Investigation into the circumstances surrounding the death of a man in October 2010, whilst in the custody of HMP Birmingham

Report by the Prisons and Probation Ombudsman for England and Wales

May 2011

This is a report into the death of a man at HMP Birmingham in October 2010. The man was 67 years old and died of natural causes. A post mortem report concluded that he died from chronic obstructive airway disease.

I offer my sincere condolences to the man's family and friends for their loss. A member of my Family Liaison Team contacted the man's daughter on 1 November 2010 to tell her about the investigation and to provide the family with an opportunity to raise any issues about the care he received in custody.

The investigation was carried out on my behalf by two of my colleagues. I would like to thank the Governor of Birmingham and his staff for their co-operation during the course of our enquiries. In particular I would like to thank the prison liaison for this investigation.

Birmingham Primary Care Trust (PCT) were commissioned to produce a clinical review of the care the man received. The PCT appointed a clinical reviewer to conduct the review and I am grateful for his contribution to this investigation. As the man died from natural causes, the findings in the clinical review play an essential part in my report. The review shows that the standard of care he received was comparable to that which could be expected in the community.

I make four recommendations concerning the transfer of medical records, discussing changes to medication with prisoners, ensuring that medication is kept in stock and the proper recording of information in electronic medical records.

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

Jane Webb
Acting Prisons and Probation Ombudsman **May 2011**

CONTENTS

SUMMARY

1. On 4 January 2010, the man was remanded into custody and sent to HMP Hewell. On arrival, he had a health screen assessment with a nurse. The man had a medical history which included chronic obstructive pulmonary disease (COPD) and asthma. (COPD is a term used for a number of conditions; including chronic bronchitis and emphysema. COPD leads to damaged airways in the lungs, causing them to become narrower and making it harder for air to get in and out of the lungs.) He had regular contact with healthcare staff. However, despite advice, he declined to keep his head raised when resting and he continued to smoke.

2. The man appeared at a magistrates' court on 29 March, and was committed for trial at a crown court, when he was remanded to the custody of HMP Birmingham. On 6 September, he was sentenced to three years in custody.

3. On transfer to Birmingham, the man saw a nurse who recorded his prescribed medication, blood pressure and assessed that he was fit to be located on the induction wing. However, his medical records did not accompany him, and he did not have any medication. The following day, he went to hospital because of breathing difficulties. He returned to Birmingham on 2 April, when he was again assessed by healthcare. It was noted that he was tearful, said he had little to live for and refused to accept his medication. He was moved to the care suite and was closely monitored.

4. In the weeks and months that followed, the man continued to receive support from staff and had regular contact with healthcare staff, including the mental health team. On 16 April, he was moved to a cell on N wing, which was adapted for prisoners with disabilities, where he remained until his death.

5. At approximately 6.15am on the morning of the man's death a uniformed officer alerted staff that the man was in his cell, on the floor under his bed and unresponsive. Due to the man's medical condition, the officer asked for urgent medical assistance and went into his cell. A nurse responded immediately and attempted to resuscitate him, and an emergency ambulance was requested. At 6.55am, the paramedics pronounced that the man had died.

6. The man's next of kin was recorded as his daughter. A prison family liaison officer visited her at home later that morning to tell her of her father's death. The prison offered financial support towards the funeral costs.

7. I am satisfied that the care the man received at Hewell and Birmingham was comparable to that which would be expected in the community. I make four recommendations, concerning the transfer of medical records, discussing changes to medication with prisoners, ensuring that there is enough medication and that information is recorded properly in the electronic medical records.

THE INVESTIGATION PROCESS

8. The investigation was opened on 21 October 2010, when my investigators issued notices announcing the investigation to staff and prisoners. No prisoners or staff came forward. The investigators met the Safer Custody Team, Deputy Governor and a representative of the Independent Monitoring Board at HMP Birmingham, and were provided with all the documentation relating to the man. They also went to N wing and saw cell N1-01 where the man died.

9. The investigators returned to Birmingham again on 11 November, and interviewed four members of staff and one prisoner. Initial feedback from the investigation was provided, in writing, to the Prison Governor on 25 November.

10. Birmingham Primary Care Trust asked the clinical reviewer to conduct a review of the man's clinical care and he was provided with all relevant documentation to assist this review. I thank the clinical reviewer for undertaking this review and for his timely report.

11. My investigators contacted Her Majesty's Coroner to inform him of the nature and scope of the investigation and request a copy of the post mortem report. Upon completion, the investigation report will be sent to the Coroner to assist his enquiries into the man's death.

12. A member of my Family Liaison Team contacted the man's daughter on 1 November, to inform her about the investigation and invite her to ask any questions or raise any concerns about the care her father received. The man's daughter spoke positively about the contact she has had with the prison liaison officer since her father's death. She has a number of general questions about her father's care that she wished the investigation to consider:

    - If her father had been located on the healthcare wing and not alone in a cell, would the outcome have been different and would he still have been locked in a cell alone? The man's daughter knew that he was not a well man and that he was very poorly but she wants to make sure that he got the best care he could have expected.

    - Why was her father's medication recently reduced and was this appropriate?

    - Her father phoned her daily and often complained about his care and that he could not get to see the doctor. The man's daughter was not sure if her father complained to prison staff about this but thinks that he must have done.

    - The man's daughter visited her father who, due to his ill health, needed a wheelchair to get to the visits room. However, it had

taken some time for him to obtain a wheelchair and, in the end, his solicitor wrote to ask for one. She asked the investigation to consider whether her father had difficulty accessing the doctor.

- The man's daughter was aware that her father had a close friend on his wing who her father had confided in. She asked the investigators to speak to him.

HMP BIRMINGHAM

13. 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.

HM Inspectorate of Prisons

14. HM Chief Inspector of Prisons last conducted an unannounced full follow up announced inspection of the prison in December 2009. The Chief Inspector noted that,

> "there was still a considerable amount to do to ensure a safe, decent and effective prison. Relationships between staff and prisoners were found to be a considerable weakness."

15. Inspectors found that healthcare provision at the prison was "mostly satisfactory". It was largely delivered from a "modern, purpose-built unit" by three distinct groups of staff working in primary care, in-patient care and visiting specialists. Relationships between healthcare staff and prisoners were identified as good, particularly on the in-patient wards. All the in-patients had a care plan and a named nurse and officer.

Independent Monitoring Board

16. 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 published 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".

Previous deaths in custody at Birmingham

17. The man's death was one of 33 to have occurred at Birmingham since April 2004 when my office began investigating all deaths in prison custody in England and Wales. Eighteen of the previous deaths were due to natural causes, and five have occurred since the start of 2010. There are no similarities between those deaths and that of this man.

Performance rating

18. Prisons in England and Wales are assessed for performance by the National Offender Management Service (NOMS). For public prisons, NOMS use a combination of the Prison Performance Assessment Tool (PPAT, which looks at 33 indicators) and the public prison weighted scorecard (which looks at a set of 44 indicators). Each establishment is then given a rating between one and four; 4 = Exceptional performance, 3 = Good performance, 2 = Requiring development, 1 = Serious concerns. For the last three performance reports, HMP Birmingham has been given a rating of 2.

Prison Service Orders and Assessment, Care in Custody and Teamwork (ACCT)

19. The rules that govern all aspects of running a prison are set out in a series of documents called Prison Service Orders (PSOs). PSO 2700 – 'Suicide prevention and self-harm management' - details prison procedures for looking after prisoners at risk of suicide or self harm. Assessment, Care in Custody and Teamwork (or ACCT) is the system used by prisons to identify, monitor and support prisoners at risk of self harm. The ACCT process is used in all prisons in England and Wales. Any member of staff can start the ACCT process, by raising a Concern and Keep Safe form, explaining the reasons for their concern. An Immediate Action Plan is written by the manager of the wing where the prisoner is located and an ACCT assessment is carried out within 24 hours by a member of staff who has the required training.

20. After the ACCT assessment has taken place, a multi-disciplinary ACCT case review is held to determine what measures can be taken to monitor and support the prisoner effectively. The prisoner attends the case review and is encouraged to contribute to the decisions being made. An ACCT CAREMAP is drawn up with details of each of the actions required to keep the prisoner safe and identifies who is responsible for carrying out each action. Case reviews are held at regular intervals, usually monthly, to review the actions and the prisoner's level of risk.

Risk assessments

21. Each time that a prisoner is escorted outside the prison to hospital, a risk assessment considers the risk to the public, potential for escape and likelihood of outside assistance. The assessment informs the decision about the number of escorting officers and the type of restraint to be used (single cuffs or two metre long escort chain with a cuff at either end). It also determines the circumstances and the authority required for the restraints to be removed. The risk assessment is reviewed each day that a prisoner is in hospital and amended where necessary.

KEY EVENTS

22. The man was born in August 1943 and, before entering custody, lived in Worcestershire. He was married, although estranged from his wife, with two adult children. Prior to his retirement, the man had worked as a floor tiler and car welder/sprayer. He was remanded into custody at HMP Hewell on 4 January 2010. He was later convicted of arson and was given a determinate sentence of three years at a crown court on 6 September 2010.

23. On arrival at Hewell, the man had an initial health screen assessment during which he confirmed he had a history of heart and lung problems, including chronic obstructive pulmonary disease (COPD). He was also prescribed a number of different medications, although he could not remember all of them. He said that he had been discharged from hospital the previous day, after having breathing difficulties. His medical history led to the decision to admit him to the healthcare centre.

24. The next morning a prison doctor saw the man and recorded that he suffered from shortness of breath due to COPD. The prison doctor noted that the man had been prescribed various medications:

    - salbutamol (for COPD & asthma)
    - fluticasone (for asthma)
    - carbocisteine (for COPD)
    - ipratropium bromide (for COPD)
    - furosemide (for congestive heart failure and oedema (the accumulation of fluid beneath the skin)
    - prednisolone (for asthma)
    - doxycycline (antibiotic for respiratory tract infection)
    - loperamide (for gastric conditions).

    The doctor advised the man on different techniques to improve his breathing, such as elevating the head of his bed and keeping his immediate environment free from pollution such as cigarette smoke. A care plan was put in place.

25. Later the same day, following consultation with the man's COPD nurse in the community, his medication was varied. Fluticasone was replaced with seretide (for COPD & asthma). He was again advised to have his head raised when resting, advice which he declined to follow.

26. The man next saw the prison doctor on 7 January. His blood pressure was recorded as 124/76. (The normal range for blood pressure is 100/70 to 140/90, although the pressure varies throughout the day depending on the individual's activities. A blood pressure reading of greater than 140/90 is classed as high and a reading of 90/60 or below is classed as low.) He was recorded as having a pulse of 88 and weighing 96.4kg. The man said that he was a smoker and he had a

hernia. The doctor recorded that he had no history of mental ill health, or had any thoughts of harming himself although at times he appeared tearful.

27. Throughout the following few weeks, the man remained in the healthcare centre where he was monitored every day. His medication was regularly reviewed and he was encouraged to be as independent as possible, in line with his care plan.

28. On 28 January, the man moved to Houseblock 6, to a cell that had been adapted specifically for those with disabilities. Although the cell was not in the healthcare centre, healthcare staff continued to monitor him regularly.

29. On 20 February, the man saw a doctor complaining of an increase in breathlessness and a cough. The doctor assessed that the man's condition required further investigation and referred him to outside hospital. The man was escorted to the hospital to be assessed and returned to Hewell the same day. A risk assessment was completed and a two officer escort and an escort chain were used to be removed only when treatment was required. (An escort chain is a two metre long escort chain with a cuff at either end.) Hospital staff diagnosed that the man had an infection and he was prescribed a course of antibiotics.

30. The man remained on Houseblock 6 until he appeared in court on 29 March. Following his court appearance, he was moved to HMP Birmingham. This type of transfer is known as a 'handover' move. All prisoners who are committed to this crown court would be transferred directly from court to Birmingham, if there is sufficient space, as Birmingham serves this court.

31. On arrival at Birmingham, the man had another initial health screen assessment. He told healthcare staff that he had COPD, also that he was deaf in his right ear, blind in his right eye and suffered from a hernia (he did not disclose these issues at Hewell). Due to his medical history and prescribed medication, a doctor's appointment was made for 8 April, which was the earliest that was available. The man was on D Wing, the induction unit, and went through the induction process. It was recorded that he smoked, although other prison documents record that he said that he was a non-smoker.

32. The next morning, the man was again assessed by healthcare and his weight was recorded as 86kg, and blood pressure 103/72. The man said that, due to his unplanned move to Birmingham, his property and medication had been left at Hewell. There is no record that his medication or clinical notes were requested from Hewell.

33. Later the same day, the man complained of shortness of breath and wheeziness. A member of healthcare staff saw him on D wing and

recorded that he said he had not taken his medication for three days due to appearing in court and his subsequent transfer. Following examination, he was sent to outside hospital where he was placed on a nebuliser (a machine which delivers medication in the form of a spray). Following assessment and monitoring, the man was discharged from hospital and returned to Birmingham on 2 April.

34. On his return, the man's prescribed medication is recorded as follows; tiotropium inhalation (for COPD), prednisalone, furosemide, quinine sulphate (used to prevent night cramps), carbocisteine, salbutamol, doxycycline, and seretide. He was extremely distressed and tearful, telling a nurse that he no longer wanted to take his medication, he had "no fight left in him" and wanted to die. The man stated that he had a number of family issues to deal with and wanted to return to Hewell. As a result of these comments and his low mood, an ACCT document was opened and he was referred to the mental health team (MHT).

35. The man was moved to the care suite, following instruction from a prison governor, and provided with access to peer support from the Listeners (Listeners are trained by Samaritans to provide confidential emotional support to fellow prisoners in distress). He was encouraged by staff to take his prescribed medication, but he refused and repeated that he had no reason to live. He said that he was aware of the adverse effects on his health of refusing his medication.

36. On 3 April, a nurse contacted Hewell to establish if they had any space for the man to go back to their prison. There was no space and the staff said that the man had also refused his medication when he was there, had been in low mood and smoked regularly. The nurse referred the man to the doctor due to his persistent refusal to take his medication.

37. Later that afternoon, the man received a visit from a mental health nurse who recorded that his mood remained low. No treatment was available from the in-reach team but the mental health nurse referred him to the primary MHT. The man denied any intention to harm himself but said that he would continue to refuse his medication.

38. An ACCT review was held on 4 April. The man said that he had no intention of deliberately harming himself and he declined anti-depressant medication. He was supported by a Listener throughout the night and was persuaded to take his COPD medication. It was agreed that he should remain in the care suite with Listener support. His mobility was to be assessed with a view to possible admission into the healthcare centre. The following day, it was recorded that he had taken his prescribed medication but that his mood continued to fluctuate.

39. A member of the primary mental health team reviewed the man in the care suite on 6 April. The nurse recorded that the man was emotional and again refused his medication, although he was aware of the

implications. It was agreed that the man should be relocated to N wing, to a cell equipped for those with mobility issues, which would be sufficient to accommodate his needs until a bed was available in the healthcare centre.

40. On 9 April, healthcare records show that the man took some of his prescribed medication, and was seen smoking. He told staff that he was happy on N wing and did not want to be admitted as an in-patient. He agreed to take his medication if he was allowed to remain on N wing. Following an ACCT review, this was agreed, subject to confirmation that he took his medication. The following day it was noted that he was still low in mood and needed lots of encouragement to collect his medication, tend to his personal hygiene and complied with the prison regime.

41. A further ACCT review was undertaken on 16 April, when the procedures were closed. A post-closure action plan was implemented for the following seven days to assess his ability to cope. He was also assessed by healthcare staff to see whether he could manage his physical disability on a normal wing. It was agreed that N wing provided the necessary facilities and that he would be provided with a wheelchair to facilitate trips to the healthcare centre. The man settled on N wing and received support from the prisoner disability representative who lived in the adjacent cell. This arrangement was to be reviewed if there was a change in his physical or mental well-being.

42. At interview, the prisoner disability representative confirmed that the man had access to a wheelchair at all times and had not approached him in his role as prisoner disability representative with any concerns. A prison officer also confirmed that the man had full access to a wheelchair at any time. My investigator contacted a firm of solicitors whose details were provided by the man's daughter. The solicitor stated that she had communicated with the man but could not recall the subject. She confirmed that it was not an issue relating to access to a wheelchair.

43. The man submitted a Form HC1 – Prisoner Enquiry Form (for concerns regarding medical care or treatment) on 26 April. He was concerned that his steroid medication was 'being messed around' and that he was receiving different doses. The man also said that his quinine medication had been withheld and was advised by healthcare staff that this was due to them having "run out". The Director of Offender Health replied to this complaint on 24 May. She apologised for the inconvenience caused and enclosed a response from the primary care nurse manager. The primary care nurse manager said that the man's medication had been reviewed and, that if he was concerned about the change in dose, he should make an appointment with the doctor. In the meantime, only the dose that had been prescribed could be administered. The man was issued with 28 quinine tablets on 28 April. Prisoners are risk assessed to determine whether they can keep

medicines in-possession. Some prescribed medicines are not permitted in-possession because they are considered to be valuable 'currency'. However, certain items such as inhalers or skin creams are permissible.

44. Over the next few months, the man was regularly monitored by healthcare staff. He took his medication and was encouraged to stop smoking, albeit without success. His mood stabilised and he continued to receive support from fellow prisoners, in particular the disability representative. The man was assessed on 9 June by the mental health team, but was not thought to pose a risk to himself. He declined anti-depressant medication.

45. On 21 June, the man saw a prison doctor complaining of a bad chest. The doctor diagnosed that the man had a chest infection and prescribed amoxicillin (an antibiotic).

46. Later that evening at 9.00pm, healthcare were called by wing staff to see the man in his cell as he complained of shortness of breath. His blood pressure was recorded as 122/101. A nurse attempted to administer a nebuliser, but the man consistently refused as he said it made him feel sick. His condition stabilised, his blood pressure was recorded as 129/59 and he was advised to alert staff if his condition deteriorated.

47. The man was observed over the next few days. His condition did not deteriorate but he continued to smoke.

48. On 28 June, healthcare staff were called again to see the man as he complained of feeling unwell, had not eaten properly for weeks and was often sick following consumption of food and drink. The man told a nurse that he had fainted the previous evening, had fallen and bruised his head and cut his right hand. He was told to rest and drink fluids. The man was monitored by staff over the next few hours but no further concerns were reported.

49. Two days later, the man was reviewed by the mental health team. He said that his mood was low due to his personal circumstances and his difficulty managing the breakdown of the relationship with his wife. A nurse from the in-reach team recorded that the man refused any anti-depressant medication and the nurse would regularly review his case. An urgent outpatient referral was made two days later as the man was still not eating properly and had lost weight.

50. A prison doctor examined the man on 2 July as he had been vomiting and unable to eat for a number of weeks, reporting that he had lost a significant amount of weight. An urgent referral was made for further investigation.

51. A Community Psychiatric Nurse (CPN) from the mental health team reviewed the man on 8 July, following concerns raised by staff and other prisoners about his low mood. The man said that he felt hopeless, although he denied having any thoughts of self-harm, and refused his medication. It is recorded that his weight was 71kg and he had lost 15kg since coming into custody. Daily clinical observations (that is his pulse, blood pressure and breathing) were to be measured and he was told to tell staff if his condition changed. These observations were undertaken and there was a small improvement in his blood pressure and appetite.

52. The Community Psychiatric Nurse (CPN) undertook a further review of the man's mental health on 14 July. The nurse recorded that he was brighter in mood, although still struggling, and had little motivation. The man agreed to start a course of anti-depressants (citalopram). It was agreed that staff would continue to monitor his health and he was given further advice to stop smoking.

53. On 17 July, the man's blood pressure was recorded as 89/66. His medication was changed and furosemide was no longer prescribed. His condition improved by the following day, and his blood pressure had risen to 101/75. At interview, a nurse clarified that furosemide was withdrawn as it was having a detrimental effect on the man's blood pressure, which was fluctuating and cause for concern.

54. The movement record in P-NOMIS (the Prison Service computerised records system) has an entry that the man went to outside hospital on 23 July. However, there is no corresponding entry on the healthcare records giving the reason for this visit. I was able to confirm, from the prison core records and hospital letters contained in the clinical file, that the man did go to hospital on this day, but a planned endoscopy (a procedure in which a camera is used to view the digestive system) did not take place as the hospital could not facilitate the procedure. A letter was received by the prison dated 26 July, rescheduling the endoscopy to 6 August.

55. Staff continued to monitor the man's blood pressure over the following 12 days. On 30 July, the man saw a nurse as he complained of pain in his foot. The nurse prescribed general pain killers and referred him for an appointment with the prison doctor on 3 August. The man saw the prison doctor as arranged. The doctor recorded that his blood pressure as 70/58 and he was now regularly using a wheelchair as he was not mobile. The man was also prescribed fortisips drinks (a nutritional supplement).

56. On 5 August, the man was reviewed by a nurse and said he was brighter in mood and receiving good support from his peers. The nurse recorded his weight as 66kg.

57. The following day, the man attended outside hospital for his outpatient appointment. The risk assessment authorised two officers to escort him and an escort chain which was only to be removed for treatment purposes. The man underwent an endoscopy to establish the cause of his sickness and weight loss. The test results indicated an infection of the digestive system and the hospital doctor prescribed:

    - omeprazole (a treatment for gastric problems)
    - amoxicillin (an antibiotic)
    - clarithromycin (another antibiotic).

    This course of treatment is known as triple therapy helicobacter pylori.

58. The man's blood pressure was regularly monitored for the next five days. On 13 August, a prison doctor recorded that the man was eating and drinking normally. The doctor requested that the man's blood pressure continued to be regularly monitored.

59. The man saw a further prison doctor on 1 September as he complained of swollen legs. The doctor did not prescribe any medication due to the concerns about the man's low blood pressure. The following day, the man was reviewed by a nurse. The nurse noted that the man was still low in mood, although there were no significant concerns. He said that he was objective about his pending court appearance, and expected to receive a custodial sentence. He continued to be monitored over the following three days.

60. On 6 September, the man attended court and was sentenced to three years imprisonment and returned to Birmingham. The following day, his blood pressure was recorded as 117/82 and his legs were swollen and red in colour. He was referred to the doctor.

61. The man saw a prison doctor two days later. The doctor encouraged him to walk around the wing to help reduce the fluid in his legs and to raise his legs when sitting. The doctor also prescribed support stockings.

62. A nurse saw the man on 11 September, as he complained that the swelling in his legs had become worse. The nurse told the man to raise his legs when sitting, and explained that the decision not to prescribe medication was because it could lead to a further drop in blood pressure.

63. A further nurse saw the man on 17 September and recorded that his legs were less swollen. The nurse noted that he had not been wearing the support stockings prescribed by the doctor because he found it difficult to get them on. The nurse referred the man to the prison doctor for a review.

64. The next entry in the man's medical record was made on 22 September, when his blood pressure was 134/76. The nurse said that the man would have been seen by healthcare staff every day when medication was taken to his cell and his blood pressure was monitored. The nurse went on to explain that many of the nurses were agency staff which may be an explanation for the lack of notes. She reflected that they should have been aware of the need to record information and would have had access to the computerised record log.

65. At interview, the Community Psychiatric Nurse (CPN) stated that, had the man been located as an inpatient in the healthcare centre, he would still have been in a single cell which would have been locked.

Events during the Morning of the Man's Death

66. A night duty officer was responsible for N wing on the morning of the man's death. Part of his duties required him to undertake a roll check, to confirm the number of prisoners on the wing. This involves a visual check through the observation hatch of each cell.

67. During the check made at approximately 6.15am, the night duty officer was unable to account for the man as he could not see anyone in the cell. A senior officer was on P wing, which is adjacent to N wing, and the night duty officer asked for his assistance as he was carrying keys (officers do not routinely carry keys whilst the prison is in patrol state during the night). The senior officer was not officially on duty, but had entered the prison early, to utilise the gym facilities before his shift. He had gone to his office on P wing, which is adjacent to N wing prior to meeting another colleague at the gym. They met at cell N1-01, could not see anyone and the man did not respond to their calls. The man's bed appeared to have been made but the covers had been moved.

68. The officers went into the man's cell and found him underneath his bed facing the wall. The night duty officer immediately called for medical assistance from Hotel 2 via his radio. (Hotel 2 is the duty nurse who provides medical assistance in emergencies to the entire prison during the night.) The senior officer and the night duty officer moved the man from under his bed to enable them to assess his condition. At interview the night duty officer said that he checked for a pulse on the man's wrist and neck but could not find one. He asked the senior officer to also check to ensure that he had not been mistaken. No pulse was found by either officer.

69. A nurse responded immediately, and, on arriving at the man's cell, moved him to start cardio pulmonary resuscitation (CPR) and asked for an emergency ambulance. An automated external defibrillator (a portable electronic device that diagnoses rhythms after cardiac arrest) was attached to the man and it advised that 'no shock' should be attempted. This was undertaken three times with the same instruction not to shock and so CPR continued. Paramedics arrived at 6.40am

and they carried out an electrocardiogram (ECG). The man's death was pronounced at 6.55am.

70. Later that morning a hot debrief was held with all the staff involved in the incident and support was made available for them. A notice to staff and prisoners was issued by the Governor the same day announcing the death of the man and reminding them of the support, through the care team and Listeners/Samaritans respectively.

71. A family liaison officer from Birmingham and a principal officer (PO) visited the man's daughter, his nominated next of kin, at 11.20am at her home to break the news of her father's death. The prison offered financial assistance towards the funeral expenses. Further contact was made by the prison family liaison officer later the same day to check on the man's daughter's welfare and ask for the contact details of the man's estranged wife. His daughter advised that she would inform her and would explain that the Prison Service would contact her tomorrow.

72. The family liaison officer from Birmingham Prison contacted the man's estranged wife the following day to advise her of the investigation process. The prison family liaison officer arranged to meet the man's daughter on 14 October at outside hospital where she identified her father's body. During this contact she was informed about the process of the inquest. On 22 October, the prison family liaison officer again spoke to the man's daughter and told her that other prisoners wanted to send a wreath to the funeral. She agreed to the suggestion.

ISSUES

Clinical care

73. When the man was first remanded into custody, he had several existing health problems. On several occasions, he exercised his right to refuse to take his medication.

74. On 29 March, the man was transferred from Hewell to Birmingham and did not have his medication with him. Prison Service Orders (PSOs) 3050, entitled "Continuity of healthcare for prisoners", and 6200, entitled "Transfer of prisoners", set out the guidelines for transferring prisoners. These guidelines include instructions for sending the prisoner's medical record with the escort paperwork. PSO 6200, Section 8, 8.2 states;

> "All sending establishments must complete a Prisoner Escort Record (PER) in respect of each prisoner being transferred. The PER must be ready for collection by the contractor at the time of handover, together with the prisoner's F2050 record and medical record (IMR)."

75. This is especially important when transferring prisoners with complex medical histories and who regularly take prescribed medication. In this case, it seems that neither the medicines nor the documentation travelled with the man, even though it was highly likely that he would move to Birmingham after appearing at court. Both prisons need to ensure that proper transfer processes are in place.

The Governors of Hewell and Birmingham should ensure that all transfers, including 'handover' transfers, adhere to the guidelines set out in PSO 6200 so that all receiving establishments have correct information about an individual's medical history and prescribed medications.

76. On 26 April, the man submitted a complaint form after his medication was changed without him being informed. This caused him some concern, which could have been allayed had staff communicated with him more effectively. He had also not received this medication for a number of days. The Director of Offender Health acknowledged that the medication had "run out". This is clearly unsatisfactory, and a robust process needs to be developed to make sure that stocks of medication are kept at sufficient levels for staff to fulfil regular prescriptions.

The Director of Offender Health should ensure that all individuals are given information regarding their medication and told if it might be varied.

The Director of Offender Health should develop a robust process to ensure that there are adequate stocks of regularly prescribed medications.

77. The clinical review looks at the care and treatment a prisoner receives in prison, ensuring that it is appropriate and comparable to that which is available in the community. Both the clinical reviewer and I are satisfied that the care the man received was comparable to that which is expected in the community.

78. The reviewer makes no specific recommendations and concluded that:

> "In my opinion the standard of medical care offered by the prison service was at the same standard or better than to be expected in the NHS. There are examples of good practice in the treatment of his COPD, duodenal ulcer and depression. The treatment offered can be commended."

Assessment, Care in Custody and Teamwork

79. The man was well supported after he disclosed on 2 April that he was not going to take his medication and felt as thought he wanted to die. The use of the care suite and access to a Listener was commendable and I am pleased to see that these facilities were made available to him.

80. Having disclosed he felt low in mood, he was appropriately monitored by prison and healthcare staff who utilised the ACCT process. During this time, Birmingham staff successfully encouraged the man to recommence his medication.

Record keeping

81. No entries were made in the man's healthcare record between 22 September to the date of the man's death. It is impossible to say with any certainty whether this had any effect on the man, but it seems unlikely that a member of the healthcare team had contact with him during this period. A visit to outside hospital was also not accurately recorded in the man's medical notes.

82. Following interviews, my investigator contacted the Director of Offender Health who confirmed that the omission of entries was probably due to the use of agency staff, reflecting that they may not have been sufficiently aware or trained or had limited access to a computer to make entries. If agency staff continue to be used at Birmingham, it is imperative that this issue is addressed. All staff, including agency staff, should be given clear instructions that accurate and comprehensive records of contacts with patients are entered on the computerised record.

The Director of Offender Health should ensure that all healthcare staff, including agency staff, comply fully with the requirements of the General Medical Council and the Nursing and Midwifery Council regarding accurate and contemporaneous record keeping.

CONCLUSION

83. I judge that this man received appropriate treatment while he was in custody, despite their being several issues about procedures to which I have drawn attention in this report. The standard of care that he received whilst at Birmingham ensured that his multiple conditions were adequately managed. The man's care was unlikely to have been further improved by admission to healthcare and staff observed his wish to remain on N wing.

84. I believe that the man was treated with dignity and respect during the time he was at Birmingham. Following his death, the prison appropriately followed the guidance given in PSO 2710, "follow up to death in custody".

RECOMMENDATIONS

1. The Governors of Hewell and Birmingham should ensure that all transfers, including 'handover' transfers, adhere to the guidelines set out in PSO 6200 so that all receiving establishments have correct information about an individual's medical history and prescribed medications.

   The prison service has accepted this recommendation.

   HMP Birmingham
   The Head of Healthcare at HMP Birmingham will liaise with the Head of Healthcare at HMP Hewell to ensure 'handover' transfers in the future adhere to PSO 6200.

   HMP Hewell
   Actions have been taken to ensure that in all cases of a prisoner leaving HMP Hewell there is at least a printed summary record (including prescribing information) that travels with them. In the case of handovers there is a print out of the prisoners' full medical record.

   HMPs Hewell and Birmingham are now on Systm1 and on this basis the prisoners' health records are immediately transferred electronically and this will include a full prescribing history.

2. The Director of Offender Health at HMP Birmingham should ensure that all individuals are given information regarding their medication and are told if it might be varied.

   The prison service has accepted this recommendation.

   Ongoing work is in place to ensure that all prisoners are seen individually and informed of any variation as well as given general information about their medication

3. The Director of Offender Health at HMP Birmingham should develop a robust process to ensure that there are adequate stocks of regularly prescribed medications.

   The prison service has accepted this recommendation.

   Regular prescribed medications are stocked and any medications used less frequently are ordered and generally received into the establishment within 24 hours. Work with BSMHFT pharmacy is ongoing to ensure out of hours and more responsive services are in place.

4. The Director of Offender Health at HMP Birmingham should ensure that all healthcare staff, including agency staff, comply fully with the

requirements of the General Medical Council and the Nursing and Midwifery Council regarding accurate and contemporaneous record keeping.

The prison service has accepted this recommendation.

A log of all staff registrations are in place for all areas and the need for accurate record keeping will be enforced to all.