man was prescribed and received four of these drinks a day along with other meals provided. The only entry that appears in the records relating to the man being unable to swallow is made on 14 January. At that point he was in the hospice.

The Clinical Reviewer confirms that the provision of a liquid food is normal practice with cachetic patients.

3 **Length of time the family were kept waiting at the prison when they attended to collect the man's personal belongings.** The family say they were kept waiting 55 minutes. On arrival the appointed governor did apologise to the family and this seemed to be accepted at the time. When the prison was asked about this delay, they confirmed that unfortunately the family did experience a wait in reception. Whilst any delay is not ideal, it is the circumstances in which the visit was taking place that made it particularly distressing and unacceptable.

4 **The man not receiving help with personal hygiene**. My investigators did ask the nursing staff, the clinical services manager and both doctors about this. The nursing staff said that they offer patients a shower everyday, it is up to the patient if he chooses to have one. A request for a bath can be made and is usually accommodated. My investigators asked if they would encourage a patient to have a shower/shave if he had not had one for a couple of days. They were assured that encouragement would be given.

Both doctors involved in the man's care said that up until the last week or so the man would have been capable of washing and shaving himself. However, the doctors felt that it should be appreciated that someone so ill and in so much pain probably just did not want the aggravation of a shower and shave. Both did feel that his cell was dirty, but this was probably due to the man having regular visitors to his cell and the amount of cigarettes being smoked in there.

The Clinical Reviewer addresses this issue in his key findings by saying "In response to the specific query about the patient appearing "unkempt" I am not at all surprised that so ill a patient should have neglected his appearance and bone pain could certainly have caused additional discomfort and failure to perform the simplest acts in someone, especially with a recent stroke".

The clinical services manager, said he would expect a note to be made within the clinical notes if there was something significant to comment on like a patient refusing a shower or being on a dirty protest. The fact that no entry was made suggested to him that the man showered daily. However, my investigators pointed out an entry on 8 January by a nurse "Given big bath, shave, bed linen changed mattress turned and made to feel comfortable". The Clinical Services Manager was unable to comment on why that entry was thought significant. The man's sister feels that this entry occurred as a result of her expressing concern about her brother to prison staff.

My investigators were sadly not entirely convinced that the man would have received the encouragement and help he required with his personal hygiene. Nurses did comment that there would only usually be two nurses working with 17 patients. It is for this reason it may not always, understandably, be possible to take the time required with certain individuals from such a demanding range of patients. However, I feel that this is no excuse and address this in my recommendations.

**5 <u>Release on Temporary Licence (ROTL) not being considered sooner</u>.**

The man had the likely diagnosis of cancer with secondaries made on 23 December. The request for release on compassionate grounds was referred to by a doctor on 28 December in the man's medical record "Awaiting decision of release on compassionate grounds". On 4 January a worker from the hospice visited the man after an urgent referral was made by the doctor. It was hoped that a decision would be made within a week regarding the hospice accepting the man into their care. The doctor and the hospice were discussing the provision of an emergency bed if and when required as in fact happened. The doctors were not planning to admit the man to the hospice at that stage. The immediate plan was for the hospice worker to visit again the following week. The doctors thought at that stage the man had three to six months to live, although they accepted this was difficult to judge. However, the man sadly deteriorated very quickly and this was not so. He was transferred to the hospice on 12 January three weeks after his initial diagnosis. It is extremely regrettable that perhaps he was not released sooner, but it is of comfort to know that when he did pass away it was with

dignity and in the presence of his family in a hospice and not in a prison cell. The sister reported to my family liaison officer that it was on her insistence following a visit to her brother that he was transferred to the hospice.

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6 **Nurses questioning the Doctors about the amount of Morphine prescribed and declining to give additional Morphine on one occasion**. Had specialist nurses been available, it is likely that the man would not have been denied additional Morphine on the evening of 27 December 2005. When my investigators spoke to nursing staff about caring for a dying man, they felt that the nurses were uncomfortable with having to do that, given the restrictions of the environment. Whilst it is disturbing to think the man was denied his additional request, I accept that the nurse acted with the best of intentions. I also note that the Nurses and Midwifery Code of Conduct says "You must acknowledge the limits of your professional competence and only undertake practice and accept responsibilities for those activities in which you are competent".

The Clinical Reviewer says "Only at home and in a hospice can an individual patient have the ability to control personal pain relief. In palliative care patient needs override dispensing protocols as clinical safety issues have become irrelevant, although it is hard to see how a prison, given its rules, could accommodate this.''

7 **Are staffing levels in healthcare adequate?**
The nursing staff gave the impression that they were under resourced. The healthcare centre has two wards, each holding 17 patients. Most of the patients are mentally ill and there are few medical admissions. The nurses have a huge demand put on them by these mentally ill patients. There are two nurses on duty in the morning and three in the afternoon, plus the discipline officers. These nurses specialise with psychiatric patients, not medically or terminally ill patients. I feel it is for these reasons the man may not have received at times the attention he required.

8 **The healthcare centre is staffed by psychiatric nurses rather than a multi-disciplinary team.** Birmingham offers 24 hour nursing care. It has a multi million pound healthcare centre, with beds for 34 patients. These patients are primarily prisoners with psychiatric issues. The nurses specialise in this field. The PCT commissions the MHT (Mental Health Trust) to provide the staff for healthcare. Whilst I appreciate in the main these staff are able to care for and manage the patients, there will be occasions when other expertise is required. It is for this reason that I recommend a skill mix review.

9 **Confusion between ROTL (Release on Temporary Licence) and Release on Compassionate Grounds.** I have concerns about the way in which the man's ROTL was handled initially. The first mention of release appears in the medical notes on 28 December, "Awaiting decision of release on compassionate grounds" (compassionate discharge is only granted in the most exceptional cases. It is a permanent release on licence. Release

on Temporary Licence is “temporary release for a said period of time, this may be attending hospital appointments, receiving inpatient treatment etc”).

When the doctor was interviewed by my investigators about who this issue was raised with, she said “Everyone, healthcare staff, head of healthcare and a governor grade”.

The governor grade, however, had no recollection of this. He became aware of events on 6 January when he was spoken to about the man and his poor health. A Form Comp 2 (Prisoner’s formal complaint under confidential access) was completed by the other doctor on behalf of the man. On this form a request was made for release on compassionate grounds. This form was signed and dated 6 January.

On 9 January a letter was sent to the Early Release and Recall Department within the Home Office from the doctor. The letter reflected on the poor prognosis for the man and the devastating effect his diagnosis had on him and his family.

“The man’s condition continues to deteriorate rapidly. I judge that his prognosis is only a matter of months but could be as short as a few weeks. I therefore urge you to look favourably on his request for release on compassionate grounds as urgently as possible”

On 11 January, the governor grade was given the Form Comp 2 by the staff officer. The governor grade was asked to look at this with some urgency.

It appears it was at this point it became clear that the man should be considered for ROTL, instead of compassionate release. However, the doctor states that at this stage it was still the plan to release on compassionate grounds and the prognosis was still looking like weeks, possibly months. The man only became considered for ROTL when he required an emergency admission on the 12 January.

By 12 January, the man was so poorly that he had a life expectancy of just 48 hours. An emergency ROTL board was organised. The board concluded by authorising the ROTL of the man and he was transferred to the hospice that same day.

It is clear from the events mentioned that, despite their very good intentions, the clinical team did not know the correct procedure or who to approach to initiate the release of the man.

## Conclusions

After extensive input from both doctors, the man was found to be terminally ill with cancer. Throughout his stay at Birmingham he was located in the healthcare centre before being transferred to a hospice for palliative care.

On the highly likely diagnosis of cancer, the doctors cared and did what was practically possible in the given environment to keep the man as pain free as possible. The general healthcare the man received was probably not as good as it would have been in the community. This is obviously a concern for the prison which needs to be addressed. The reason for this may be due to the fact that the PCT commissions the Mental Health Trust to provide the staff for the Healthcare Centre. This means that the staff are mainly registered mental nurses. These staff specialise with psychiatric patients, not medically ill or terminally ill patients. Whilst I appreciate that they did their best, it is sad that that the services of cancer specialists were not sought sooner. Had specialist nurses been available or consulted, it is unlikely that the man would have been denied his request for additional pain relief. Nevertheless, I commend the nurses for their attempts at caring for a dying man in such a restricting environment with the other demands put on them.

With regards to the ROTL Application I feel that, given the poor prognosis for the man, it would have been emotionally beneficial to the family had he been released sooner. This would have allowed the family more time with the man, especially those family members who were unable to visit the prison. The possibility of release was first mentioned within the medical notes (28 December) and at that time I accept that the doctors genuinely thought the man had weeks, possibly months, to live. Sadly, the man suffered a rapid deterioration that could not have been foreseen. On the man hitting crisis point of a life expectancy of 48 hours I feel that the expediency of his ROTL was handled very well. I feel on the whole the staff at Birmingham did a reasonable job in caring for the man. However, there are lessons to be learned from the man's death and changes that should be implemented.

## Good Practice

- I commend both doctors for the care and support they provided to the man.
- Sending a nurse to accompany the man in the ambulance to the hospice is considered good practice.

I endorse the good practice identified by the Clinical Reviewer.

- The quality of the entries made within the clinical notes indicate that medical staff acted diligently to keep the patient's family informed of his clinical problems.

## Recommendations

- The PCT should undertake a skill mix review to ensure there are appropriately trained staff on duty to manage and meet the clinical needs of both physically and mentally ill patients located in healthcare at all times.

| Prison Service Response | | Target Date for Completion |
|---|---|---|
| Recommendation partially accepted | The PCT is responsible for the provision of primary care nursing support to the prison. In-patient services are subject to a Commissioning agreement between the PCT and Birmingham and Solihull Mental Health Trust (BSMHT). The PCT needs to review the Service Level Agreement and discuss with BSMHT the nature of the service requirement for effective management of in-patients.<br><br>The Project Director – Prison Healthcare has submitted a report identifying key risks relating to nursing provision and a proposal to increase nursing budgets and staffing levels. If approved the Lead Nurse will be able to implement wing based nursing services. The Healthcare Unit, including in-patient areas, will be considered as an individual wing for this review. | November 2006 – subject to PCT approval to budget and staffing increase and ability to recruit |

- Healthcare staff must provide terminally ill patients with appropriate levels of health and social care to ensure their personal needs are met and maintained at all times.

| Prison Service Response | | Target Date for Completion |
|---|---|---|
| Recommendation partially accepted | NHS services are not commissioned to provide 'social care'. The PCT will work with HMP Birmingham, Healthcare Commissioners and Strategic Health Authority to identify how social care needs will be met in the prison( The project director- prison healthcare has already had initial discussions with the DOH Prison Healthcare team) | January 2007 |

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| | The newly appointed Lead Nurse has been asked to undertake a training needs analysis for clinical staff- palliative care will be an element of this work and, subject to outcome, will be included in the clinical education/development programme. | November 2006 |

- In accordance with the NHS Cancer Plan steps should be taken to address the training needs of staff to ensure they are able to deliver appropriate palliative care pathways for patients and involve the patient in their care planning and end of life wishes.

| Prison Service Response | | Target Date for Completion |
|---|---|---|
| Recommendation Accepted | Lead nurse has now been appointed and is in post. Key responsibility is to undertake training needs analysis for members of the Healthcare Team and to organise appropriate training for staff. All staff will have a personal development plan. | October 2006 |

- The PCT in partnership with the Governor of Birmingham should develop a multi-professional pathway for the dying patient in line with the Liverpool Care Pathway. It should include transfer to hospice, diet, pain relief and communication. I would recommend that there needs to be further dialogue between Prison Health and the Primary Care Trust, its cancer lead and the Birmingham Cancer Network about the specific problems of palliative care in prison.

| Prison Service Response | | Target Date for Completion |
|---|---|---|
| Recommendation Accepted | The Healthcare manager will be asked to lead the development of a multi-disciplinary pathway for management of dying patient. The Liverpool Pathway will be used as a basis for development of the local pathway. Healthcare manager will seek advice, as appropriate from PCT Cancer Lead and Birmingham Cancer Network.<br>Draft pathway will be submitted to Prison Clinical Governance Committee for ratification | January 2007 |

- I recommend that the healthcare staff are refreshed in ROTL procedures and are aware of how to initiate this process. It would also be beneficial to train the staff on the differences between compassionate discharge and release on temporary licence.

| Prison Service Response | | Target Date for Completion |
|---|---|---|
| Recommendation Accepted | All GP's to be given refresher training on ROTL and compassionate discharge by Governor | Sept 06 |

- Computerisation of medical records is now virtually universal in primary care in the NHS and has been shown to be essential for the demonstration of good quality care. This should be a major priority for the service here.

| Prison Service Response | | Target Date for |
|---|---|---|

| | | Completion |
|---|---|---|
| Recommendation Accepted | PCT has approved funding proposal for the provision of an EMIS clinical management system in HMP Birmingham. BSMHT have ‘signed up’ to use of EMIS. Project plan agreed. | December 2006 |