Investigation into the circumstances surrounding the death of a prisoner at City Hospital, Birmingham while in the custody of HMP Birmingham in December 2007

Report by the Prisons and Probation Ombudsman for England and Wales

July 2008

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This is the report of an investigation into the death of a prisoner at HMP Birmingham who died at City Hospital, Birmingham in December 2007. The man who died was 70 years old. Sadly, no family or friends were identified, despite efforts by the prison and other agencies to trace them.

One of my investigators conducted the investigation on my behalf. In addition, Birmingham Teaching Primary Care Trust was asked to provide a clinical review into the man's care whilst in custody.

I would like to thank the Governor of Birmingham, and his staff for their co-operation and assistance with the investigation. I am particularly indebted to the Safer Custody Governor at Birmingham, who ensured the relevant documentation was made available to my investigator.

The man had been in custody for less than two months when he died. He had already been admitted once to City Hospital for a short period when, in early December 2007, he collapsed in the shower room. Other prisoners alerted staff who responded quickly. The staff worked hard to resuscitate him and by the time paramedics arrived, they had managed to get him breathing again. He went to City Hospital where his condition was considered to be critical. He remained in the intensive care unit until mid December when he was considered well enough to be moved to the coronary care unit. Medical staff continued to monitor him closely and, in view of his improvement, the hospital made enquiries about him returning to the prison's healthcare wing. However, at the end of December, the man suffered a further cardiac arrest and, despite the best efforts of medical staff, he failed to respond to treatment and was declared dead at 3.42am.

The man was handcuffed during his initial period in hospital. The handcuffs were removed when his condition deteriorated and he became immobile. However, once he improved and was mobile again, restraints (an escort chain) were re-applied and remained in place until his death. Management checks and risk assessments had been conducted regularly. In response to my recommendation in a previous report about strengthening the guidelines regarding prisoners who are gravely ill or dying, the Prison Service has revised its guidance to take account of the needs of such prisoners. I therefore make no further recommendation on this point in this report. However, I have made a recommendation and highlighted good practice in relation to electronic medical records. I would also like publicly to acknowledge the great professionalism shown by those prison and healthcare staff who responded to the man in early December 2007, and the sensitive way in which his funeral was organised.

Stephen Shaw CBE
Prisons and Probation Ombudsman **July 2008**

CONTENTS

SUMMARY

The man was remanded into custody at HMP Birmingham in November 2007. On his reception into custody, he had a routine health screen. Following this, a more in-depth assessment of his medical condition was conducted. During these health screenings, it became apparent that he was not a healthy man. He had a history of chronic illness as well as of heavy drinking.

Staff recorded on reception documents that the man lived a transient lifestyle and had moved around the country frequently in recent years. At the time of his remand, he was of no fixed abode. Following his death, this made tracing a next of kin impossible for the prison and other agencies despite various attempts to do so.

He was admitted to outside hospital in November after experiencing chest pains. He remained in hospital for four days during which time tests were carried out. The cardiology department gave him advice about his heart condition and possible medical interventions before he was discharged.

On a morning in early December, the man attended G wing for association and took a shower there. He had just finished and was drying himself when he collapsed. Other prisoners who were in the area at the time immediately notified staff who were quick to respond. It was clear that he was not breathing and officers began cardio pulmonary resuscitation (CPR). Nursing staff and other staff were quickly in attendance and medical intervention continued. The man's heart stopped ten times before the arrival of paramedics. Through the efforts of staff, paramedics were able to stabilise him before taking him to City Hospital, Birmingham.

He remained in intensive care where his prognosis was considered to be poor. However, after around three weeks, his condition began to improve. The improvements continued to the point where in late December the hospital was in discussion with the prison about him returning to the prison's healthcare wing. Unfortunately, the man suffered a heart attack the following day which was so severe that medical staff decided that it was not in his interests to continue resuscitation.

As noted, the prison was unable to identify any family or friends. The Governor therefore assumed responsibility for the funeral arrangements and he was given a respectful and decent funeral.

INVESTIGATION PROCESS

1. My investigator conducted the investigation on my behalf. In February 2008, he contacted Birmingham's appointed liaison officer, the Safer Custody Manager. The Governor and the Safer Custody Manager provided the man's prison records for examination, including his medical record. Notices were issued to staff and prisoners to inform them of the investigation process and to give them the opportunity to speak with my investigator. No responses were received.

2. I asked Birmingham Teaching Primary Care Trust to conduct a clinical review into the medical care the man received while in custody, in accordance with my Terms of Reference.

3. The prison made enquiries in order to trace a next of kin but no one was identified. There were also attempts by other external agencies to trace family, again with no success.

4. The investigator wrote to HM Coroner to inform him of the nature and scope of the investigation.

HMP BIRMINGHAM

5. HMP Birmingham is a local prison for adult male offenders, holding up to 1,450 prisoners. It has recently undergone a programme of refurbishment that has provided new workshops, educational facilities, a new healthcare centre and gymnasium. Improvements to existing facilities have also been made.

6. Heart of Birmingham Primary Care Trust (PCT) is responsible for the delivery of healthcare. General Practitioners (GPs) deliver primary care clinics. The inpatient facility is staffed by registered nurses, mental health nurses and discipline officers during the day, and a nurse and discipline officer at night.

7. Since I took over responsibility for investigations into all deaths in prison custody in April 2004, there have been seven previous deaths at Birmingham from natural causes.

8. An announced inspection by HM Chief Inspector of Prisons, Ms Anne Owers, was carried out in February 2007. The inspection concluded that:

> "Birmingham was suffering from many of the pressures of an overcrowded prison system. Those pressures made it much more difficult to deliver safe, decent and purposeful outcomes for prisoners. It was a credit to staff and managers that the prison remained a much better place than it had been in 2000, and the scale of the task should not be underestimated. But this inspection found that the prison was not responding sufficiently proactively and robustly to the challenges it now faced, and indeed that some of the old culture was now reasserting itself. We do not underestimate the difficulty of sustaining progress, with increased pressures and increased expectations of delivery. The fact that Birmingham was not performing sufficiently well against three of our four key tests is a measure of the challenge facing its managers."

9. The Independent Monitoring Board (IMB) at Birmingham published their 2007 annual report in which they said of A wing and G wing where the man who died was housed for part of the time:

> "A wing houses 147 prisoners, consisting mainly of those on remand or awaiting trial. Because of its proximity to G wing (Vulnerable Prisoners), A2 is used as an overspill area for Rule 45 prisoners. This is unsatisfactory, as the prisoners suffer from being part of the regime on neither wing. They are regarded as 'separate' on A wing and have to be kept apart from normal A wing residents because of verbal taunting and threats from other prisoners.
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> "On G wing, where most of their regime should take place, they are again, because they have no base there, regarded as 'separate'. Efforts are continually being made to resolve the situation."

KEY FINDINGS

Events leading up to the man's death

10. The man was remanded into custody to HMP Birmingham on a charge of burglary in November 2007. A nurse saw him on his reception to complete a health screen. During the screen, it was established that he had a history of chronic illness and was taking a combination of medicines to manage this. When asked about his alcohol consumption, he indicated that he had been a heavy drinker prior to coming into custody and a referral was made for him to be seen by the doctor. The prison GP saw him later that day and prescribed medication to help with his alcohol detoxification. The GP also diagnosed him as having Type 2 diabetes mellitus, chronic obstructive pulmonary disease (COPD), essential hypertension and alcohol dependence syndrome. The following day, he was seen in the Well Man Clinic and a more in-depth assessment of his medical history and condition was completed. The man told nursing staff that he had a history of heart disease and in October had undergone an angiogram (this is a technique where x rays are used to examine blood vessels in any part of the body and is very useful for diagnosing heart problems).

11. The man was located on D wing. Due to the state of his health, medical staff decided that he should be 'located flat' (this is a term used in prisons to describe someone who requires a cell on the ground floor), and the induction process was started. During his induction, he told staff that he had been released from custody in Liverpool within the previous six months and that he had been in custody at least ten times before. There were no other significant points raised during the induction and he was moved to K wing. The day after he arrived onto K wing, the man asked to be placed on Rule 45. (This is a Rule whereby prisoners who feel vulnerable either because of the nature of their offence or other reasons can be separated from the rest of the prison population.) However, following a discussion with staff, he opted to remain on ordinary location.

12. In mid-November, the man told staff that he had fallen off a chair in his cell during the night and had hurt his back. An officer therefore took him to be seen by a nurse. He told the nurse that he had fallen against the toilet. On examination, he had redness to his upper back and pain. The nurse gave him paracetomol and told him to come back if the pain persisted. After two days he was still experiencing backache and was prescribed more paracetomol as he said it had worked previously. An appointment was also made for him to be reviewed by a nurse after the weekend.

13. The following day, a nurse went to see him on the wing as he was complaining of chest pains. The nurse checked his blood pressure and provided him with a saline nebuliser (a machine that creates a mist of medicine, that is then breathed in through a mask or mouthpiece). A referral was also made for him to be seen by the doctor that afternoon. Around lunchtime, after complaining of continuing chest pain, the man again saw a nurse who took his blood pressure.

14. The prison GP saw him in the afternoon and recorded that he had been having chest pain for two hours prior to her examination. The doctor decided to transfer him to the healthcare centre for 24-hour observations. However, due to continuing pain and given his previous medical history, the man was taken to the local hospital. Following an examination, he was admitted and placed in the care of a consultant. Tests were carried out and a course of warfarin (an anticoagulant medication) was started. The Cardiology Department advised the man that he should consider having a coronary artery bypass graft (CABG) and he said he wanted to think about it.

15. He returned to the prison after a few days. On his return, he again requested to be placed on Rule 45. He believed that he was at risk from prisoners to whom he owed money outside of prison. A governor interviewed him and, after listening to his reasons for the request, the decision was taken for the man to be placed on Rule 45. Normally prisoners requesting Rule 45 are located on G wing but, when no spaces are available, A wing is used as an overflow. While segregated on Rule 45, the man was located on A wing and attended G wing for exercise and association.

16. At the start of December, the man went to G wing for association. While he was there, he took a shower. Other prisoners using the shower at the time recalled seeing him. They said that he had just finished his shower and was in the process of drying himself when he collapsed onto the floor. The other prisoners then immediately alerted staff who were out on the landing.

17. Staff responded immediately and found him lying on the floor of the shower recess. There was a cut to the back of his head that appeared to have been sustained in the initial fall, and he was bleeding heavily. On examination, it became apparent that he was not breathing. The staff proceeded to administer cardio pulmonary resuscitation (CPR), with officers giving mouth to mouth and other officers performing chest compressions. Officers made a request for nursing staff to attend and also for additional staff support to look after the other prisoners who were out on association. The staff attending to the man managed to get him breathing again and placed him in the recovery position.

18. Once informed, the nursing staff were quickly in attendance. Nurse 1 collected emergency equipment from the office on G wing and requested an ambulance. Nurse 2, who had attended with Nurse 1, checked the man and found that he had stopped breathing again and that no pulse could be detected.

19. Other staff had arrived to assist the nurses and CPR resumed with Nurse 2 being assisted by four officers. Nurse 1 had collected a defibrillator and this was connected to the man. The defibrillator assessed him automatically and delivered five shocks at regular intervals. By the time the ambulance staff arrived, nurses and officers giving first aid had resuscitated the man ten times although he remained unconscious. The determination and success of staff in administering first aid made it possible for ambulance staff to stabilise him before taking him to City Hospital.

20. On arrival at hospital, the man was taken immediately into the resuscitation room. Medical staff found that he had arrested again on arrival at the hospital and proceeded to attempt resuscitation. The man had to be resuscitated a further five times before he was eventually stabilised. The doctor attending to him decided, along with the other medical staff, that resuscitation would not be attempted if he arrested again as it was considered not to be in his best interests.

21. Hospital records show that on his admission he was suffering from ischaemic heart disease and chronic obstructive pulmonary disease (COPD). Once his condition had stabilised, the man was moved to the intensive care unit (ICU).

22. During the afternoon, the man was taken for x-rays. He was also seen by a heart specialist, who told the escort staff that he would require surgery at some point. However, this depended on his condition improving. Due to the man's condition, the staffing on the bed watch was reduced to one officer and restraints (handcuffs) were not applied.

23. The prison contacted the ICU the following day to obtain an update on the man's condition. The GP from the prison, who made the call, was informed that he had suffered a severe myocardial infarction (heart attack). As a result he was being ventilated and given medication to support his heart. The prognosis given by the hospital was poor. Despite this, plans were in place for him to be operated on if his condition stabilised.

24. Over the next couple of days, there was no significant change in the man's condition which was described as 'stable'. He remained unconscious and heavily sedated. Nursing staff continued to monitor him closely. They informed prison staff that the plan was to take him off the ventilator to see if he could breath unaided which would increase his chances of survival.

25. At around 6.30am on the fourth day, the man woke up for a few minutes. This was the first time that he had been conscious since being admitted, and he was able to respond to questions by nodding his head. Nurses attending to him made plans to remove the breathing tubes later that day as he was now able to breathe unaided.

26. Throughout the morning, he drifted in and out of consciousness. A consultant informed the escorting officer that he considered the man's condition to be improving. The consultant and a physiotherapist examined him. The breathing tube was removed and as the day progressed he became more alert and talkative. Another consultant informed him that he had suffered a heart attack and that he might need surgery in a few days to clear blocked arteries.

27. During that afternoon, he was able to get out of bed and sit in a chair. This surprised hospital staff. The escorting officer kept the prison updated on the man's condition and improvement. A management check by the prison was carried out later that day. The manager who conducted it concluded that as he remained immobile there was no increase in risk. As a result, the escort remained at one officer to be kept under daily review.

28. With the continued improvement in the man's condition, a review of the risk assessment the following day increased the bed watch to two officers. However, he remained free of restraints to enable medical attention to be unhindered. The man had developed a chest infection and this was causing him some breathing difficulties. For this reason, escort staff were informed that he would remain in the ICU for the time being.

29. He remained there for a further week before being moved to the coronary care ward. The escort staff notified the prison and arrangements were made for the risk assessment to be reviewed in relation to restraints. The day after arriving on the ward, in line with the outcome of the new risk assessment, an escort chain was applied to him. He had no concerns about this and remained talkative with both hospital and prison staff.

30. Over the next week, with the help of the physiotherapist, the man's mobility continued to improve but he still was experiencing breathing difficulties. After three days, arrangements were made for him to be given a full body scan to determine whether a pacemaker (a medical device to regulate the beating of the heart) needed to be fitted. However, as he was experiencing a lot of pain, this and a follow up treatment planned for the following day had to be cancelled.

31. Over the following week, the man continued to receive treatment for the pain and wheezing in his chest and made good progress. He was also seen by the physiotherapist to continue work on his mobility. In late December, a Senior Nurse recorded that the man would be returning to the prison's healthcare wing on the following Monday.

32. However, the next day, the man suffered a further cardiac arrest. Medical staff attempted to resuscitate him without success. In view of his previous cardiac arrest and other medical history, the team decided that it was not in his best interests to continue resuscitation. The Senior Registrar, declared the man dead at 3.42am. He had remained in restraints (the escort chain) up to the point of his death.

ISSUES

Healthcare

33. It was discovered on the man's reception into Birmingham that he was not in very good health and the necessary follow up appointments were scheduled. In November, when the man informed staff that he had fallen in his cell, he was again seen by medical staff. The follow up care that he received and the earlier information that had been recorded meant that he was referred quickly to outside hospital when his symptoms persisted. I consider that this demonstrates the benefits of both sharing information and recording it correctly. The clinical reviewer has also recognised this and says:

    Healthcare interventions delivered at HMP Birmingham were well documented on the electronic medical records system (EMIS).

    The clinical review highlights this as an area of good practice which I endorse.

34. Contact between the prison and the hospital following the man's admission in December was not regular or at least not recorded as such. The clinical review says that his medical record does not demonstrate that contact with the hospital occurred consistently between him being admitted and the man's death. The clinical reviewer makes the following recommendation, which I endorse:

    All EMIS entries need to have the time logged consistently to facilitate the establishment of a timeline between episodes of healthcare interventions. More robust systems need to be established to ensure that regular updates are ascertained from external agents delivering healthcare to prisoners of HMP Birmingham.

Staff intervention

35. Following the man's collapse, both discipline and healthcare staff acted quickly and professionally to assist him. They worked tirelessly to keep his heart going until the arrival of the ambulance staff. These actions enabled the paramedics to stabilise him before transferring him to hospital. Although the onus was on response staff to maintain resuscitation until paramedics arrived, for the staff involved in this case it must have been particularly traumatic and exhausting. The man was bleeding quite heavily and his heart stopped ten times. I am aware that the staff involved have already been commended for their actions. I share that view of their actions and would ask the Governor to share my observations with his staff.

Actions after the man's death

36. The man had no identifiable next of kin. Therefore, the prison made arrangements for his funeral which was attended by members of the senior management team and chaplaincy. There is no national guidance on prisoners like this man where there are no family contacts. In spite of this, staff at

Birmingham, most notably the Safer Custody Governor, ensured he had a respectful and decent funeral. Although a rare occurrence, it might benefit prisons were Headquarters to consider issuing guidance for local contingency plans where a prisoner has no identifiable next of kin. Acting without the benefit of such guidance, I commend the way in which this was handled by HMP Birmingham.

Use of restraints

37. The balance between public protection and the compassionate management of seriously ill or dying prisoners is a difficult one to strike and one that I frequently address in my reports. In four recent reports on deaths of prisoners from Birmingham, Gartree, Maidstone and Norwich, I have been critical of the lack of flexibility in local policies on bed watches. There are, of course, many factors to consider when arranging a bed watch. I also appreciate they require discretionary judgements. In this case, the management checks and risk assessment reviews were carried out frequently and in accordance with the National Security Framework (NSF) guidelines. I also acknowledge that there were times when his condition appeared to be improving significantly.

38. In addressing these matters in earlier reports, I have suggested that consideration be given to incorporating into the NSF explicit instructions on how to deal with gravely ill or dying prisoners in outside clinical environments. The Prison Service accepted this recommendation. In addition, a review of the use of restraints on hospital escorts and bed watches has been undertaken following the case of 'G' in the High Court in November 2007. The policies within the NSF have been amended to take account of prisoners who are seriously or terminally ill, and the sensitive nature of balancing their changing physical condition against the need to provide the public with adequate protection. The revised guidance was to be issued to all Governors during February 2008. In view of this, I make no further recommendation on this point.

RECOMMENDATION

All EMIS entries need to have the time logged consistently to facilitate the establishment of a timeline between episodes of healthcare interventions. More robust systems need to be established to ensure that regular updates are ascertained from external agents delivering healthcare to prisoners of HMP Birmingham.

GOOD PRACTICE

Healthcare interventions delivered at HMP Birmingham were well documented on the electronic medical records system (EMIS)