Investigation into the circumstances surrounding the death of a man at HMP Birmingham in July 2010

Report by the Prisons and Probation Ombudsman for England and Wales

November 2011

This is the report of an investigation into the death from natural causes of man, at hospital, while in the custody of HMP Birmingham in July 2010. He was transferred to hospital as an emergency at 11.00am after complaining of abdominal pain for four days. His condition deteriorated and he died at 3.43pm. He was 42 years of age. His cause of death was ischemic heart disease, coronary artery disease, cirrhosis of the liver and a small obstruction of the bowel.

I extend my condolences and those of my colleagues to the man's family. I regret that my report is delayed and apologise for any additional distress that this may have caused.

The investigation into his death was undertaken by one of my investigators. In addition, a review of his healthcare while in Birmingham was conducted by a clinical reviewer on behalf of the local Primary Care Trust (PCT).

I make six recommendations with regard to the care provided to him whilst he was in the custody of Birmingham prison. My first five recommendations are for the attention of the Head of Healthcare. A review of the systems for booking urgent primary care appointments and the handover of care amongst the prison staff should be undertaken. There should also be a review of the triage skills of the Registered Mental Nurses compared to the Registered General Nurses and the primary care nursing team to ensure that there are suitably qualified and experienced nurses on duty who are able to appropriately respond to the physical and mental health needs of prisoners at all times. An audit of essential emergency equipment so that basic life saving procedures can be performed should also be completed. Furthermore I make a recommendation relating to healthcare staff reading the medical history of a prisoner held in the electronic medical records.

My final recommendation is for the attention of the Governor and Head of Healthcare to ensure that staff immediately responds to a request from a qualified healthcare professional for an emergency ambulance.

I also note one point for the head of healthcare and the Governor seeks to ensure the use of restraints for security purposes is appropriately balanced against a prisoner's medical condition and dignity when transferred to hospital as an emergency.

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.

Thea Walton
Acting Deputy Ombudsman **November 2011**

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SUMMARY

1. This was the man's sixth time in custody and his third time at Birmingham. During his first reception health screen he told staff of his drug dependency and past medical history, including surgery for a strangulated hernia. He had a good insight into his medical conditions and knowledge of the medications he was taking, such as insulin and Methadone, which he was prescribed by a community drug support programme.

2. On his arrival at Birmingham on 8 July 2010, he told healthcare staff of his medical history and drug use, reporting that he did not have any concerns for his health at that time. His Methadone support programme was continued to assist with his withdrawal symptoms.

3. Three days later, he complained of abdominal pain to a nurse. He was assessed and given pain relief of paracetamol. Later, he began to vomit and told healthcare staff that he had blackened loose stools. He was seen by various healthcare staff on numerous occasions during the following two days. He became extremely anxious as the pain did not subside and he likened the pain to the previous hernias he had undergone surgery for. He asked staff on several occasions to be admitted to hospital.

4. Healthcare staff continued to give him pain relief, and anti sickness medication believing his abdominal pain was related to opiate withdrawal.

5. A nurse was called to his cell around 10.00am on 13 July. The nurse found him to be seriously ill and in need of urgent medical attention. Despite calling for an emergency ambulance, prison staff told the nurse that a doctor should see him before the ambulance could be called for. Five minutes later, a doctor arrived at his cell and immediately asked for an emergency ambulance.

6. The doctor was unable to administer intravenous medication due to the lack of equipment. He was transferred to hospital at 11.00am escorted by two officers. He was restrained despite an increasing deterioration in his condition. On arrival at the hospital's accident and emergency department, the staff asked for the removal of the restraints. At 1.30pm, the doctors decided that he was too ill to undergo surgery and he died with his family at his bedside at 3.43pm.

7. It is evident from the post mortem report that he had serious heart disease and cirrhosis of the liver. However, the investigation has taken into consideration the events leading up him being transferred to hospital. I am concerned that he was not seen by a doctor when he persistently complained of pain and symptoms related to an abdominal illness.

8. I make five recommendations for the attention of the Head of Healthcare, and one for the Governor and Head of Healthcare. I note one point for consideration for the Head of Healthcare and the Governor.

THE INVESTIGATION PROCESS

9. The investigation into the man's death was carried out by one of my investigators. Notices were issued to staff and prisoners at the prison informing them of the investigation and inviting them to contact the investigator should they wish to talk to him. No-one came forward in regard to the notices.

10. He visited Birmingham on 1 September 2010, meeting with the then Governor, as well as other prison managers. My investigator also met with the Independent Monitoring Board (IMB) and members of the Prison Officers Association (POA) and explained the nature and scope of the investigation. During this and a subsequent visit by an Assistant Ombudsman, on 16 December 2010 and 3 February 2011, interviews were conducted with a number of the prison and healthcare staff.

11. The investigator reviewed prison and health records and other documentation relating to the man's time in custody. During the course of the investigation, he provided regular feedback to the former Governor of Birmingham, identifying issues that became apparent during the investigation.

12. An independent clinical review was commissioned by the local PCT. A clinical reviewer carried out that review on behalf of the PCT. I have relied on his findings when arriving at my own conclusions. I am most grateful to the doctor. I would also like to take this opportunity to thank all of the staff at Birmingham for their cooperation with my investigation.

13. My investigator liaised with HM Coroner for Birmingham and Solihull. A copy of this report will be sent to him, to assist his enquiries into the man's death. A copy of this report will also be sent to the National Offender Management Service.

14. One of my family liaison officers contacted the man's sister shortly after his death. He explained the investigation process and gave her the opportunity to raise any concerns or questions she wished to be addressed as part the investigation. She said that she had no concerns that she wished to be addressed as part of the investigation. However, I hope that this report helps her to better understand what happened to her brother and the healthcare he received whilst in the custody of HMP Birmingham.

HMP BIRMINGHAM

15. HMP Birmingham is a local prison serving the Crown Courts of Birmingham, Stafford and Wolverhampton in addition to local Magistrates Courts. The prison consists of 11 accommodation units which include the original Victorian wings and additional accommodation, built in 2002, providing space for a further 450 prisoners. The prison can hold a maximum number of 1,450 prisoners.

16. Healthcare at Birmingham is provided by the local Primary Care Trust (PCT). The PCT provides primary healthcare and contracts the Birmingham and Solihull Mental Health Trust to provide mental health care services within the prison and the in-patient facility.

HM Inspectorate of Prisons Report 2009

17. HM Chief Inspector of Prisons (HMCIP) conducted an unannounced follow up inspection in December 2009. It followed an inspection in 2007 that had made many recommendations. The then Chief Inspector of Prisons stated that:

> "While some progress had been made, there was still a considerable amount to do to ensure a safe, decent and effective prison. Only two of our 10 main recommendations at the previous inspection had been fully achieved, and we needed to make nine new main recommendations in areas that had not previously been matters for serious concern."

Healthcare

18. HMCIP reported that healthcare services were managed by a senior nurse as the director of offender health, supported by an operational manager who also attended meetings of the prison senior management team. Primary care services had 13 nurses in post and 15 vacancies, the Integrated Drug Treatment System (IDTS) had 25 nurses and healthcare assistants in post, in-patient services had 10 nurses in post and seven vacancies and mental health services had seven nurses in post and two vacancies. The skill mix of nursing staff on the IDTS team would have benefited from the addition of some general nurses. The report recommends that:

> "More general nurses should be allocated to the integrated drug treatment system team."

19. Prisoners requiring healthcare services used a separate healthcare application and were triaged by nursing staff who had received minimal triage training. (Triage is the process of determining the severity of a patient's illness.) Prisoners who needed to be seen routinely by a GP could wait up to a week, but were usually seen within three days. There were plans to further develop wing-based nursing. There was one GP

employed by the trust for three days a week. The remaining clinics were covered by six locum GPs, all of whom had worked at the prison for a long time and were familiar with the procedures. Out-of-hours cover was provided by the same service as that for the local community.

Integrated Drug Treatment System IDTS

20. HM Chief Inspector of Prisons reported that the drug strategy was under review, but there was no comprehensive needs analysis and no alcohol policy. The CARAT service was well resourced and multidisciplinary, but the team had to meet an extremely high target of drug intervention records. (CARATs is an organisation specialising in the treatment of substance abuse have drugs and alcohol workers based in most prisons. CARATs workers can run programmes, offer counselling, support and referral to rehabilitation centres to prisoners and on release. Access to CARATs is voluntary, by application.) Prisoners could attend individual sessions and IDTS group work modules and there were strong links with local drug intervention program teams. The short duration drug programme was well managed.

21. A recommendation made in 2007 had been partially achieved. HM Chief Inspector of Prisons recommends that:

> "Prescribing regimes for substance-dependent prisoners should be flexible, based on individual need and adhere to national clinical guidelines. The integrated drug treatment system (IDTS) had been implemented in 2007, but an interim service had been provided until very recently. The clinical substance misuse service consisted of two specialist GPs, a service manager, a lead nurse, nine qualified nurses and three healthcare assistants. T he team still carried seven nurse vacancies. Substance-dependent prisoners initially received only first night symptom relief. They were assessed by a substance misuse nurse and a specialist GP the following morning, at which point treatment began."

Independent Monitoring Board

22. Each prison in England and Wales has an Independent Monitoring Board responsible for monitoring day-to-day life in the prison and ensuring that proper standards of care and decency are maintained. In their annual report for July 2009 to June 2010 the Independent Monitoring Board (IMB) stated that:

> "All Health Care staff will receive dual training, enabling them to work as part of an integrated service in all areas of the prison. In the longer term there will be benefits from the prison nursing module which is to be introduced in collaboration with the University of Birmingham and the NHS."

KEY EVENTS

23. The man was born in March 1968, in Walsall. He was single and had one daughter. He is survived by his mother, brother and sister. Between February 1992 and his death in July 2010, he had been sentenced to prison on six separate occasions. Three of these occasions, including the last, were at HMP Birmingham. His convictions were for offences including petty theft, driving offences and failing to comply with community sentences.

24. On 24 September 2008, he served a term of imprisonment at Birmingham. He arrived with no medication and told the nurse who assessed him that he was diabetic and was dependant on insulin. He also said that he misused drugs daily and asked to see the doctor. The nurse wrote in his medical record that he was fit for normal location and referred him to the drug treatment service (IDTS).

25. Prison Doctor A assessed him later that evening. She noted that his anti-diabetic medication dose was too high and checked his blood glucose level, which was 5.5mmols. The normal range for blood glucose levels is 4-7mmols. He told her that he had not had insulin or taken his anti-diabetic medication for two days, but was eating normally. He gave her his community doctor's details to enable her to clarify his medical conditions before she prescribed any medications.

26. Following contact with his community doctor, it was confirmed that he was diagnosed in 2000 with Type Two diabetes and that he had been methadone dependant since 2003. He also had a history of intestinal obstruction, strangulated hernias (hernias that have had the blood supply cut off and quick surgery is imperative.) He had emergency surgery for the removal of his appendix and a perianal abscess.

27. Primary Care Nurse (PCN) A noted a general medical history in his medical record including his diabetes and blood sugar readings. The nurse recorded that he had no history of mental health problems, and had an operation in 1993 as a result of a stab wound to his bowel.

28. He started methadone stabilisation treatment on 27 September. No other issues or concerns were noted. A doctor entered the results of a full blood test in his medical record on 3 October but wrote that the test needed to be repeated. His thyroid function, cholesterol level and kidney function were all normal; however he needed to have his liver function tested. On 6 October, a hepatitis antibody test showed that he was suffering from Hepatitis C. (Hepatitis C is a blood-borne virus that infects the cells of the liver.) The doctor referred him to the liver unit at hospital.

29. He saw a doctor on 21 October and told him that he had been suffering from abdominal pain for the past hour and that he felt nauseous. He told the doctor that he had undergone an operation to treat a strangulated hernia a year earlier. He said that his bowel habits had not changed

recently, although the doctor thought that he looked colicky (cramping abdominal pain), achy and was uncomfortable which seemed to progress during the consultation. When the doctor examined him he noticed that he had large scars on his stomach from the operation and there were hernias on either side of the scar. The doctor was able to reduce the hernias with ease and subsequently the pain disappeared. He advised him to drink plenty of fluids. On 24 October, he was released from Birmingham.

30. He started his second period of custody at Birmingham on 25 March 2009, this time serving a two month sentence. A nurse conducted his first reception health screen. (A first reception screening takes a list of medications and general medical observations.) He told the nurse he had a history of drug abuse, was diabetic and was concerned as he had recently suffered from two abdominal hernias. The nurse noted that he appeared settled in mood and had no outstanding appointments. He referred him to see the doctor and to the IDTS. A doctor assessed him later that evening and noted he was prescribed medication for diabetes, and had a history of drug use. Furthermore, it was noted that he had mild drug withdrawal symptoms of nausea, stomach cramps, muscular tension and aches and pains.

31. He was examined by a doctor the following day. He told the doctor that he had last used drugs a week ago and was prescribed methadone treatment through a programme in the community. He also told the doctor of his history of hernias and that although he had been referred to a gastroenterologist, a medical professional who specialises in the treatment of patient conditions affecting the liver, intestine and pancreas, the last time he was at Birmingham, he was still to see a specialist. The doctor noted in his medical record that he looked healthy, was not sweating or jaundiced. The doctor said that he would confirm his methadone treatment with the community programme so it could be continued at Birmingham.

32. Later, he told a nurse during a routine appointment about his previous operation to repair a hernia, and that he was diabetic. He continued to be prescribed methadone. Prior to his release on 6 May 2009, he was offered a discharge summary of his medical record, doctor's letter and discharge pack however he declined to accept them.

33. He entered Birmingham for the third time on 8 July 2010, having been sentenced to 112 days imprisonment at Magistrates Court for theft and for failing to allow a specimen of blood to be taken for analysis.

34. He told Registered General Nurse (RGN) A during his first reception health screen, that he had seen a doctor in the last few months for a diabetic check. He listed the medications he was prescribed and spoke of his daily drug usage. He said that he had no concerns about his current health. She referred him to see the first night doctor for his prescriptions and made an appointment for 23 July for a chronic disease check. She

also referred him to the first night detoxification unit.

35. At approximately 8.30pm, he was taken to D wing, the prison's first night centre. He had a first night interview with staff and was issued with a smokers pack, a telephone card and was given a free two minute telephone call. He completed the day one interview with Officer A. He provided various personal information including that he was a drug addict, was suffering from withdrawal symptoms and thought that he would benefit from a detoxification programme. He also told staff that he had never harmed himself or had any thoughts of doing so.

36. Integrated Drug Treatment Services (IDTS) Registered Mental Nurse (RMN) A, conducted his second health screen the next day. (This screening is carried out to take the prisoner's medical observations and a full medical history.) She listed his previous drug treatments in prison through the community treatment programme. The nurse noted that he was diabetic and the medications he was usually prescribed. He was taking methadone and needed his drug withdrawal monitoring; therefore she referred him to the drugs treatment services. The nurse told the investigator during an interview, that she would not have had the opportunity to look back at his previous medical history during his health screen and so would not have known about his previous hernias or stomach problems.

37. At around 9.00am, he was given his induction and second day interview. During the induction process, he said that he would not be appealing against his sentence. During his second day interview, he told staff that he was not concerned about being in custody and that there were no new concerns from his first night in prison.

38. He attended an appointment with Prison Doctor B later that morning. He said that he daily smoked two bags of heroin and had last taken it two days ago. He stated that he also used cocaine, but denied any other drug use. He said he was receiving methadone treatment in the community and was currently prescribed 60mgs daily, although he had not had it for the last two days. The doctor discussed his current medication, which he claimed he had not taken for some weeks due to taking heroin. The doctor noted that he looked flushed, although his speech was calm and coherent, and his pupils appeared normal.

39. He provided a urine sample which was positive for morphine, cocaine and benzodiazepine, a commonly used drug that has a sedative effect. The doctor did not test for methadone to see if it was in his system, although he made a note that he would confirm his community treatment and then continue with the methadone maintenance programme. The doctor made a note in the medical record that he had an abdominal scar with an incisional hernia (a hernia that develops in scar tissue from surgery). On examination, he recorded that he found it was reducible and not tender.

40. A Counselling, Assessment, Referral, Advice, Throughcare worker later saw him. (CARATs is an organisations specialising in the treatment of substance abuse have drugs and alcohol workers based in most prisons. CARATs workers can run programmes, offer counselling, support and referral to rehabilitation centres to prisoners and on release. Access to CARATs is voluntary, by application.) During this initial assessment a record was made of his extensive drug habit, and he was provided with information regarding the risks with sharing and mixing drugs. A support care plan was written to support his programme in the community and to make an appointment with a drug worker on release. His goal was to continue with the methadone maintenance programme.

41. RGN B went to his cell on 11 July around 5.39pm as he had complained of abdominal pain which he said had started about one hour earlier. The nurse took a blood pressure reading, which was 136/92. (The average blood pressure range is 130/80 but this can vary depending on the individual.) He stated that the pain was no longer as painful as when it started as he had taken paracetamol at the treatment hatch prior to her arrival. He mentioned that he had undergone surgery previously for a strangulated hernia and the pain felt the same as it had then. She said that she would review him again if the pain became worse. The nurse agreed to give him insulin to keep in his possession and a blood glucose monitor machine.

42. At 7.50pm, she returned to his cell to give him his insulin. He was still complaining of abdominal pain and said that he had vomited twice. The nurse noted in his medical record that she was not sure of the cause of his complaint and that she had given him some more paracetamol. The nurse asked a detoxification nurse to review him to get another opinion on his condition. She took his blood pressure again which was slightly lower this time.

43. At 10.52pm, RMN B was on night duty and was called to his cell. He continued to complain of pain in his abdomen and said that he had vomited several times throughout the evening. His blood pressure was still within the normal range and his temperature was normal. He said that he was experiencing a sharp pain, which he had experienced before and told her he had previous suffered a strangulated hernia which had required surgery to correct it.

44. She told the Assistant Ombudsman during an interview that at this time she did not physically examine his abdomen. He told her that he had a poor appetite and had opened his bowels two days previously which had been watery. He had no problems passing urine and had taken his prescribed methadone that morning. She also recorded in his medical record that he had misused heroin and cocaine on a regular basis and that he last used drugs around four days previously.

45. The nurse contacted the Badger out of hours service, an on-call doctors' service for further advice and told the doctor of his symptoms and medical

history. She told the Assistant Ombudsman that she would have had his medical history on the computer while calling the out of hour's service, although she did not have a chance to read everything within it.

46. The doctor advised the nurse to observe him and to contact them again if he got worse. She said during interview that it would be the responsibility of the wing officer to observe him, as nurses did not have keys to be able to access the wings as and when they wanted to.

47. At 11.16pm, Officer B wrote in his case summary,

> "Seen by nurse on three separate occasions this evening. Complaining of stomach pains and vomiting. Nurse did obs and contacted doctor for advice. As obs are normal at present nurse informed me she had been told by the doctor it would not be necessary to send him to outside hospital. I informed him of this decision."

48. RMN B was called to his cell again at 1.29am on 12 July, as he was still complaining of pain in his stomach. The nurse took his blood pressure again, which was still normal and offered him some more paracetamol, but he said that it would not help. The nurse advised him that she could not administer anything stronger and he eventually accepted the paracetemol. She spoke to the detoxification nurse and told her of his situation. The detoxification nurse offered to attend with her if she was called out again.

49. The detoxification nurse, RMN A, accompanied RMN B to assess him at approximately 2.36am. He told RMN A that he had severe stomach discomfort radiating around his back and that he had vomited. He also said he had passed loose blackened stools, though the nurses did not see them as he had flushed the toilet. It was also noted that there was no smell of vomit in the air. He repeated that he had had previous abdominal surgery and believed himself to be in need of emergency medical treatment. He requested to be transferred to hospital as a priority. RMN B wrote in his medical record that he was quite animated in describing his pain and showed no obvious signs of discomfort in his voice.

50. He was assessed by RMN A according to the Opiate withdrawal scale. (This is a form used to record a patient's symptoms of withdrawal from drugs to assess their level of dependency.) He presented with observable restlessness, was irritable and anxious. He had moderately dilated pupils, was nauseous and had loose stools. However, he was not sweating nor had a runny nose, tearing or gooseflesh. There were no visible signs of yawning and tremors, neither did he complain of muscle or joint aches. RMN A told the investigator:

> "I suggested to him that it could be because he'd just started back on methadone. He'd been experiencing withdrawal symptoms when he came into prison … stomach cramps are signs of opiate withdrawal."

51. He denied having swallowed any packages containing illicit substances prior to coming into Birmingham. RMN A made an entry in his medical record that she tried to offer him reassurance that he would be transferred to hospital if his physical condition severely deteriorated, but due to his degree of irritability and anxiety, reassurance was difficult.

52. She said during interview that registered mental nurses sometimes feel that they are asked to do general nursing duties which they have not received training for. The nurse told him that she would request a priority medical review with the detoxification doctor at the morning clinic. The nurse asked the night duty officer to tell N wing morning staff to bring him to D wing detox clinic at 9.00am so he could be reviewed. She told my investigator that once she was able to access his electronic medical record, she reviewed his medical history and saw that he had previously suffered from strangulated hernias. The nurse thought he would be prepared to see the detoxification doctor in the morning as he had seen him before.

53. She gave him a single dose of Prochlorperazine 5mg (anti-sickness drug) and Hyoscine Butylbromise 10mg (abdominal pain relief). The nurse noted that she had entered him onto the IDTS clinic list for that morning. She told the investigator:

> "I wasn't clear on the clinical picture that he was presenting, that's when I thought 'well let me try and get him in front of the doctor in the morning'."

54. N wing staff contacted RMN A at around 4.30am, and said that he was requesting further abdominal pain relief. The nurse told the night officer that it was too soon for a second dose, but that she would return later. She went to N wing at 6.00am. However, he appeared to be sleeping and, as he had been awake for most of the night, she decided not to disturb him for further medication.

55. Although she had requested for morning staff to take him to the 9.00am IDTS clinic he was not escorted and did not attend. At 10.17am, he was moved to A wing. (A wing is a wing that holds a mix of convicted and unconvicted prisoners.) Unfortunately, the healthcare assistant who was in the clinic that day did not tell the nurses that he had not arrived. This meant that staff were unable to follow up where he was and why he had not attended for his appointment.

56. His wing observation book shows that at around 7.10pm, he was complaining of severe stomach pains. Wing staff asked for a nurse to come and assess him. RGN C attended and took his blood pressure. The nurse noted in his medical record that he had not mentioned any vomiting, his blood pressure reading was within normal limits and she had given him paracetamol. She noted that he immediately sat upright to take the paracetamol and that he did not show any signs of discomfort in doing so.

57. The nurse told him she would hand over to the night shift nurse and that if his symptoms persisted he was to inform staff. She told my investigator at interview, that healthcare staff only have one handover during the day, at lunchtime. There are no handovers between shifts or any formal handovers. He requested more pain relief at around 10.00pm for abdominal pain. Primary Care Nurse (PCN) A told him that as he had already been given pain relief by evening staff, she was unable to give him anymore at that time.

58. The PCN was called to his cell at 10.45pm. The nurse told my investigator that when she arrived at his cell he was on his bed and doubled over in pain. She brought him out of the cell to assess him and he put himself up on the pool table. She noted that his blood pressure and temperature were within the normal range but his blood glucose level was high. The nurse wrote in his medical record that he was very anxious. He told her that he was feeling unwell with the abdominal pain and had vomited that evening. He asked for further pain relief and anti-sickness drugs as he believed that they would help him. She noted that while he was explaining his problem he relaxed and seemed much more comfortable. The nurse asked him to point to the area of pain and he did a large hand movement that covered most of his abdomen.

59. On examination of his stomach, she found there was no specific area of tenderness, hardness or swelling. He told the nurse that he had had multiple surgical procedures, but was unable to explain what these were. She told him that she would contact the detoxification nurse to try and get him the pain relief he had asked for. The nurse did not give him any pain relief at that time and asked him if he had been taking his insulin as his blood glucose level was so high. He said that he had not had his insulin all day as he had not eaten much. She then advised him that he needed to keep his blood glucose levels under control as failing to do so could also make him feel unwell. The nurse noted that he was very dismissive of her advice on diabetic control and told him to have a reduced dose of insulin. He said that he wanted the medication he had first asked for.

60. Officer C wrote in the wing observation book at 11.00pm that he had been pressing his cell bell constantly since 9.00pm. She noted that the PCN had entered his cell so she could assess him. She told my investigator that he continued to ring his cell bell a couple of times an hour. When the officer told the PCN of this, she was told that he had been seen and there was nothing more that could be done for him. The nurse added that there was nothing else she could do until the arrival of day staff. The officer said she then relayed this information to him. The officer said that at the start of a shift, wing staff have a verbal handover of all relevant information on the wing. She had told staff coming on duty that he had been seen by the nurses throughout the night and staff should continue to keep an eye on him.

61. The PCN discussed his condition with the detoxification nurse at 11.55pm. The nurse confirmed that he could have the medications he had requested

to relieve his symptoms. It was noted in his medical record that he would be booked for a detoxification review in the morning. He was given the pain relief and anti-sickness medications. His blood glucose reading was at this time 26.6mmols and he refused any further checks, but did say he would take some of his insulin.

62. At 1.10am on 13 July, the PCN visited him and recorded that his blood glucose result had lowered to 22.4mmol. The nurse noted that he appeared much more settled and that he had had some insulin. He requested pain relief again, so she gave him paracetamol and left him some more for later in the night should he need it. The nurse wrote in his medical record that he was booked for a medical review in the morning and had been referred to see the doctor due to his continuing abdominal pain. (The only entry made in the nurse handover diary between 11 and 13 July was regarding him being taken to hospital. There was no mention of his abdominal pain or vomiting, or his need to see a doctor. However, there were other entries for prisoners on A wing.)

63. Officer D started duty at 7.30am. He wrote in his statement that when he answered the man's cell bell at 7.40am he stepped out of his cell and told the officer that he felt unwell and had been up all night being sick. He went to the landing office and asked Officer E to call for the emergency nurse to attend.

64. RGN D went to his cell and took his observations which were normal. The nurse checked his blood sugar levels and left some diabetic sweets for him. Officer D said that the nurse told the man that he had been booked in to see the doctor later in the day. He then took a shower.

65. His cell mate complained to Officer D that due to the man being ill he had been unable to sleep. To avoid any friction between the two prisoners, the officer asked the man to pack up his kit and, at 9.15am, moved him to another cell on the wing and locked the cell door behind him.

66. Later, RGN D made a note of her assessment of him in his medical record. The nurse said that his blood pressure was within the normal range and his blood glucose level had gone down to 14.4mmol. She noted that he had told her he had suffered from abdominal pain for 24 hours, and that he had appeared in discomfort holding his stomach. He told her that he couldn't eat as he was vomiting everything back up and that he needed to go to hospital. She told my investigator that she asked him if he had suffered from any problems with his stomach before. He told the nurse that he had a history of strangulated hernias. The nurse said she could see a slight swelling to his stomach, but she did not examine it as she was not qualified to do so. The nurse advised him that she had contacted the healthcare unit to ensure he had an urgent referral doctor appointment that day. She told him to rest and drink plenty of fluids.

67. A further entry in his medical record was made by RGN D at 9.29am. The entry noted that he had an urgent appointment at 1.30pm that afternoon.

The nurse told my investigator that there is a receptionist that makes the doctor's appointments. She had asked the receptionist for an appointment before lunchtime, however the first available was after lunch. She said that there was not a system in place to prioritise urgent appointments.

68. Officer F said that the man was unlocked at 9.30am for association. (This is the period of time when prisoners are out of their cells and are able to associate with each other.) The officer said that he was lying on his bed and told him that he was just going to use the toilet. He left the cell door unlocked and continued to unlock the rest of the cells on the landing.

69. At 9.55am, the officer responded to his cell bell and his new cellmate appeared at the cell door. The cellmate pointed to him and he told the officer that he had chest pains. The officer went to a healthcare treatment area near to A wing and asked for a nurse to attend.

70. His medical record shows that RGN E went to the cell and asked him where the pain was, to which he told him it was his stomach. The nurse said that he was lying on his bed clutching his stomach and was breathing rapidly. The nurse told the investigator that he had said to him that he had been seen by other nurses, but they were not listening to him. He tried to reassure him.

71. The nurse saw that he had a large protrusive swelling to the right side of his abdomen which was very tender to touch and the size of a 'fist'. He was cyanosed (where the skin is blue to purple in colour due to a lack of oxygen to the skin) so the nurse gave him oxygen.

72. He told the nurse that he had been vomiting what looked like ground coffee and had passed black stools (black stools are associated with a gastrointestinal haemorrhage). The nurse said that he thought he had a strangulated hernia and would need to go to hospital. During interview, the nurse said that he had come on duty at 7.00am that morning. He had not received a handover from the night staff as they only have one handover during the day, which is after lunch. The nurse had no knowledge of any previous medical contact with him regarding his abdomen.

73. The nurse asked an officer to call for an ambulance. However he was told that they would not be able to do so until a doctor arrived and confirmed that an ambulance was necessary. The nurse went on to say that a wing officer had come to the cell door and he asked him to call an ambulance. The officer replied that he was "rattling" (slang expression for drug withdrawal) and had been seen by various nurses who had said the same. The nurse told the investigator that he:

> "was dying, you only had to look at him. I knew he was dying as soon as I saw him".

74. A doctor arrived at the cell within five minutes and confirmed that an ambulance needed to be called immediately. The communications log record shows that at 10.30am, RGN F requested an ambulance for A wing. The doctor was unable to administer drugs intravenously as Birmingham did not have the appropriate equipment. RGN E told the investigator that when a person goes into hypovolemic shock (severe fluid loss), one of the first things you would do is insert a cannula (intravenous needle) into a vein. This equipment is used to administer fluid or medication, however Birmingham do not have a supply of cannula or packs of fluid.

75. The ambulance arrived at 10.41am and the doctor assisted the paramedics in trying to find a vein to insert a cannula. Preparations were made for him to be escorted to hospital and the ambulance left Birmingham at 11.00am.

76. Before going to the hospital, he was assessed to determine the level of risk he presented to the public and the level of restraint required. Duty governor recorded on the person escort record (PER) that hospital management had not been contacted prior to the escort taking place. Furthermore there were no medical objections to restraints being used.

77. The duty governor said during interview that a prisoner is escorted according to any security information on their file, including their offence. This includes any previous security intelligence such as a risk to public or history of attempting to escape. The higher the score the higher the level of restraint. He said that there was no score on the man's PER as it would have been done quickly and he would have not seen his security file information.

78. RGN F risk assessed him according to observation of his present medical condition. The nurse did not have the opportunity to look at his medical record. (A nurse carries out this part of the risk assessment to determine whether there are any medical reasons for restraints not to be used, such as if hand cuffs would worsen their condition or hinder medical intervention.) She said during a telephone interview with my investigator, that the nurse's recommendation is often taken into consideration although there have been times when recommendations have been challenged when the emphasis of security has been at odds with the nurse's medical assessment.

79. The nurse said that she completed the paperwork in the centre of the prison while he was being carried down the stairs in a wheelchair and she did not speak to him or RGN E. She based her judgement on his appearance. The nurse said that he was sat in the wheelchair with his arms in his lap, seemed quite relaxed and was able to hold himself upright. This is somewhat different to RGN E's description in which he said that he was losing lucidity and was unable to hold himself upright. She recommended that his condition at the time was not thought to reduce the risk of him escaping unassisted and that his treatment would not require

the restraints to be removed.

80. From the information that he had, the duty governor authorised a two officer escort. Two officers escorted him and he was double–cuffed. (This is one hand to the other on an escort chain. An escort chain is a 1.8 metre length of chain with one cuff attached to the prisoner and the other cuff attached to an officer.)

81. He arrived at hospital at 11.10am and was taken straight into a resuscitation bay. Ten minutes after arriving, hospital staff requested that the restraints be removed so they could treat and assess him. Hospital staff found it difficult getting intravenous lines into his veins and it is documented in his escort record that they stopped treatment on him at around 1.20pm.

82. Doctors told the officers that he would need surgery and his next of kin details should be made available to them so they could be told. Officer G telephoned the duty governor and asked for the next of kin details and said that the restraints had been removed. A nurse asked the officers if they could contact the prison for his medical history.

83. At 1.30pm, a hospital consultant told the escort officers that he was too ill to have surgery. The duty governor contacted the next of kin and informed them of his current condition and that he had been taken to hospital. Half an hour later, a Developing Prison Service Manager (DPSM) and Nurse A arrived at the hospital to liaise with the bedwatch officers. Later, two further officers arrived at the hospital and took over the escort duty at 3.10pm.

84. Around 3.20pm, the man's next of kin (his brother and sister-in-law) arrived at the hospital. A doctor told them that their brother's death was imminent. The DPSM asked the escort officers to leave the room to give the family space and privacy. One officer wrote in the bedwatch log that the doctor had told them that he had died at 3.43pm.

85. At 4.15pm, the man's sister arrived at the hospital and was spoken to by the DPSM. He took her to her family and left them to spend some time with their brother. The Governor attended the hospital to speak with the family and to offer his condolences. The family stayed until around 5.25pm and as they left they thanked staff for their support and consideration.

86. The duty governor held a hot de-brief at 7.00pm that evening. Staff involved in the man's care were invited to attend the meeting and the events leading up to his death were discussed. (A hot debrief is a meeting for staff to discuss issues and any lessons learned following serious events such as deaths in custody, hostage situation or escape attempt. The meeting should focus on reassurance, information sharing and how staff can support each other.) The two cell mates were offered support by the chaplaincy and an officer from the care team who had also been at

hospital to support staff shortly after the death. The family were offered funeral expenses by the prison.

ISSUES

87. A review of the man's healthcare while at Birmingham was commissioned with the local Primary Care Trust (PCT). A clinical reviewer carried out that review on behalf of the PCT. He had access to the medical record and the transcripts of the interviews with healthcare staff.

88. In his clinical review he concludes that the care that the man received was that as he would have expected in the community. However, he highlights a number of concerns which are addressed in this section of my report.

Clinical care

The diagnosis of the man's medical symptoms

89. On arrival at Birmingham on 8 July 2011, his previous medical record (dating back to September 2008) was available through the electronic medical information system, EMIS). Entries in the records show that he had previously been treated for a strangulated hernia, was receiving medication for high cholesterol and was an insulin dependent diabetic. Additionally, his previous drug support programmes and medication were noted in his record.

90. Prison Doctor B assessed him on 9 July and noted there were no outward signs of withdrawal other than that he looked 'flushed'. Two days later, a nurse saw him when he complained of abdominal pain. He told her that this pain was similar to what he experienced when he suffered from a strangulated hernia in 1996. Having taken paracetamol for pain relief, the nurse advised him he would be reviewed if the pain got worse.

91. Despite his complaints that he was suffering from similar symptoms of which he had suffered with regard to his hernia, the nurse with whom he had contact neither physically examined him nor referred to his previous medical history, where it was clearly recorded that he had suffered from and had been operated on for a hernia.

92. Over the next four days, he complained on ten further occasions to the healthcare staff of abdominal pain with intermittent nausea and abnormal bowel movements. At no time during these four days did he see a doctor, despite an appointment being made with the IDTS clinic where he would have seen a doctor, because there was no escort for that appointment.

93. Believing that he was suffering from the effects of detoxification, the night nurses gave him medication used to manage those symptoms such as stomach cramps. He was treated with pain relief of paracetamol, Buscopan for stomach cramp pain, and Prochlorperazine for nausea. His medical observations were variable on the five occasions they were taken. His complaints, that he again was suffering from the symptoms of hernia, of which he had previously been operated, appear to have gone unheard.

94. Indeed there is no evidence from any entries in his medical record that nurses referred to previous entries made by their colleagues. It is clear that he had been persistently complaining of abdominal pain for several days. This issue of concern was noted by the clinical reviewer, who writes:

> "From examination in detail, the statements given by the RMN, RGN and primary care nurses, it seems that no observation of previous nursing entries took place at any interval and the diagnosis of detoxification was not questioned at any point. The medications he received were in line with this [detoxification]."

95. Whilst I understand that there may be difficulties in accessing electronic health records directly during consultations, it is important, to ensure the continuity of care for a patient, that staff are aware of a patients history. Had nursing staff reviewed previous entries, including those made during his previous sentences at the prison, the diagnosis and therefore outcome may have been very different. As such I make the following recommendation.

The Head of Healthcare must remind all medical practitioners of the need to review previous entries including those made during previous sentences at the prison, should they be available.

11 -12 July 2010 – the man's missed appointments

96. During the night of 11 to 12 July, both RMNs visited him on four occasions. He complained of sharp abdominal pain and told RMN B that he had previously had an operation for a strangulated hernia. At 10.52pm on 11 July, the RMN rang an out of hours' doctor's service for advice. The nurse wrote, "Contacted Badger out of hours service for further advice, informed dr of the above, he advised to observe and if he [the man] got worse to contact them again".

97. The nurses saw him on three further occasions that night. The clinical reviewer noted this sequence of visits to him along with his presenting symptoms and said,

> "The OOH [out of hour's service] not contacted again, this should have been done at this point given the change in symptoms. The symptoms of vomiting and passing blackened stools are potentially serious and the OOH services can be contacted and a doctor visit requested."

98. At 2.40am on 12 July, both RMNs visited him, who continued to complain of severe abdominal pain and said he wanted to go to hospital. Following an assessment, RMN A reassured him that if his condition further deteriorated he would be transferred to hospital. The nurse then made an appointment for him to be seen in the IDTS clinic at 9.00am and noted this in the electronic medical records. The RMN arranged with D wing night staff for him to be escorted to the clinic when the day staff took over their

shift. At interview, my investigator asked the RMN where the note was made she said,

> "We just have a desk diary that contains all the names of the men who are going to be seen in clinic the next morning so I entered his name into the diary and then I did write for priority medical review and highlighted it and put a note there saying see EMIS entry."

99. However, that morning he was transferred from D wing to A wing at 10.17am and did not attend the appointment. No enquiries were made by the healthcare staff with wing staff as to why he had failed to attend.

100. It was important that he attended this appointment with the IDTS clinic and saw a doctor. He had been suffering from severe abdominal pain for over 24 hours, which had been apportioned to withdrawal symptoms. When he failed to attend the clinic, healthcare staff should have made contact with D wing staff to find the whereabouts of him. Seemingly there was no communication between the healthcare staff and wing staff.

101. Furthermore, RGN E told my investigator that a handover for healthcare staff only takes places after lunchtime each day. Staff reporting for day duty in the mornings do not receive a formal handover from the night shift into any concerns regarding an individual prisoner's health.

102. The clinical reviewer noted these concerns and wrote,

> "The erratic nature of the appointments made with both the IDTS team and primary care triage service, the prison diary does not seem that easy to follow and the handover system is not clear. The need for an urgent doctor's assessment did not seem to be communicated."

103. I endorse the clinical reviewer's recommendation for the attention of the head of healthcare.

The Head of Healthcare must review the systems for booking an urgent primary care appointment and handover of care amongst the prison staff. This needs to be made much clearer and a computerised system would be much easier to interpret as in the case in most GP surgeries.

12 – 13 July 2010

104. He was not seen by healthcare staff from 6.08am until 7.31pm on 12 July. Despite his history of abdominal pain, numerous visits by healthcare staff the previous night, and the failure to attend his IDTS appointment he was not medically assessed.

105. RGN C saw him at 7.31pm. She gave him paracetamol, took his observations and advised him "to inform staff if pain persists". During that night, he was seen on three occasions by PCN A. When the nurse

examined him at 10.45pm, she physically felt his stomach and wrote, "When assessing his [the man's] stomach there was no specific area of tenderness, no hardness or swelling noted." After discussing his symptoms with a detoxification nurse, she arranged for him to have medication for stomach cramps and anti sickness. The nurse also advised him to keep his blood sugar levels under control, as she had noted that his blood sugar level was high at 24.2 mmol/L.

106. Two and half hours later, she noted that he "appears much more settled and reported that he has had some insulin. 1g paracetamol given as per pgd (patients' guidance directive) and left 1g paracetamol for later in the night if required. Booked for nurse review in morning and referred to GP due to this continuing abdominal pain".

107. The clinical reviewer comments:

> "When assessing his [the man's] stomach there was no specific area of tenderness, no hardness or swelling noted. Assumption was made in (my opinion incorrectly) that patient was suffering drug withdrawal and the detox nurse to be contacted for further medication. I would not expect the nursing team to palpate the abdomen but to have acknowledged the repeated complaint with more suspicion would have been helpful."

Although I make no formal recommendation I would ask the Head of Healthcare to take on the comments made by the clinical reviewer and advise those staff involved of his concerns.

Nursing skills

108. The healthcare nursing staff at Birmingham is a mix of RGNs, PCNs and RMNs. Both RMNs are nurses trained in mental health as opposed to a RGN/PCN. While RMNs are given some general nursing experience they are not trained to the standard of RGNs in caring for physical illnesses.

109. The clinical reviewer raises this as a concern over the variable skills base of these nurses and their nursing experience. Seemingly RGNs respond to the medical needs of prisoners that might be beyond their own expertise.

110. Both RMNs are nurses trained in mental health as opposed to a RGN/PCN. While RMNs are given some general nursing experience they are not trained to the standard of RGNs in caring for physical illnesses.

111. The clinical reviewer commented on the triage skills (triage is the process of determining the severity of a patients illness) of RMNs in establishing a prisoner's physical illness. As already noted, RMNs are not fully qualified in the care of patients with physical illness. Therefore their role in triage is not a primary remit of their skill base. Triage is ideally carried out by

RGNs.

112. The clinical reviewer comments on the role of the RMNs in assessing the man's physical medical condition. He said:

> "A concordant [of the same opinion] agreement approach may have helped to identify serious illness earlier."

113. I endorse the clinical reviewer recommendation for the attention of the Head of Healthcare.

The Head of Healthcare should review the triage skills of the RMNs compared to the RGNs and the primary care nursing team.

114. The clinical reviewer noted that the ratio of RMNs, RGNs and PCNs should be sufficient to ensure a skill mix is present within the prison healthcare unit. This would ensure that nurses are able to assess prisoner's medical and mental health needs in accordance to their training and qualifications.

115. I endorse the following recommendation for the attention of the Head of Healthcare.

The Head of Healthcare should ensure that there are suitably qualified and experienced nurses on duty who are able to appropriately respond to the physical and mental health needs of the prisoners at all times.

The man's detoxification and diabetes monitoring

116. He received full detoxification from drug addictions on his previous and last prison sentences. On all three occasions he was, through his own admission, a user of heroin and crack cocaine. Furthermore he admitted to misusing methadone. Following his arrival at Birmingham on 8 July 2010, he was placed on D wing (the first night centre) and a referral was made to the CARAT team.

117. Prison Doctor B appropriately prescribed him a medication support programme of methadone, with medication for his diabetes and high cholesterol. A CARATs worker spoke to him and a care plan was written. The plan would support him during his time at Birmingham and his subsequent discharge back into the community. The aim of the programme was to continue with the methadone maintenance prescription.

118. The care of his diabetes included daily monitoring of his blood sugar levels. He had a blood sugar monitor and his insulin as in-possession medication. (In-possession medication means the prisoner has been assessed as able to appropriately manage their own medication.)

119. It was noted that he did not always take his insulin as prescribed and staff monitored his blood sugar levels. He was reminded by healthcare staff to ensure that he took his insulin. On one occasion he was provided with diabetic sweets when he told staff he was not eating.

120. Over four days, he was seen and assessed by nurses experienced in detoxification. He received his methadone as prescribed, however he complained of nausea, sweating, restlessness and abdominal pain. These symptoms are closely related to withdrawal from opiate based drugs. Additionally, he was prescribed pain relief of paracetamol to reduce the severity of those symptoms. However, it was subsequently found that the symptoms were related to a small bowel obstruction.

121. The clinical reviewer comments:

> "The existing care he was receiving for his diabetes and substance misuse was appropriate and would have no effect on his eventual death."

The nurse's request for an emergency ambulance

122. RGN E, who is an agency nurse, assessed him as being seriously ill when he saw him in his cell around 10.00am on 13 July. The nurse noted that his skin colour was blue and that his breathing was rapid and in his own words: "was dying, you only had to look at him. I knew he was dying as soon as I saw him." Furthermore, his observations were abnormal with extremely low blood pressure and a very fast pulse rate. The RGN saw a large swelling protruding from his abdominal area.

123. The nurse asked the wing staff to call for a 'blue light' (emergency) ambulance and informed his colleagues in healthcare that this was a medical emergency. However, a prison officer said that a doctor had to be called to see him before an emergency ambulance could be summoned. The RGN again repeated his request to a prison officer to call for an emergency ambulance. He told my investigator what he said to the officer:

> "He's [the man] dying, can you go and phone an ambulance'; it was like bashing my head against a brick wall you know. And we've had similar incidences since you know. As far as I'm concerned I'm a professional registered nurse. I mean surely if I say 'this guy needs an ambulance, he needs to go to hospital', he needs to go to hospital. What's the point of having me here as a professional nurse otherwise, there's no point. You might as well get a healthcare assistant to do my job."

124. A doctor arrived at the cell about five minutes later. When my investigator asked him if the ambulance had been called for before the doctor arrived at the cell. The RGN said,

> "I don't think it was called until the doctor arrived. I can't say for

definite though but you see I, first of all I couldn't leave the patient because I knew he was in such a significantly poor state of health and he would have had no-one then with medical experience with him. Secondly, I can't dial out on the phones here because I don't have access to any outside phone line."

125. It was noted in the communication log that RGN F rang for an ambulance at 10.30am. The ambulance arrived at 10.41am.

126. I am disappointed that prison staff failed to respond to RGN E's request for an emergency ambulance when he first asked for one to be called. The nurse is a qualified healthcare professional whose judgement on the severity of a patient's medical condition should not be challenged by non-medical staff. As with all potential medical emergencies, time is of great importance. Whilst in this case this short delay in calling for an ambulance did not make any difference to the eventual outcome, in a future emergency this may not be the case.

127. I make this recommendation for the attention of the Governor and Head of Healthcare.

The Governor and Head of Healthcare must ensure that staff immediately responds to a request from a qualified healthcare professional for an emergency ambulance to be summoned.

Medical equipment

128. When the doctor arrived at the man's cell he was unable to administer intravenous fluids or medication as Birmingham does not have the equipment to do this. To treat a patient intravenously a needle called a cannula is inserted directly in to the vein. Birmingham does not have cannulas. The doctor had to wait until the paramedics arrived, with their medical equipment that included a cannula, to carry out this procedure. Nevertheless, both the doctor and paramedics were unable to find a suitable vein to insert the cannula.

129. The provision of emergency life saving equipment is essential to the care of prisoners being held at Birmingham. Whilst the paramedics, with their emergency equipment, arrived eleven minutes after they were called for, vital medical supplies should be made available to healthcare staff so they begin the process of caring for seriously ill prisoners.

130. I make the following recommendation to the Head of Healthcare

The Head of Healthcare should carry out an audit of the essential emergency equipment held at Birmingham. Emergency bags should be fully equipped to carry out basic life saving procedures.

Restraints

131. The man was restrained when he was escorted to hospital by two officers. RGN F told my investigator that she carried out a medical risk assessment for the escort based on her visible observation when he was being taken to the ambulance. The nurse did not refer to his medical record. She assessed him and advised that he should be restrained by a double hand cuff and an escort chain.

132. Usual practice for a prisoner escort would be carried out by the security department however, due to the medical nature of this emergency, the RGN carried out this risk assessment based on her medical expertise.

133. It was established in the evidence of RGN E that the man was, in his opinion, in an extremely serious medical condition. On arrival at the hospital the staff asked for restraints to be removed at 11.10am, which the officer did. It was therefore unfortunate that he left Birmingham in restraints.

134. The clinical reviewer noted that the need for him to have been hand-cuffed must be questioned given his unstable condition. Although I make no formal recommendation I ask the Governor and Head of Healthcare to ensure staff are aware of the use of restraints and balance this against the security risk, when prisoners are so seriously ill.

CONCLUSION

135. The man was a prisoner at Birmingham on three separate occasions between 2008 and 2010. Each time on his arrival at Birmingham his medical history was noted on the electronic medical record system. This history included the problems he had with hernias. His drug misuse was recorded and treated appropriately.

136. During his last sentence, nursing staff repeatedly visited him in his cell over two days from 11 July. He complained of abdominal pain, nausea, abnormal bowel movements and feeling unwell. Nurses attended to him and considered the symptoms to be of opiate withdrawal. An appointment was made for him to see a doctor; however that appointment was not kept as he moved wings. There was a lack of communication between the healthcare staff and wing staff. As result of that missed appointment, he was not seen by a doctor until he was escorted to hospital. This was an oversight in his care and I make a recommendation to reflect this.

137. The investigation has found that RMNs are used to carry out general nursing and triage duties for which they have not been trained. The clinical reviewer has commented on this practice and recommended that the skill mix of nursing staff should be reviewed.

138. I note that nursing staff should have read his full medical history and, by doing so, would have seen that he had a history of abdominal problems. This would have given them further information and they might have formed a different diagnosis of his symptoms other than that of opiate withdrawal.

139. Prison staff failed to respond to a request from a qualified nurse when he called for an emergency ambulance. It was clear to this nurse that he was dangerously ill and in need of urgent hospital treatment. The failure of prison staff to react to this request is of concern and I make a recommendation to reflect this.

140. Cannulas are not available at Birmingham. I see the lack of this basic life-saving equipment as an oversight in the provision of providing essential care to prisoners. I have recommended that an audit of all life saving equipment is carried out.

141. The use of restraints was, in my opinion and that of the clinical reviewers, unnecessary as his medical condition was deteriorating. Whilst recognising that his transfer to hospital was an emergency, I have asked the Governor and Head of Healthcare to remind staff that a prisoner's medical condition should be balanced against their risk of escape or risk to the public.

142. In conclusion, I judge that there were shortcomings in his medical care at Birmingham. This was also the opinion of the clinical reviewer who has raised his concerns when comparing the care he would have expected to

receive in the community.

RECOMMENDATIONS

The Head of Healthcare

1. The Head of Healthcare must remind all medical practitioners of the need to review previous entries including those made during previous sentences at the prison, should they be available.

   Accepted – *Regular GP Services are being tendered to a stable supplier and regular general practitioners will be employed reducing the need for locum GP's. All medical practitioners are regularly reminded of reading all previous medical histories of prisoners whilst in custody.*

2. The Head of Healthcare must review the systems for booking an urgent primary care appointment and handover of care amongst the prison staff. This needs to be made much clearer and a computerised system would be much easier to interpret as in the case in most GP surgeries.

   Accepted – *Handover is now done at the start of each shift ensuring that all prisoners who need to be seen urgently are seen at the first opportunity by a GP.*

3. The Head of Healthcare should review the triage skills of the RMNs compared to the RGNs and the primary care nursing team.

   Accepted – *Triage training is ongoing – all nurses have to complete core competency training in order to work at HMP Birmingham.*

4. The Head of Healthcare should ensure that there are suitably qualified and experienced nurses on duty who are able to appropriately respond to the physical and mental health needs of the prisoners at all times.

   Accepted – *There is a skill mix of experienced nurses on duty at all times of the day.*

5. The Head of Healthcare should carry out an audit of the essential emergency equipment held at Birmingham. Emergency bags should be fully equipped to carry out basic life saving procedures.

   Accepted – *The emergency response staff carry bags that have all the equipment to deal with all emergency situations – whether breathing difficulty or severe bleeding. Defibrillators are located at nine prominent sites throughout the prison.*

The Head of Healthcare and the Governor

6. The Governor and Head of Healthcare must ensure that staff immediately responds to a request from a qualified healthcare professional for an emergency ambulance to be summoned.

Accepted – *Once a request is made by a qualified healthcare professional that an ambulance is needed the ambulance is called without delay.*