Investigation into the circumstances surrounding the death of a man at HMP Birmingham in March 2006

Report by the Prisons and Probation Ombudsman for England and Wales

September 2006

This is the report of an investigation into the death of a man who died from apparent natural causes on 9 March 2006 at HMP Birmingham. He was 64 years old.

I would like to add my personal condolences to those already expressed by one of my Family Liaison Officers on behalf of this office.

The investigation was undertaken by one of my investigators. I would like to thank the Governor of HMP Birmingham and his staff for their active participation and assistance during the investigation.

Two members of staff were identified by the Heart of Birmingham Primary Care Trust to undertake reviews of the man's clinical care, and I also appreciate their assistance.

The principal clinical reviewer raises no concerns about the level of care that the man received, but makes a number of recommendations about recording and sharing information. I endorse all those recommendations.

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.

Stephen Shaw CBE
Prisons and Probation Ombudsman **September 2006**

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SUMMARY

1. The man was born in 1941. He was 64 years old when he died in Birmingham prison on 9 March 2006.

2. The man had been received into custody after being sentenced to five years imprisonment for firearm offences. He arrived at HMP Birmingham on 3 February 2006. During his first health screen, it was noted that the man had chronic obstructive pulmonary disease and severe asthma.

3. On 14 February, the man was taken to a local hospital. On 20 February, following an outbreak of diarrhoea and vomiting on the wards near to where he was staying, the man was discharged from hospital and returned to Birmingham prison. On the following day, the man was moved to the healthcare wing.

4. During the early hours on 9 March, the man complained to staff of being breathless. He was given a nebuliser at 2:00am and 4:00am, and staff carried out regular checks on the man throughout the night. When healthcare staff checked on the man at around 7:30am on 9 March, he was again short of breath and distressed. After healthcare staff entered the man's cell, he collapsed onto the floor. An ambulance was called and staff immediately commenced cardio pulmonary resuscitation (CPR).

5. The prison's medical officer and the ambulance crew arrived at the man's cell at the same time. The paramedics took an electro cardiogram (ECG) which indicated that the man's heart had stopped beating. Consequently, there were no further attempts to resuscitate the man and he was pronounced dead by the prison doctor at 8:16am.

6. The principal clinical review concludes that the man's clinical care was, overall, of an appropriate standard. However, it highlights a number of areas where improvements could be made to systems of recording and sharing information. The review makes ten recommendations, all of which I endorse.

THE INVESTIGATION PROCESS

7. My investigator studied all relevant prison records relating to the man. These included his main prison record, his medical records and statements from prison staff.

8. Heart of Birmingham Primary Care Trust identified two staff to carry out reviews of the man's clinical care. I am grateful that these reviews have been undertaken in a most timely manner.

9. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the Post Mortem report. Upon completion, this report will be sent to the Coroner to assist him in his enquiries into the man's death.

10. One of my Family Liaison Officers met with the man's family in the company of my investigator. The family told them of their concerns which are considered later in this report. I hope what I have written and the contents of the clinical review will provide them with answers to some of their questions.

11. My investigator discussed aspects of the man's treatment with staff at Birmingham prison and with the principal clinical reviewer.

HMP BIRMINGHAM

12. Birmingham is a local prison for adult male prisoners. It serves the Crown and Magistrates' Courts of Birmingham, Stafford and Wolverhampton and the Magistrates' Courts of Burton, Cannock, Litchfield, Rugeley, Sutton Coldfield and Tamworth.

13. The prison has recently undergone a period of considerable change as a result of a multi-million pound investment programme by the Prison Service. Some 450 additional prisoner places have been added together with new workshops, educational facilities, a new healthcare centre and gymnasium as well as extensions and improvements to existing facilities. The prison is now well resourced and equipped to provide for its population of around 1,450.

14. The provision of healthcare within the prison is the responsibility of the Heart of Birmingham Primary Care Trust. Primary care clinics are delivered by GPs and visiting consultants. The healthcare centre has the opportunity to draw upon the broader expertise and range of healthcare services at the local hospital. The healthcare team comprises doctors, nurses and healthcare assistants. Medication is administered on a weekly and/or monthly basis to those prisoners who have been assessed as capable of holding it in their own possession. It is administered on a daily basis to other prisoners, when either they are considered to be at risk or the medication is unsuitable to be held in their cell.

15. There is an in patient ward where all cells have integral sanitation. The ward is staffed by registered mental health nurses who provide care for patients with mental health needs and those with physical needs requiring 24 hour nursing presence.

KEY FINDINGS

16. The man arrived at Birmingham on 3 February 2006. During his health screen it was noted that he had chronic obstructive pulmonary disease (COPD) and severe asthma. The man asked to see a doctor during his health screen. The prison doctor assessed the man as being fit for normal cell location and sharing a cell but stipulated that, for medical reasons, he should be accommodated on one of the lower levels

17. During the evening on 13 February, the man was short of breath and healthcare staff were called to his cell. He was given oxygen and an appointment slip to see the prison doctor the following day.

18. During the early hours of the following morning, staff were again called to the man's cell. The man was complaining of chest pains and shortness of breath. When treatment did not alleviate the man's symptoms, he was immediately referred to the local hospital. After the man arrived at hospital, he collapsed and had to be resuscitated. When healthcare staff contacted the hospital at 9:10am on 14 February they were told that the man was sedated, ventilated and had been prescribed medication to stabilise his blood pressure. The man's condition was described as critical and it was noted that he was being kept in the Intensive Care Unit (ICU).

19. The man remained in ICU until 18 February when he moved onto a general ward. Once the man's condition improved, the security risk assessment identified that a closeting (escort) chain should be used. This was entirely appropriate and enabled the nursing staff to have easy access when they carried out their duties. Whilst the man was a patient at the hospital, a bedwatch was carried out by prison officers.

20. The discharge letter of 20 February indicates that the man had recovered well. He was prescribed a nebuliser for 24 hours and then "discharged to inhalers". As there was also an outbreak of diarrhoea and vomiting (D&V) on nearby wards, it was felt to be in the man's interest to return him to prison. A non-smoking cell was recommended. On the following day, the man was moved to the healthcare wing.

21. Entries in the nursing record indicate that the man settled back into prison life. One describes him as "pleasant, mixes well with fellow inmates". He complied with his medication, but continued to cough and complained of breathlessness on 2 and 8 March.

22. During the early hours on 9 March, the man complained to healthcare staff of being breathless. The man had asked to be let out of his cell for some fresh air, but this request was refused as the prison was in night patrol state at the time. The man was given a nebuliser at 2:00am and again at 4:00am and staff carried out regular checks on him throughout the night.

23. When a nurse checked on the man at around 7:30am, he was again short of breath and distressed. After the nurse entered the man's cell, he collapsed onto the floor. An ambulance was called and staff commenced cardio pulmonary resuscitation (CPR). Staff applied a defibrillator which stated that there were no signs of circulation and to continue with CPR.

24. The prison's medical officer and the ambulance crew arrived at the man's cell around 8:15am. The paramedics took an electro cardiogram (ECG) which indicated that the man's heart had stopped beating. There were no further resuscitation attempts and the man was pronounced dead by the prison doctor at 8:16am

25. The Duty Governor and a representative from the prison chaplaincy visited the man's family to inform them of his death and to offer condolences and support.

26. Contact was maintained with the family and the prison assisted with the arrangements for the funeral.

27. The post mortem states that the cause of death was due to natural causes as a consequence of an acute bronchial asthma attack which was caused by chronic obstructive airways disease.

THE CLINICAL REVIEW

28. The principal clinical review records that the man suffered from significant long-term chronic diseases (chronic pulmonary obstructive disease and asthma) which had appeared settled. The review draws attention to a number of issues which are also noted below.

29. The review finds that prison staff were unable to download a record from the defibrillator used in the attempt to resuscitate the man. This meant that an assessment of the resuscitation attempt could not take place.

    The defibrillator used in any resuscitation incident (successful or not) should be immediately quarantined by the healthcare manager and passed to the resuscitation team as quickly as possible, so that the information stored on the defibrillator is downloaded and assessed. This will allow the resuscitation team and subsequently the clinical review team to review the actions taken and make recommendations if improvements are needed.

30. The medical records for the man were in a disorganised state, and did not include the nursing records from the in patients wing. It is essential that all the clinical records for a patient are kept together so that each clinician reviewing the care has all the available information.

    The standard of record keeping must be improved including the information being recorded, to ensure that all entries are recorded in the same folder so that it is accessible to all staff, and that additional forms such as prescriptions are filed in the appropriate records.

31. There is no section in the medical notes for recording the name, signature and designation of each member of staff using them. This is particularly important for a department which uses a significant number of locum and agency staff.

    All decisions regarding the care and location of prisoners must be recorded in the medical records, including who made them and why they were made.

    The medical records should record the printed name, designation and signature of every person who makes an entry, so that they can be identified if further questions are needed.

    All records produced by clinical staff must be recorded in a single file. This includes daily nursing records.

32. The medical records did not include the prescriptions for medication provided to the man prior to his transfer to the local hospital. However, the record of attendance to the man on the wings shows that he had his medication in his possession. It is important that when the prescription charts are finished they are filed with the medical record. The pharmacy records showed that the man received his medication on 7 February 2006 and that it was consistently provided during his time in prison.

    When they have been completed, all prescription charts must be filed in the medical record so that clinicians can review them when they consider the patient's future care and treatment.

    It is essential that all patients who require medication are provided with it as soon as possible after they enter the prison, irrespective of weekends and holidays.

33. There does not appear to be any record of discussions between the hospital and prison healthcare regarding the man's return into prison. The only record is the discharge information provided by the hospital itself.

34. The man was received back from the hospital onto B wing, which is close to the primary care nurses who could therefore monitor his progress. Whilst the clinical reviewer could not find a record of the short period the man spent on the wing, he could see no indication that the man's treatment was not appropriate.

    Clear documentation for the acceptance and receipt of patients from Hospital or other institutions must be made so that there is a record of the circumstances and advice given when the prisoner arrives. This is especially important if limited information is provided in the discharge letter.

35. In response to issues raised by the man's family, the clinical review states that records following the reception screening suggest the man was seen by a GP who probably prescribed him medication. As the man was living in the community when he came into prison, and had been managing his own medication, it is probable that the man would not have been recommended for in patients by the examining doctor although there is no evidence to support that assertion.

    The records of the reception screening process need to show all the interactions and recommendations made.

36. It is believed that the move from ITU was on 18 February 2006, as the prison medical records identify that ward staff were unable to update them on his condition on that day. When they did receive the information the following day, the medical record simply reads as if the man was moved that day.

37. The local hospital had a number of outbreaks of diarrhoea and vomiting (normally caused by a virus and very easily spread) on the wards in February, but not where the man was being treated. The fact that diarrhoea and vomiting was circulating in the hospital appears to have been a consideration, albeit not the only one, in the decision to discharge the man.

38. The clinical reviewer refers to comments made by the consultant who dealt with the man in the local hospital. The consultant reported that during a diarrhoea outbreak the hospital will take action to treat each affected patient individually, with separate facilities as far as the ward environments will allow. Patients with diarrhoea will be kept on the ward until the infection has cleared, treated in a side room where this is possible and staff will be advised of the potential risk of spread and use appropriate infection control procedures to minimise the risk of spread. The consultant noted that the diarrhoea outbreak at the time did not adversely affect the clinical management of the man's condition.

39. The consultant's review of the man when he was discharged from hospital stated, *"Clinical examination showed that he was fully conscious, there were very few rhonchi on his chest with good air entry, his pulse was 77 per minute, which is normal, with normal temperature. He was not on any IV fluids or intravenous antibiotics, he was mobilizing well and deemed safe to be discharged. Overall his clinical picture revealed excellent recovery and we planned his discharge".*

40. The introduction of an electronic patient record could resolve a number of issues relating the recording of patient information and should be implemented as soon as possible.

    The introduction of an electronic patient record should be implemented as soon as possible.

41. The man's collapse appears to have been sudden and unexpected. Given that the man underwent a comparable respiratory arrest in the local hospital less than four weeks previously, it would appear to have been a potential risk wherever he happened to be. From the clinical reviewer's experience of the West Midlands Asthma Mortality Audit, this is not an uncommon cause of sudden death in asthma patients, both at home and in hospital. Certainly, the man had access to more trained care and attention in the prison than he would have had at home and he was already on appropriate maintenance treatment, including oral steroids.

ISSUES RAISED BY THE MAN'S FAMILY

42. From comments made by his family, it seems the man was a well loved father and grandfather.

43. His family was surprised that, given his medical history, the man was not immediately admitted to the prison's healthcare wing after his first health screening. However, as the clinical review concludes, there was no indication in the screen that he should be admitted to hospital. The man was managed in his own home whilst in the community and there was no initial clinical indication that he should not be managed in a normal environment whilst in prison. The prescription of an oxygen cylinder for emergency use at home did not warrant immediate assessment in the prison's healthcare wing. The view expressed by the clinical reviewer is reinforced by the records indicating that the man was not unwell during his first days in custody.

44. HMP Birmingham has acknowledged that they did not notify the man's family of his discharge from hospital and have apologised to the family for the omission. The family was also concerned that their attempts to arrange a visit to the man after he left hospital were hampered by the limitations of the prison phone system for arranging visits. Visits may be booked by telephone, by e-mail or by asking a member of staff to contact the visits centre. Family members may also attend the visitors centre in person to make a booking. However, the prison accepts that having only one telephone line can lead to difficulties and have agreed to review the system. (I welcome the prison's action. From my investigations into both complaints and fatal incidents, I am well aware of the difficulties members of the public face in booking visits or otherwise making contact with a prison.)

45. The man's family was also concerned that, when the man's heath improved in hospital, mechanical restraints were re-applied. The use of physical restraints on those in hospital, especially those prisoners whose condition is life-threatening, understandably causes distress. However, the Prison Service also has a duty to prevent escapes and protect the public. My investigation has confirmed that the re-application of restraints on the man was properly carried out following a security risk assessment, and I have no criticism of the result.

46. In general, the security arrangements at the hospital seem to have been appropriate, and struck a good balance between public protection and sensitivity to the man's circumstances. In reviewing the bedwatch log, my investigator concluded that the staff involved with the man's care behaved with sensitivity.

47. The family also drew attention to some of the positive practices employed by the prison. These included handing back the man's belongings in a timely manner and assisting with the costs for the man's funeral.

CONCLUSIONS

48. The post mortem report concludes that the man died from natural causes.

49. In light of the findings of the clinical review, and my own investigation, I judge that the man's medical care was appropriate and satisfactory. However, clearer, more detailed recording would have provided further evidence in support of such a conclusion.

50. The principal clinical review makes ten recommendations, which I endorse.

RECOMMENDATIONS

Medical

The defibrillator used in any resuscitation incident (successful or not) should be immediately quarantined by the healthcare manager and passed to the Resuscitation team as quickly as possible, so that the information stored on the defibrillator is downloaded and assessed. This will allow the resuscitation team and subsequently the clinical review team to review the actions taken and make recommendations if improvements are needed.

Accepted - This will be done by the Healthcare Manager unless the police seize the defibrillator as evidence before he has an opportunity to download the information.

The standard of record keeping must be improved including the information being recorded, to ensure that all entries are recorded in the same folder so that it is accessible to all staff, and that additional forms such as prescriptions are filed in the appropriate records.

Accepted - Written into Performance targets for Practice Manager.

All decisions regarding the care and location of prisoners must be recorded in the medical records, including who made them and why they were made.

Accepted - Written into Performance targets for Practice Manager.

The medical records should record the printed name, designation and signature of every person who makes an entry, so that they can be identified if further questions are needed.

Accepted - Written into Performance targets for Practice Manager.

All records produced by clinical staff must be recorded in a single file. This includes daily nursing records.

Accepted – In patient nursing notes will be filed in IMRs (Inmate Medical Records).

When they have been completed, all prescription charts must be filed in the medical record so that clinicians can review them when they consider the patient's future care and treatment.

Partially Accepted - Logistically difficult for management of supervised medications. Prescription charts have to be available in 'hatches' and therefore separated from IMRs. EMIS development will solve problem

It is essential that all patients who require medication are provided with it as soon as possible after they enter the prison, irrespective of weekends and holidays.

Accepted - Facility available for prescription medication to be available to prisoners following initial health screen.

Clear documentation for the acceptance and receipt of patients from hospital or other institutions must be made so that there is a record of the circumstances and advice given when the prisoner arrives. This is especially important if limited information is provided in the discharge letter.

Accepted – Lead nurse to review and introduce appropriate documentation.

The records of the reception screening process need to record all the interactions and recommendations made.

Accepted - EMIS development will address this action.

The introduction of an electronic patient record should be implemented as soon as possible.

Accepted - Funding for EMIS system agreed. Project plan finalised. Mental Health Trust signed up to use of EMIS.