Investigation into the circumstances surrounding the death of a man in June 2010 in hospital while in the custody of HMP Birmingham

Report by the Prisons and Probation Ombudsman for England and Wales

December 2010

This is the report into the circumstances surrounding the death of a man on 27 June 2010, in hospital, whilst in the custody of HMP Birmingham. He had numerous medical conditions including heart disease, diabetes, arthritis and high blood pressure. On 22 June 2010, the man was admitted to hospital with chest pain and high blood pressure. Over the next five days his condition deteriorated and he died on 27 June. He was 57 years old.

The man did not inform the prison of any next of kin when he arrived at Birmingham, or wish for anyone to be notified of his death. However, I extend my condolences to anyone touched by his death.

One of my investigators carried out the investigation. A post mortem examined was carried out on behalf of Her Majesty's Coroner for Birmingham and Solihull. The man's death was of natural causes, from his medical notes I am given to understand this was due to heart and renal failure. At the time of circulation of this report the post mortem report was not available.

A review of his healthcare whilst at Birmingham was commissioned with the Heart of Birmingham Primary Care Trust (PCT). I am grateful to a doctor for carrying out that review and attach it as an annex to my investigation report.

I would like to thank the Governor of Birmingham and his staff for their help and assistance with this investigation. I am especially grateful to the liaison officer.

I make one recommendation to the Head of Healthcare about following up outstanding medical appointments of newly arrived prisoners. I note the clinical reviewer's recommendation for a doctor to review prisoner's medical history.

Jane Webb
Acting Prisons and Probation Ombudsman **December 2010**

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SUMMARY

The man was sentenced to 14 years imprisonment in November 1997. He was released in 2006 however, he returned to prison on two separate occasions in 2007 and 2009 after failing to comply with his licence conditions. On his last reception into Birmingham in December 2009, it was noted that he was suffering from several chronic medical conditions including, arthritis, diabetes, high blood pressure, angina and fluid retention. The man also used a wheelchair.

At a reception medical screening on 28 December, the man told the nurse he had recently been treated in hospital for breathing problems and had a follow up out patient appointment. (This appointment was apparently not confirmed by healthcare staff and the man did not attend the hospital.) His medication was reviewed and he was prescribed an appropriate drug regime for his illnesses.

Following a period in healthcare, the man was accommodated in a cell adapted for prisoners with disabilities. He mostly looked after himself with the help of the prison disability liaison officer, wing and healthcare staff.

On 3 June 2010, the doctor referred the man to a chest physician as he was experiencing breathing difficulties. The doctor prescribed an antibiotic for inflammation and swelling to his leg. Healthcare staff regularly changed the man' dressing on his infected leg and took his medical observations.

A nurse was called to see the man on the evening of 22 June, on her arrival at his cell she found him to be unwell, complaining of chest pain and struggling to breathe. An emergency ambulance was called for. The man was restrained, by an escort chain and escorted to hospital by two officers. (An escort chain is 1.8 metre in length with one cuff attached to the prisoners and the other to an officer.) The day after he was admitted to the assessment unit at a hospital, the man was told that he had a lung infection and a serious heart condition. The hospital doctor explained to the man that if he did not respond to treatment then his prognosis was poor and he would not be resuscitated should he go into heart failure.

A bedwatch officer, Senior Officer (SO) who knew the man well, made contact with the duty governor to inform them of the prognosis. The SO also spoke to the man about his next of kin and if there was anyone he would like to be told of his illness. The man said he had no family and did not anyone to be told about his condition.

The man's medical condition further deteriorated and he did not respond to treatment. At 7.10pm on 24 June, a governor authorised the removal of restraints. The escort of officers remained at his bedside. The man died at 8.50am on 27 June.

I recommend that new prisoners' outstanding medical appointments are confirmed with their hospital and rescheduled appropriately. I note the clinical reviewer's recommendation of doctors reviewing prisoner's medical history.

THE INVESTIGATION PROCESS

1. The investigation into the man's death was opened on 6 July 2010, when my investigator visited Birmingham and met the Safer Custody Manager. My investigator reviewed the man's prison and medical files and asked for copies of relevant documents to be forwarded to her.

2. The Ombudsman's terms of reference and notices of investigation were sent to the prison in advance of my investigator's visit. No members of the Independent Monitoring Board (IMB) or the Prison Officer's Association (POA) asked to see my investigator. (The IMB are volunteers drawn from the community who monitor the day to day life of the prison, staff and prisoners.) My investigator's contact details were made available to their representatives.

3. Later my investigator visited the man's cell. She informally spoke to a Senior Officer (SO) and the man's personal officer.

4. A member of the POA contacted my investigator on 8 July, to offer their support for members should she wish to interview officers. No other responses, from either staff or prisoners have been received to the notice of investigation.

5. The man did not want any family or friends to be told of his death and this was noted on the bedwatch escort notes. A copy of this report will be retained by my office should any of the man's family make contact with us in the future.

6. In this final report there are several amendments. Firstly, a change of name for a Senior Officer (SO), for which I apologise and an amendment to the name of the Head of Healthcare There were three minor inaccuracies. Paragraph seven has been updated to include an extract from Her Majesty's Inspector of Prisons latest report on Birmingham. This paragraph now refers to the unannounced inspection of 2009. The recommendation has been accepted.

HMP BIRMINGHAM

7. HMP Birmingham is a large local prison, serving the courts of Birmingham and much of the West Midlands. It holds up to 1,450 adult male prisoners, both on remand and sentenced. The prison has undergone significant improvement over the last few years, including the building of a new healthcare centre.

8. HM Chief Inspector of Prisons last conducted an unannounced inspection of the prison in 2009. The Chief Inspector noted,

> "Birmingham remained a better prison than it was, but it was not yet the prison that it could be, or needed to be. Some of its problems are common to overcrowded local prisons – too few activities, despite some improvements, and too many prisoners who are transient or far from home. But some required much closer management of, and engagement by, staff, not all of HMP Birmingham whom were sufficiently active in supporting and working with prisoners. There had been some progress in this area, and we saw examples of good practice, and some committed staff. However, this needs to be promoted and extended if Birmingham and its prisoners are to fulfil their potential."

9. The healthcare unit has two inpatient wards each containing 15 large single cells. Ward one is designated for prisoners with physical illness/disability and ward two is solely for prisoners with mental health needs.

10. All prisons are also monitored by an Independent Monitoring Board (IMB), members of which are drawn from the local community. They have full access to each prisoner and every part of the establishment. The last annual report by the Birmingham IMB covers the period July 2007 to June 2008. The Board noted that overcrowding within the entire prison system, and at Birmingham specifically, remained a concern. Healthcare provision was recognised as having gone through significant changes over the year. The Board highlighted that healthcare facilities at Birmingham were viewed as both a local and national resource and that, as a result, "more robust partnerships" were necessary. Overall, however, the Board was "impressed … with the dedication and professionalism of the staff".

11. The man's death is the fifteenth death to occur at Birmingham since my office took responsibility for investigating deaths in custody in 2004. Some of those deaths had similarities to that of the man, due to multi medical conditions. Previous recommendations relating to the use of restraints have been actioned and this investigation indicates that restraints were used appropriately.

KEY FINDINGS

12. The man was born in September 1952. He was divorced, unemployed, had previous convictions and had served two custodial sentences. Very little is known about the man's personal history and his prison record indicated that he did not talk about family or life prior to his time in prison.

13. In November 1997, at Crown Court, he was sentenced to 14 years imprisonment for serious sexual offences. The man served his sentence at Birmingham, HMP Rye Hill and HMP Albany. On 21 December 2006, he was released on licence however, the man was re-called to prison in March 2007 for failing to comply with his licence conditions. (Licence conditions are rules for prisoners who are released from prison to live in the community and supervised by the probation service.)

14. The man was released from custody in February 2008. However, he was again re-called to prison in December, for breaching his licence conditions and taken to Birmingham. On his arrival at the prison, the man's medical history from his previous custody in Birmingham was noted. Two days later, his medication was reviewed for arthritis, diabetes, high blood pressure, angina and fluid retention. The nurse noted that the man was immobile and used a wheelchair. He was accommodated on a residential wing.

15. The man had an appointment with a nurse and she updated his medical history on 28 December. (It is unsure as to whether this appointment was a secondary health check. (A secondary health check is a thorough medical assessment, usually completed within 72 hours of a prisoner entering prison.)

16. The nurse wrote that he had recently been in hospital with a pulmonary embolism (a blood clot on the lung that causes breathing difficulties) and had an appointment at a hospital in January. His blood pressure reading was 134/84 (an average reading is 130/80) and his pulse rate was 92 beats per minute (bpm - an average reading is between 60-100 bpm). The man told the nurse he was a smoker and had no thoughts of self harm or mental health problems. The nurse made a referral for the man to be assessed by the prison's disability officer.

17. It was noted in the clinical review that a member of the healthcare staff was asked to "chase up" his outstanding appointment at the hospital. However, this seems to have been missed and no further reference to this appointment is recorded in the man's medical notes.

18. The man was transferred to the healthcare unit on 13 January 2009 to accommodate his physical needs until a suitable cell adapted for his mobility problems could be found. The man was recorded as sleeping well, taking his medication and associating with his peers.

19. On 11 March, the man was moved to the vulnerable prisoners' unit (VPU), and located to a cell that had been adapted for prisoners with a physical disability. He was given in possession medication ('in possession' refers to prisoners

who are risk assessed to look after their own medication as opposed to having it dispensed by healthcare staff on a daily basis). The man was assessed as being able to monitor his diabetes and take his insulin appropriately.

20. A doctor saw the man on 9 July 2009 after he complained of back ache. He told the doctor he had previously used a Transcutaneous Electrical Nerve Stimulator (TENS) machine. (This machine sends an electrical pulse to ease pain.) One of these machines was available to prisoners and given to him for his back ache. The man continued to remain on the VPU with the support of wing and healthcare staff.

21. A doctor examined the man on 3 June 2010. The doctor wrote that both the man's shins were inflamed and swollen and would need a regular change of dressing. The man was also prescribed an antibiotic to help with possible infection. It was further recorded that he was having episodes of shortness of breath. The man told the doctor he had been in hospital in 2008 for a similar problem. The doctor made a referral for him to be seen by a chest physician. Later, a nurse made an entry in the man's medical notes to the effect that he had dressed the inflammation wounds on his legs.

22. Three days later, a nurse saw the man in his cell to change his leg dressings. The nurse noted that there were multiple ulcers on the legs and they were oozing fluid. On further examination, the nurse wrote that the legs were swollen and hard, indicating poor blood circulation. The man was advised to elevate his legs and do some basic foot and leg exercise to improve the blood flow. His observations were taken and recorded as: low blood pressure 98/70, an average pulse rate of 88bpm and his temperature was normal. The man's chest was examined for any abnormal sounds and found to be normal. He was advised to call for a nurse if he felt unwell or thought he had a raised temperature.

23. A nurse saw the man on 11 June to change his leg dressings. The nurse wrote that both legs were still wet and the man should have the dressing changed twice a week. The man had his dressings changed on 14 and 19 June. On 22 June, a nurse attended to the man in his cell and changed his dressings. The nurse was concerned that his legs were oozing a lot of fluid and wrote that the man should see the doctor the following day.

24. At 8.48pm, a nurse was called to see the man in his cell. She saw that he was struggling to breathe, shivering and complaining of chest pain. The nurse took his observations: blood pressure 151/119, pulse rate 85bpm. She noticed that he had a low level of oxygen and gave him some aspirin and oxygen via a facemask. She asked the control room to telephone for an emergency ambulance.

25. On arrival at the man's cell, the paramedics took an electrocardiogram (ECG) of his heart rate. With this information and his presenting symptoms, it was decided that the man should be taken to hospital. An escort of two officers accompanied him the ambulance and he was restrained on an escort chain.

(An escort chain is a 1.8 metres in length with one cuff attached to an officer and the other cuff to the prisoner.)

26. On arrival at the hospital, the man was admitted to the medical assessment unit. The following day, at 9pm, he was seen by a cardiac registrar who told him that he had a lung infection and a serious heart condition. The doctor explained that the man's condition might not respond to treatment. If his body failed to respond, the doctor estimated that he may only have one or two days left to live. The registrar told him that he would not be revived should his heart stop.

27. An SO, a manager on the VPU, happened to be on bedwatch duty and knew the man well. The SO wrote in the bedwatch notes that he contacted the duty governor and told him of the latest news. The governor was unhappy that the man had been told he would not be revived and referred this to the Head of Healthcare. Later, she spoke to hospital staff about the seriousness of the man's condition. Once the hospital had explained his prognosis, she was satisfied that it was the right decision not to resuscitate him.

28. The SO spoke to the man about notifying his next of kin. The man told the SO that he did not want any friends or family to be told of his illness or to be informed of his death. At 10.22pm, the bedwatch notes record that the Head of Healthcare had spoken to the registrar.

29. A bedwatch officer, an SO, wrote that at 7.35am on 24 June, the man was settled and aware that should he go into cardiac arrest he would not be revived. Despite being very unwell, he was described as in good spirits and talking to the officers. Later, at 6.50pm the man was visited by a member from the chaplaincy team. Twenty minutes later, a governor authorised the removal of the escort chain whilst the escort of two officers remained at his bedside.

30. The following afternoon the man was moved to a general medical ward, and it was written that his condition was deteriorating. A nurse from the prison visited the man on 26 June. She wrote that he was acutely unwell and struggling to speak, however, he did recognise her. The man died at 8.50am on 27 June.

31. Staff and prisoners on the VPU were told of the man's death by the duty governor. In the absence of next of kin, his funeral service was arranged by a governor. Prayers and a memorial service were held in the chapel. .

ISSUES

Clinical Care

32. A review of the man's healthcare was commissioned with the Heart of Birmingham PCT and undertaken by a doctor on their behalf. I am grateful for this review which is annexed to the investigation report.

33. On 28 December 2008, the man told the reception nurse of his recent admission to a hospital for breathing difficulties. Apparently this information was passed to a member of healthcare staff to make enquiries with the hospital for a follow-up appointment. There is no record in the medical notes relating to these enquiries, for the man's outstanding hospital appointment as written in the clinical review.

34. The man's out patient appointment should have been verified by healthcare staff and arrangements made for him to attend the hospital. I therefore make the following recommendation.

    The head of healthcare should ensure that pre-arranged hospital appointments for newly received prisoners are confirmed and actions are taken to ensure those appointments are kept or appropriately re-arranged.

35. The importance of secondary health checks are essential to determine the prisoners full medical history and identify any follow up appropriate medical tests or treatments. It was not recorded as to whether the man was seen by a doctor following his arrival at Birmingham despite his medical history of chronic diseases. Furthermore, I note the recommendation made by the clinical reviewer that consideration should be given to the doctor formally reviewing the admission histories of new prisoners.

36. Despite the man's chronic illnesses he remained in a stable condition until 3 June 2010, when he was referred to a chest physician because he was complaining of shortness of breath. The rapid deterioration in his health was seen to be due to a serious heart related condition given his history of chronic illnesses and previous treatment for blood clots in his lung.

37. In conclusion, the clinical reviewer writes that the man received appropriate and swift medical attention when he became very unwell on 22 June and was appropriately admitted to hospital. He recorded two points of good practice, of which I bring to the attention of the Governor and the Head of Healthcare.

38. Firstly, the clinical reviewer observes the man's diabetes and high blood pressure was well monitored by healthcare staff whilst in prison. He added that this was closer observed that would have been the case if the man had been living in the community. Secondly, his prompt treatment, when his condition deteriorated on 22 June, was appropriately managed with the man receiving greater attention in Birmingham rather than his own home.

39. At the time of this investigation, the post mortem report was unavailable. However, the clinical reviewer noted that the man's medical notes from the hospital recorded that, three days before he died, he had been diagnosed with cardiac and renal failure. In his clinical review, the clinical reviewer writes that the swelling to the man's leg might have been caused by a deep vein thrombosis. He commented that the post mortem report would be able to indicate whether this was the case. The clinical reviewer said:

> "At this stage it is not clear whether the man would have benefited from anticoagulation (thinning of the blood to prevent further blood clot formation)."

Managing the man's disability

40. When the man arrived at Birmingham, he was referred to the prison's disability liaison officer**.** On 13 February**,** he was allocated a cell in the healthcare unit where his physical health needs could be appropriately accommodated. This was a temporary transfer until a suitably adapted cell became vacant for him. One month later, the man moved to the vulnerable prisoner unit, into a cell that had space for his wheelchair.

41. The disability liaison officer at Birmingham, told my investigator that she had assisted the man with the maintenance of his wheelchair and liaised with healthcare staff in relation to his diabetes. My investigator spoke to a SO and the man's personal office. They told my investigator that the man was helped by officers and prisoners on the wing when it was felt that he needed some assistance. Otherwise, he was able to maintain his own personal hygiene and cell cleaning.

42. It is my view that the man' mobility and disability were appropriately managed and the inclusion of the disability liaison officer made sure that a trained member of staff could assess his individual needs.

The decision not to resuscitate the man

43. Hospital staff normally discuss resuscitation orders with a patient's family. It would have been expected, therefore, that the registrar in this case would have spoken to the man's family about the seriousness of his condition and discussed with them the decision not to resuscitate him. However, he had not recorded any next of kin details in his prison record. I am pleased that the duty governor referred this to the Head of Healthcare, so she could ask relevant questions of hospital staff, in the absence of his family. I hope the support of the prison at such a distressing time was of some comfort to him.

CONCLUSION

44. In December 2008, the man arrived at Birmingham and was noted to be suffering from several chronic illnesses. Despite a pre-arranged outpatient appointment in 2008 (which was not followed up by healthcare staff), the man was not seen by hospital staff until he was admitted on 22 June 2010.

45. The man was cared for by both prison and healthcare staff and, apart from a short period in the healthcare unit, he was accommodated on a wing, in a cell adapted for disabilities. With the support of staff and prisoners he settled into the prison routine and was able to remain largely independent. I further acknowledge the good work of the prison disability liaison officer for the support offered to the man.

46. The clinical reviewer concluded that the man medical was as more than equal to that of which he would have received in the community.

RECOMMENDATIONS

For the head of healthcare

The head of healthcare should ensure that pre-arranged hospital appointments for newly received prisoners are confirmed and actions are taken to ensure those appointments are kept or appropriately re-arranged.

Accepted – “New receptions with existing healthcare appointments will have them re-booked without delay. However, a small variation will be unavoidable due to the obvious security risks if prisoners are aware of the venue and times of external hospital appointments.”