

**The circumstances surrounding the death of a prisoner whilst in the
custody of Birmingham Prison in June 2004.**

Prisons and Probation Ombudsman for England and Wales

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Introduction

This is the report into the investigation of the circumstances of the death from end stage liver disease due to hepatitis C and liver cirrhosis of a prisoner at City Road Hospital, Birmingham on 18 June 2004 whilst he was in the custody of HMP Birmingham.

Since 1st April 2004, the Prisons and Probation Ombudsman's Office (PPO) has been responsible for investigating all deaths of prisoners in custody. Previously, the task was carried by the Prison Service itself but was passed to PPO to bring greater independence and consistency. During a transitional phase, which included the time of the prisoner's death, I did not conduct all investigations directly but oversaw the work of experienced Prison Service investigators who worked under my supervision. I am most grateful to the Prison Service for agreeing those arrangements. The investigation into the prisoner's death has been carried out on my behalf by Head of Residence from HMP Blakenhurst, with the assistance of a Principal Officer from HMP Brockhill. My colleague liaised between PPO and the Prison Service.

A clinical review to examine the prisoner's medical care and treatment at HMP Birmingham has been carried out by the Consultant Lecturer in Public Health at the Heart of Birmingham Teaching NHS Trust.

It is hard to cope with any family loss and losing someone while they are in custody is especially difficult. My colleagues and I would like to extend our condolences to the prisoner's family and all those touched by his death.

I would like to thank the man who provided effective liaison between my team and the prison, and the Governor of HMP Birmingham, together with his staff for their full co-operation with the investigation.

Stephen Shaw CBE
Prisons and Probation Ombudsman

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Summary

This is the report of an investigation into the death of a prisoner in hospital on 18 June 2004 whilst released on Temporary Licence from HMP Birmingham. He had been in prison custody since 19th May 2004. The man was received at HMP Birmingham following his court appearance at Sutton Coldfield Magistrates Court where he had been sentenced to four months imprisonment.

On 6 June 2004, the prisoner complained of feeling unwell and was taken to hospital. He remained in hospital accompanied by two Prison Officers until 11 June, when due to a deterioration in his condition, he was released on compassionate licence. This meant that although he was still in the custody of the prison, the officers were withdrawn. On 18 June 2004, the prisoner died. HMP Birmingham appear to have been unaware of his death until 21 June. An internal investigation was commissioned by the Governor as a result of this incident.

I also refer to a review of the prisoner's medical care whilst in prison conducted at my request by Consultant Lecturer at the Heart of Birmingham Teaching Primary Care Trust. This report comments on the quality of record-keeping at the establishment but concludes that the care the prisoner received whilst in custody would not have prevented his death.

My report examines the circumstances surrounding the death of the inmate and draws conclusions in relation to the quality of the written documentation, the effectiveness of the prison's arrangements for monitoring the well-being of prisoners temporarily located in hospital in the community and the communication of those arrangements within the prison.

The report makes eight recommendations.

Background

The prisoner was separated from his wife (who died shortly before him) and was living with his partner before he came into custody. He was convicted of several offences on 15th April 2004 and remanded on bail until 19th May 2004 when he was sentenced to four months imprisonment and sent to HMP Birmingham.

Birmingham Prison

Birmingham prison is a Category B local prison serving two Crown Courts and numerous Magistrates Courts in the West Midlands. It is a Victorian prison for adult males built in 1849. The establishment has recently been extended and can now offer accommodation to 1,400 prisoners in ten residential wings. A new Healthcare facility was also opened recently as part of the expansion programme. The healthcare provision is commissioned by Heart of Birmingham Teaching Primary Care Trust in accordance with the transfer of commissioning responsibility from the Prison Service to the NHS.

The last Security and Standards Audit was in September 2004. The prison achieved 76% compliance.

Investigation Process

My investigators had a very helpful discussion with a governor on their arrival at the prison as he had established contact with the prisoner's family.

They also spoke with the chair of the Independent Monitoring Board (IMB) and the branch secretary of the Prison Officers' Association (POA) to ascertain whether they had concerns about the prisoner's death.

Although the investigation proper commenced some two weeks after the death of the prisoner, it became clear when the team visited that other inmates had not been told of the prisoner's death. Notices to prisoners and staff, inviting anyone with information relating to his death to make themselves known to the inquiry had also not been published. This matter was rectified on 17th July 2004 when the Ombudsman's notices were published. No responses were received from staff or prisoners.

My investigators interviewed a Senior Manager who had been involved in discharge and licence arrangements for the prisoner. They also spoke to a member of staff who dealt with his healthcare problems at the time he was sent to hospital and two health care managers. The man's prison records, covering the duration of his time in custody from his conviction and admission on 15th May 2004 were reviewed. In addition, a Lecturer in Public Health Medicine with no management responsibility for HMP Birmingham was asked to conduct a clinical review of the prisoner's care whilst in prison custody.

A governor initiated contact with the prisoner's partner, and my office's Family Liaison Officer (FLO) contacted both the prisoner's sister and partner. His

sister told the FLO that her brother had been suffering cirrhosis of the liver for some time. She said that his son, who had been at Birmingham prison at the same time as his father, had told her that he might have suffered for longer than was necessary. Unfortunately, despite several letters offering to discuss the investigation, our invitation to members of the prisoner's family was not taken up.

The prisoner's recent history at HMP Birmingham

On arrival at HMP Birmingham from the Magistrates Court, there was no information of note on the inmate's Prisoner Escort Record (PER), a form which accompanies all prisoners when they travel outside an establishment. The prisoner was seen by Healthcare staff and a First Reception Health Screen form, which largely consists of a series of questions to be asked on interview, was completed. The form has "none" written across the space where name and address of GP should be. The prisoner was asked whether he had, or was suffering from a serious illness and replied that he was not. However, he said he was receiving treatment for psoriasis. There were no issues of concern raised about his health or any evident issues regarding self harm or vulnerability.

A Cell Sharing Risk Assessment was completed. Section 2 of this document comments "inmate sick", but this is not clarified by any further information. The signature on this section is also unclear. It concluded the prisoner was suitable to share a cell.

The following day he was seen on his Induction Board where he stated he had no problems. He was subsequently placed on an ordinary rather than a medical residential unit. Available documentary evidence regarding his physical condition does not suggest he was ill.

In the early hours of the morning of Sunday 6th June 2004, the prisoner complained he felt unwell. At about 5:30am, the Staff Nurse on duty examined him. He was concerned that the prisoner's abdomen was distended. The prisoner became short of breath if he lay flat and was noted as being jaundiced in colour. An entry in the prisoner's medical record made at 5.30am on 6 June states that he said he had suffered from similar symptoms once before and eight to nine litres of fluid had been drained from him. As a result, the Staff Nurse informed the Night Orderly Officer in charge of the prison at that time that the prisoner needed to go to hospital. When he asked the prisoner how long he had been feeling unwell, he replied he had had tummy problems from the Thursday before but had not told anyone. Arrangements were made to transport him to hospital by taxi, as his symptoms were not considered to be life threatening and he left at approximately 06.00. Neither a referral letter nor his prison Medical Record (IMR) accompanied him to hospital at this time, although the Staff Nurse told the investigators that the part time hospital liaison officer would have checked the prisoner's Inmate Medical Record the next day. The prisoner could not confirm whom he handed over to when the next shift came on duty, but added he would have completed the night handover book used by the Nursing staff.

At approximately 06:30, the escort arrived at City Road Hospital. At about 07:40, staff escorting the prisoner, were advised that he would be admitted for a few days to undergo treatment for his liver. At 08:40, he was admitted to the Medical Assessment Unit and staff informed the prison. Shortly after 17:00, an escorting officer telephoned the prison and requested a Bed watch Booklet, toiletries, cutlery and underwear for the prisoner. Later on in the evening, he was moved to D15 ward and once again the prison was informed of this new information.

The staff changed shift at 20:20. The bedwatch booklet did not accompany the staff and was not opened until the following morning when once again the staff changed shift.

In the afternoon of 7th June 2004, a governor conducted a management check at 15:30. The checklist was completed in accordance with local instructions but I note that the review of the original risk assessment, which should have been conducted on 6th June 2004 following confirmation the prisoner was to be admitted to hospital, did not take place. This was in contravention of Core Standard G contained in the Local Security Instructions published in October 2000.

On 8th June 2004 at about 13:45, an Officer recorded that the prison was updated about the prisoner's condition and informed he was to stay in for another couple of days. Later in the day at 16.40, another Officer noted the prisoner had a catheter inserted and made an unnecessary comment relating to this treatment in the occurrence log. This was an unprofessional action on the officer's part.

On 9th June, the prisoner was informed he was required to stay in hospital, as his condition had not improved. His condition and demeanour during the day was reported by staff to be unsettled and uncomfortable.

The next relevant entry in the log was made on 11th June at 10:47. This entry said that the prisoner was visited by a priest and that prayers were said, possibly the last rites. This is followed by an entry at 12.00 which states a telephone call was made to a Senior Officer at the prison. Unfortunately there is no indication as to the content of that conversation. At 12.30, the prisoner's mother and a friend visited him. They left at 12.50.

At 14:20, a governor visited the bedwatch. He discussed the prisoner's prognosis with the nursing staff. He had been told it was very poor and that the prisoner would deteriorate in the following week. He was advised it was unlikely the prisoner would move to ITU. The governor left the ward at approximately 14:45. During his visit, he completed the Management check list contained in the Bedwatch Log and instructed escorting staff to remove the restraints from the prisoner. He noted the management check sheet to this effect but also entered a question mark in the column which required confirmation that management checks had been conducted.

On interview, the governor said he thought it possible that the checks had been done but not recorded hence the question mark. This was an issue he intended to check on his return to the prison. In addition, whilst the prisoner was at the hospital he reviewed the original escort risk assessment which had been completed by a principal officer. At this time he agreed that the staffing level should remain as two officers but instructed that all restraints be removed from the prisoner. The governor returned to the prison and recommended to the governing governor that the prisoner be released on compassionate licence.

A Temporary Release Board was convened with the result the governor authorised his release on licence. He prepared the licence and returned to the hospital at about 18:20 on the evening of 11 June 2004. He explained the licence to the prisoner who then signed it.

It has since become evident that the systems and procedures that were in place relating to the management checks of the prisoner were not adhered to. He should have received daily visits by a managerial grade member of staff but did not. These management checks were not completed due to a breakdown of communications between a number of different departments.

However, the governor was aware that the prisoner's son was also in the prison and, in view of the seriousness of his condition, requested another member of staff to make arrangements for him to visit his father. This visit took place on 12 June 2004.

Prison staff left the prisoner in hospital on 11 June at approximately 18:20. The governor's involvement with the prisoner ended at this point because he was going on annual leave.

A number of copies of the prisoner's release licence were distributed in the prison, but a copy of his licence appears not to have been sent to the Discipline Office, the administrative hub of the prison. As a consequence, staff there were unaware that the licence required reviewing on 18th June 2004 and this was not done.

The Chair of the Birmingham Independent Monitoring Board (IMB), the function of which is to act as a watchdog on the running of each prison, made enquiries about the prisoner on 17 June at the prison's Health Care Centre. She was unable to find a member of staff who knew about him and, following an query to the Head of Prisoner Services, she received an email saying that the prisoner had not died and had returned to the prison. Manifestly, this was incorrect.

Sadly, the prisoner died at approximately 23:30 on 18 June 2004, some hours after his licence had expired. Technically, he was not in lawful custody of HMP Birmingham, although in practice he was and City Road Hospital regarded the prison as having responsibility for him. It would appear that the prisoner's family, and his partner, were informed of the prisoner's death by the hospital. Whether or not the hospital informed the prison at this point is

disputed. There is no record of that information being relayed to the prison at the time the prisoner's death occurred. It is true to say, however, that there was a breakdown of communication between the prison's healthcare department and the hospital. Communication with the hospital by the prison's healthcare staff had not been forthcoming. The hospital liaison officer, responsible for liaison with outside hospitals was only a part-time member of staff and was not on duty following the prisoner's admission to hospital. Nor were there any subsequent checks that resulted in him becoming aware of the prisoner's admission.

The healthcare manager was aware the prisoner had been admitted as this information had been passed on by the night staff following the prisoner's complaint that he was unwell. However, it is clear from her statement that there was no protocol from a Healthcare perspective whereby the department had a responsibility to check on the progress of in-patients. Their view was that it was the job of the part time hospital liaison officer, and perhaps that of the Security Department to make daily checks. Once again, it is unfortunate that the PO did not pass the information regarding the prisoner's admission to anyone else in the Healthcare Department.

The PO also offered an explanation of why the prisoner's Inmate Medical Record was not in an appropriate cover. New covers are being designed and a shortage of the current one had occurred. When asked about the limited information contained in the Inmate Medical Record, the PO was able to say that initial information was indeed reliant on that given by the prisoner. There was no information given that indicated the prisoner had a serious liver complaint. The PO went on to say that reference to a prisoner's IMR would not necessarily take place on account of a prisoner being admitted to outside hospital particularly if there had been no referral to the hospital from the doctor.

It also became apparent during the interview that a new induction package is being collated for new nursing staff.

Whilst the PO gives no indication in her statement of receiving the initial telephone call informing the prison of the inmate's death, it was her that the Coroner's Office had contacted. The governor is aware of some of the protocol issues affecting the Health Care Centre at HMP Birmingham. These issues are further addressed in the recommendation section of this report.

Discovery of the prisoner's death

The governing Governor first became aware that the prisoner had died on Monday 21st June 2004, when the information was relayed to him by the prison's Security Department. On receiving this information, he instigated the appropriate procedures to be followed for a Death in Custody. The Prison Service's computer Incident Reporting System entry for 22 June 2004 has recorded that the prisoner's next of kin were informed of his death but no date

is given. Arrangements to visit the prisoner's next of kin on 25 June 2004 were made, to offer the condolences of the Governor, but unfortunately she was not at home. She did not have a home telephone and the prison was therefore unable to make contact before visiting.

A governor visited the prisoner's partner at a later date and gave her her brother's belongings. The prisoner's partner later contacted the prison to say that the funeral had been well attended. Further contact was maintained throughout this initial period following the prisoner's death and help and advice offered in relation to funeral expenses. This all seems to have been handled sensitively and well.

The Coroner's Office provided the Ombudsman's office with the contact details of the prisoner's sister, whom they understood to be his next-of-kin. She told our Family Liaison Officer that the prisoner's son had told her that his father had complained of feeling unwell and that the prison had been slow to respond. Despite requesting contact details for the prisoner's son, my office has not been able to obtain more information from him. I have not found any evidence, however, that the prisoner mentioned feeling ill until the morning when he was taken to hospital, but that is not to say that he had not expressed any anxieties to his son. Apart from the prisoner's son visiting him in hospital on 12 June 2004, however, I was unable to find any reference to any contact between them occurring whilst both were in the prison. Indeed they were not located in the same residential wing.

As a direct result of the issues raised by the prisoner's death, in terms of the lack of communication between the prison and the hospital, the Governor instigated an internal simple inquiry to identify any immediate issues that needed to be rectified. This was welcomed by the Investigation Team, and I have included the inquiry report as an annex.

Consideration

Available medical information on reception

There is no evidence to suggest that the treatment of the prisoner whilst in custody contributed to his death. His healthcare provision whilst in the custody of HMP Birmingham appears to have been satisfactory but it is clear that staff caring for him knew very little about him. Information contained in his IMR is limited. At the time the prisoner complained of feeling unwell, he was dealt with promptly and taken to hospital following examination. We are satisfied that access to IMR's can be obtained during the night, even if this means the information contained in an IMR is given to another nurse over the telephone.

The prisoner's admission and stay in hospital

The systems that were in place to monitor the progress of a prisoner in hospital were patchy and failed. Daily management checks which were required to be undertaken by Senior Managers in the prison did not happen in accordance with the prison's local security instructions. The Health Care Centre did not have an adequate system for keeping staff informed when there was a prisoner in hospital. They relied on one member of staff to contact the hospital daily for a progress report and there was no follow-up to ensure whether or not this was done.

These communication failures, however, did not contribute to the prisoner's death. However, the reality is that during the last week of his life, no visits were made to him by anyone from the prison.

Risk Assessment

The initial risk assessment completed on the prisoner (and indeed on any other prisoner who is escorted to outside hospital) states on the form that there should be no contact allowed with family and friends including visits for the first 36 hours. This is designed to discourage prisoners from feigning illness in an attempt to arrange illicit meetings or receive contraband in external hospitals. Whilst I appreciate the security benefits of this standard approach, it does not consider the individual's needs.

Communication procedures, management systems and risk assessment procedures in place at the prison should be reviewed in the light of the above comments.

Quality of documentation

Other prison documentation, i.e. Cell Sharing Risk Assessment (CSRA), First Reception Health screening form and the bedwatch booklet, raise issues concerning the quality of written entries and staff's understanding of how to complete these documents adequately. The officer who completed the CSRA has since been identified but her signature on the form was unclear. Not only did the bedwatch booklet not have correctly numbered pages for additional days and a tasteless comment by one of the prison officers, it contained only a limited number of meaningful entries giving a overview of the prisoner's life in the hospital. These issues need to be reviewed and training needs of staff considered in an effort to improve the quality of the information contained in these documents.

Written policies with regard to Healthcare protocols for dealing with prisoners admitted to outside hospitals need to be developed and implemented to avoid a recurrence of this situation in the future.

Other departments who have a responsibility for managing prisoners' care whilst outside of prison need to co-ordinate their actions with the Healthcare Department, ensuring a prisoner's well-being is maximised.

Medical care

While the Clinical Reviewer notes that any delays in the prisoner receiving treatment would have been unlikely to change the outcome of the prisoner's liver disease, he does make some telling points about the adequacy of the medical records kept by the prison. In his prison medical record (IMR), the prisoner is described as "stout and strong" by the Medical Officer. Less than three weeks later he appears to be suffering gross liver-ascites. However, the doctor concedes that rapid liver decompensation is possible. The doctor posits that the prisoner may have requested a medical consultation and suggests that it is unlikely that such a consultation went unrecorded. I have not found evidence that the prisoner did complain but certainly his IMR appears incomplete.

The doctor states:

"The PCT is aware that the present assessment system is unsatisfactory and has identified it as a priority for review and change ...The on-going medical record consists of separate sheets of paper. In my opinion it is quite possible that some of these sheets are missing. The PCT is aware that the present record system is unsatisfactory ...funds have been made available and a project team established to introduce an electronic patient record."

Of course an electronic record will only be as good as the information entered into it. I cannot say with any certainty that the prisoner did not raise concerns about his health with medical staff prior to 6 June but it is true to say that when he had an opportunity on reception to disclose his illness, he did not do so. That was the prisoner's choice.

The doctor concludes that there are operational lessons to be learned from the prisoner's death. I am heartened to learn that the Head of Health Care did raise an NHS Incident Report Form (IR1) which evaluated the risk of the incident as extreme. The Director of Nursing with responsibility for care at HMP Birmingham has been asked to prioritise the omissions of documentation and of care.

Conclusion

Whilst it is acknowledged by the prison and the Investigation Team that some local policies were either not in place or not adhered to, and that communication between various departments in the prison and City Road Hospital was poor, these issues would not have prevented the unfortunate death of the prisoner. He was a poorly man prior to coming into prison, and it is a pity that a more informed picture of his health was not volunteered by himself or identified by healthcare staff.

Recommendations

1. A Healthcare Protocol needs to be developed as a matter of urgency which ensures effective and appropriate liaison with hospitals when prisoners are admitted to them, enabling continuity of care.
2. A system should be put in place to ensure that daily contact is made and recorded in the prisoner's medical record between the Health Care Centre and any outside hospital when prisoners are admitted for treatment.
3. The Governor should consider revising contact restrictions on Risk Assessments in individual cases when prisoners are admitted to hospital following escort from the prison.
4. Management checks should take place as specified in the Local Security Instructions, Annex 43, dated October 2000, and the subsequent memo to all Duty Governors dated 19th April 2004, distributed by email.
5. Management checks must ensure that the quality and detail of entries in Bedwatch logs are both informative and appropriate. In particular, they should include details of contact with the prison as per the Local Security Instructions.
6. Staff supervising prisoners in outside hospitals should understand the importance of completing the documentation accurately and professionally. Staff Briefing sessions should be scheduled to address this.
7. Regular visits should be made by management to prisoners in hospital who have been released on licence. These visits should be recorded in the Duty Governor's log.
8. The Discipline Office must be informed of any prisoner released on Temporary Licence. A system which meets this requirement must be put in place, even if the Discipline Office is not the department initiating the licence. The system should also incorporate procedures which ensures that all licences are renewed on time.

Glossary of Terms

Bedwatch	The deployment of staff to oversee a prisoner who has attended hospital and has been admitted as an in-patient
DSM	Duty Shift Manager
ECR	Emergency Control Room
F2050	Prisoner's Main Core Record
Governor	Senior Manager Graded A – F
HCC	Healthcare Centre
Hotel 2	Healthcare radio contact in an emergency
IMB	Independent Monitoring Board
IMR	Inmate Medical Record
LIDS	Local Inmate Database System (computerised)
LSI	Local Security Instructions
NOU	National Operations Unit
Oscar 2	Assistant Night Orderly Officer
PER	Prisoner Escort Record
PO	Principal Officer
POA	Prison Officers Association
SIO	Senior Investigating Officer
SIR	Security Information Report
SO	Senior Officer
Standard Audit	Prison Service Internal Audit System
Visiting Order	Form which enables someone to visit a prisoner