

**Investigation into the circumstances surrounding  
the death of a man while a prisoner at HMP Birmingham in  
December 2011**

**Report by the Prisons and Probation Ombudsman  
for England and Wales**

**July 2012**

This is the report of an investigation into the death of a man, a prisoner at HMP Birmingham. He had been convicted of drug offences and remanded to Birmingham in October 2011, to await sentencing. He died only weeks later. He was 48 years old. The post mortem report found that his death was caused by heart disease.

I extend my condolences to the man's family and others affected by his death.

The investigation was carried out by one of my investigators. Heart of Birmingham Primary Care Trust commissioned a clinical reviewer to produce a review of the clinical care the man received in prison.

The man had a family history of heart disease and complained of symptoms to a locum general practitioner at the prison shortly before his death. The clinical reviewer found that, while the consultation was not as thorough as he would have expected, it was unlikely that any action at that time would have changed the outcome and an appropriate hospital referral was made. Similarly, while there were unfortunate delays in the emergency response to the man's collapse, the clinical reviewer considers it unlikely that he would have survived the condition.

There are lessons to be learned from this man's sad death and a number of recommendations are made for improvements at HMP Birmingham. For example, better continuity of care is needed when reception health screening is undertaken and prisoners should be encouraged to disclose all relevant health information before they are allowed to undertake sporting activity. Prison doctors ought to have appropriate professional development and some aspects of prescribing practice needs scrutiny. There is also a need to enhance emergency response procedures and, wherever possible, to ensure next of kin are notified in person of a death.

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

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**July 2012**

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## SUMMARY

1. The man was convicted of drug offences on 10 October 2011, and remanded into custody at HMP Birmingham to await sentencing.
2. During his reception health screening the same day, the man was assessed as fit to live on the wing, share a cell and work. He told healthcare staff that he was currently prescribed medication for back pain. During an appointment the next day, the man also told healthcare staff that he had a family history of heart disease.
3. On 7 December, the man was seen by a locum GP after complaining of chest pain. After examining him, the GP thought that an emergency referral to the accident and emergency department was unnecessary. He wrote in the clinical record that the man was, “unlikely [to be] cardiac pain”.
4. The man did not at that time meet the criteria for the rapid access chest pain clinic (because he did not experience pain when he exerted himself). However, the GP made a routine referral to the cardiac department at outside hospital in light of the man’s family history of heart disease.
5. Although the man complained of chest pain, he did not have an electrocardiogram (ECG) test to check his heart rhythm. He was prescribed diclofenac (a pain killer). The clinical reviewer comments in his clinical review that diclofenac has been linked to deaths from heart disease.
6. At 1.45pm on a day in December, the man attended the gym, taking part in a game of football in the sports hall. Part way through the game, he complained to another prisoner, (a gym orderly), that he felt unwell. The man told the gym orderly that he had been experiencing chest pains since lunch.
7. The game finished at around 3.00pm. Afterwards, the man spoke to the gym orderly again and said that he was now having pains down his left arm. He was bending over in pain. The gym orderly told him to go to the gym office and speak to the prison officer who had been refereeing the game.
8. The officer advised the man to sit near the gym door to get some fresh air. As the man went to sit down, his condition deteriorated quickly and he lost consciousness. Officers raised the alarm and came to assist.
9. The officers decided to place the man in the recovery position rather than attempting cardiopulmonary resuscitation (CPR). When calling for help the officers did not use an emergency code on their radios, so the emergency response nurse was unaware of the seriousness of the incident. Consequently, she arrived with only basic first aid equipment.
10. Other healthcare staff arrived a few minutes later. The nurses performed CPR, gave the man oxygen and attempted to restore a normal heartbeat by applying a brief electric shock using a defibrillator. Paramedics arrived and took over CPR. They gave the man adrenaline to try to restart his heart. He

was transferred to an ambulance and taken to outside hospital. On arrival at hospital, the man was pronounced dead at 3.50pm.

## THE INVESTIGATION PROCESS

11. The investigator issued notices announcing the investigation to staff and prisoners. She asked anyone with information about the man's death to contact her. No one came forward.
12. Another investigator visited HMP Birmingham on 20 December 2011, and collected copies of the man's prison files and medical records. He visited the healthcare unit, viewed the man's cell and introduced himself to the staff on the wing. The investigator also met the Deputy Director during his visit.
13. The investigator visited Birmingham prison on 7 February 2012, to interview seven members of staff and three prisoners. She gave initial feedback to the prison's liaison officer after the interviews. The investigator also wrote to the Director drawing attention to areas of potential concern.
14. A review of the clinical care the man received in prison was carried out by a clinical reviewer on behalf of Heart of Birmingham Primary Care Trust. The review was received by the investigator on 20 February.
15. This report will be forwarded to the coroner's office to assist with their enquiries.
16. One of the Ombudsman's family liaison officers (FLO) contacted the man's brother (who was acting on behalf of the wider family). The FLO told him about the investigation and provided him with an opportunity to raise any concerns. The man's brother said that the family accepted that his death was the result of natural causes. However, he outlined some concerns which the family hoped might be addressed for the benefit of other prisoners.
17. The man's family were concerned that he had been allowed to take part in sporting activities despite having complained of chest pains two days before his collapse. His brother explained that there was a family history of heart problems and questioned whether healthcare staff were aware of this and whether this was considered when his brother complained of chest pains.
18. The man's family were surprised by how the prison had contacted his wife by telephone to break the news of his death. His brother understood that distance was a problem but wondered if this might have been better done in person by the police or someone from a prison nearer to them.
19. Following the draft report one of the FLO contacted the man's family. His family raised further concerns. The man's brother and sister-in-law are employed by the prison service and commented that, from their own experiences they believed that he (the man) should have been 'gym restricted' and not allowed in the gym or allowed to play football.
20. The man's family felt that appropriate thorough care was not provided for their relative's high blood pressure found on reception into Birmingham in October

2011, and that had he been given appropriate medication for this his death could have been prevented.

## **HMP BIRMINGHAM**

21. HMP Birmingham is a large prison in the Winson Green area of Birmingham. It holds a maximum of 1450 men, both sentenced and unsentenced.
22. The prison is the first public sector prison to have its management transferred to the private sector. Since 1 October 2011, it has been managed by G4S Care and Justice Services.
23. Healthcare services are commissioned by NHS Birmingham and Solihull. The prison healthcare centre treats physical health, mental health and substance misuse problems 24 hours a day. Since 2010, there have been nine deaths at Birmingham as a result of natural causes, three of these the result of heart attacks. There are no similarities as the exact cause of death. However, in one of these previous cases we made a recommendation that Birmingham should introduce an emergency radio code system. This had not been done.
24. The physical education (PE) department provides prisoners with the chance to exercise with a sport hall, a weights room and cardiovascular equipment. Prisoners can play a range of team sports. Up to 75 prisoners can use the gym at any one time and a team of qualified Physical Education Instructors (PEIs) supervise and instruct the prisoners throughout their sessions.

### **Independent Monitoring Board**

25. All prisons have an Independent Monitoring Board (IMB) appointed by the Secretary of State for Justice. Members of the Board are unpaid volunteers from the local community and have full access to the prison. They help to ensure that standards of care and decency are maintained. The Board is required to produce an annual report about the prison, highlighting good practice and flagging up areas of concern. Their latest report covered the year from July 2010 to June 2011, prior to the arrival of G4S. The IMB commented:

“In general the IMB has observed a good level of care being provided by staff towards a sometimes very difficult group of prisoners.”

26. The IMB discussed the prison’s impending move from the public to private sector:

“Significant and welcome changes were made when interim Governor [Director] and Deputy Governor [Deputy Director] respectively were appointed late in the reporting period. In a very short time through strong leadership and robust management, also working alongside G4S staff, they have made a noticeable difference”

### **Her Majesty’s Inspectorate of Prisons**

27. The most recent inspection of Birmingham was in January 2012, but the report of that inspection has not yet been published. At the previous

inspection in December 2009, inspectors found that a previous recommendation about the need for first aid training for staff had been achieved. Staff had received annual training in resuscitation and the use of defibrillators. Inspectors also commented in the report that:

“Resuscitation equipment was distributed in many locations, including the in-patient wards, and was regularly checked. Some of the different methods of recording checks were not adequate, but those used in the in-patient wards were very good. All clinical staff were in date for mandatory life support training, including the use of defibrillators”.

## KEY EVENTS

28. On 10 October 2011, the man was remanded into custody for drug offences and taken to HMP Birmingham.
29. During the man's reception health screening the same day, a nurse assessed him. He had been taking diclofenac to relieve back pain. He provided the nurse with the details of his community GP. He said that he had a hospital appointment the next day for his back problem. Staff neither requested the man's community GP records nor followed up his hospital appointment. He was assessed as fit to live on the wing, work and share a cell. Later that day, he was issued with diclofenac for his back pain.
30. The next day, 11 October, the man was seen by a nurse for a 'well man' healthcheck. He told the nurse that he had a family history of heart disease. His blood pressure was 170/93 (which is high); his height was 5 feet 10 inches and his weight 15 stone 4 pounds. The nurse planned to check the man's blood pressure the following day. However, it was not checked again until 7 December.
31. A locum GP saw the man on 7 December, after he complained of chest pains. He explained to the doctor that he had been experiencing pain behind his eyes for the previous few weeks and had discomfort in the centre of his chest lasting for a few minutes at a time. He said that he had been experiencing chest pains roughly once or twice a week. The GP wrote in the clinical record:

"No SOB [shortness of breath]. Feels unwell when has chest pains. Aches in chest – feels like trapped wind. Not related to exertion. Non smoker. Dad and granddad had angina in 40's. HS [heart sounds] normal. Chest clear. BP [blood pressure] ok – 130/93".
32. After examining the man, the GP decided that a referral to the local Accident and Emergency department was unnecessary. He recorded that the man's symptoms were "unlikely [to be] cardiac pain", but that he would make a referral to the cardiology department at outside hospital in light of the family history of heart disease. During this consultation, the GP provided him with a repeat prescription of diclofenac. The same day he referred the man to outside hospital, writing a letter detailing his symptoms and family history of heart disease.
33. On a day in December, the man attended work as normal in the morning before returning to his cell for lunch. At 1.45pm, he went to the gym where he used the running machine for a short time before taking part in a game of football in the sports hall. The football game started around 2.00pm. A Physical Education Instructor (PEI) refereed the game. Part way through the game of football, the man told a prisoner who was also a gym orderly that he felt unwell and said that he had been having chest pains since lunch. He thought that he was suffering from indigestion. The gym orderly suggested that if he felt unwell, he should play in goal so he could rest a little. The game

finished at roughly 3.00pm, and while the gym orderly collected the dirty sports kits, the man approached him to say that he still felt unwell and was now experiencing pain down his left arm. After seeing the man bend over in pain, the gym orderly advised him to go to the gym office and alert the PEI.

34. The man went to the gym office, sat down on a chair and told the PEI that he felt light headed. The PEI offered the man some water (which he declined) and suggested that he sit by the open door of the gym to get some fresh air. When interviewed, the PEI recalled that, as the man went to sit down by the door, 'It quickly became apparent that his condition was deteriorating quite rapidly'. The man's breathing changed and he became unresponsive.
35. The PEI asked his colleague to watch the man while he went to raise the alarm. The PEI called the communications room and asked for immediate medical assistance. At 3.08pm, a call went out over the radio network asking the emergency response nurse to attend the gym immediately.
36. The PEI who remained in the gym to watch over the man asked a prisoner who was in the gym at the time to alert the PE department manager. When the PE department manager arrived, he noticed that "[the man] was not breathing normally". As the man's condition deteriorated further, the PE department manager and his fellow PEI colleague decided to place him in the recovery position.
37. The gym staff did not use an emergency code when they reported the emergency over the radio network. Consequently, the nurse did not know what kind of incident she was being called to. Therefore, she only brought the initial response emergency bag to the gym. This bag contains limited equipment such as a mask with a manual pump to aid breathing, and does not include a defibrillator.
38. It is not clear what time the nurse arrived at the gym because there are no CCTV cameras. However, witness accounts indicate that she arrived within minutes of the emergency call. After assessing the man's condition, she instructed gym staff to call for an ambulance. The control room called for an ambulance at 3.13pm and a request was made for a second nurse also to attend the scene.
39. The nurse arrived a few minutes later carrying another emergency bag which contained oxygen and a defibrillator. The first nurse to arrive on the scene had turned the man over onto his back and, after both nurses were unable to find a pulse or any signs of breathing, they attached the defibrillator. The machine advised that they shock the man and they did so. The nurses performed chest compressions and gave oxygen. They administered two further shocks from the defibrillator.
40. An ambulance arrived at 3.20pm and a second came two minutes later. When they got to the gym, the paramedics took over and gave the man two doses of adrenaline to try to restart his heart. After trying to stabilise his condition, they moved him onto a stretcher at 3.35pm. They continued to

perform CPR on the way to the ambulance. The man was accompanied by the PEI who refereed the game and an officer to outside hospital. He was not handcuffed during the journey. They arrived at the hospital at 3.37pm. Unfortunately the resuscitation attempt proved unsuccessful and the man was pronounced dead at 3.50pm.

41. Shortly after the man was taken to hospital, a member of the prison care team attended the gym with the Director to speak to the prisoners and staff.
42. The Duty Director telephoned the man's wife (his nominated next of kin) at 5.55pm to break the news of his death. His wife asked that another family member be spoken to, as the news had come as a shock and she was too upset to speak. One of the man's brothers worked at HMYOI Hindley as a prison officer. At 6.30pm that evening, the Duty Director called the Governor at Hindley to ask that the man's brother be informed of the news.
43. A hot debrief was held that afternoon. (This meeting gives the staff involved the chance to discuss the emergency response and learn any immediate lessons. It also allows them to check on each other's welfare.) Notices were put up around the prison, informing staff and prisoners of the man's death and offering support to those who required it.

## ISSUES

### The reception health screening process

44. At his reception health screen on 10 October, the man provided details of his community GP and a hospital appointment the next day for his back problem. His community GP records were not requested and nothing was done about his hospital appointment.
45. The locum GP explained to the investigator that the man would have been asked to sign a medical consent form when he first arrived. An administration officer in the healthcare department was then supposed to request his community GP records and re-arrange any pre-booked medical appointments. The man signed a medical consent form the day he arrived, but his GP never received a request for the man's community records.
46. High blood pressure and obesity are also recorded in his clinical record but there is no evidence that these issues were followed up or investigated.
47. The clinical reviewer completed a review of the man's clinical care. He comments that "previous GP records should always be requested and these requests followed up". He explains that the prison's electronic clinical record system should make this a straightforward process. The same system could also be used to follow up on high blood pressure recordings. We make the following recommendations:

**The Head of Healthcare should ensure that staff request and obtain each newly arrived prisoner's community GP records.**

**The Head of Healthcare should ensure that, where necessary, any outstanding outpatient appointments that a newly arrived prisoner has are rescheduled and consideration of this is documented.**

### The prison gymnasium and the Physical Activity Readiness Questionnaire (PARQ) form

48. All prisoners wishing to use the gym are required to fill in a PARQ form to identify if they are fit enough to participate. The form contains nine questions about various conditions that could prevent a prisoner from using the gym. It does not include advice about what to do if circumstances change. The clinical reviewer thinks that this would have been useful. The man had seen the locum GP after experiencing chest pains two days previously and had been suffering with chest pains since lunchtime on the day he died. These continued throughout the football match. The man failed to tell staff about this.
49. The clinical reviewer comments on the seventh question on the PARQ form:

'Do you suffer from or have you suffered from, asthma, diabetes, bronchitis or epilepsy'

50. The clinical reviewer thinks that this question is too specific and should be modified to allow for a variety of possible health problems. This should help to ensure that heart problems like this man's can be identified by staff. We make the following recommendation:

**The Director should ensure that the PARQ form is improved so that the diseases listed are less prescriptive and cover the range of medical conditions that might raise a concern about participation in physical activity.**

51. The PE instructor records who uses the gym on an attendance sheet. This sheet has a section entitled 'injuries' where the PEI will record if the prisoner has any injuries that might prevent him from participating in gym activities. All three PE staff in attendance on the day the man died told the investigator that it is the responsibility of the prisoner to inform staff of any reason why they should not participate. The man did not report his chest pains to the PE staff before or during the football match. We make the following recommendation:

**The Director should ensure that all gym users are warned to report any relevant health issues to PE staff before taking part in physical activity.**

#### **Consultation on 7 December 2011**

52. The man saw the locum GP on 7 December, and complained of chest pains. The locum GP thought that his pains were not cardiac related. The doctor told the investigator

"He [the man] came across as an anxious patient and he described the discomfort as not lasting very long and then describing anxiety symptoms to me. The way he described also was a sensation of trapped wind rather than a typical crushing sensation. I asked questions around it to try and find out whether there were other risk factors and the notable one was the fact that he had got quite a strong family history of cardiac problems".

53. The locum GP explained that the man was not suffering from chest pain that day so an emergency admission to hospital was unnecessary. However, in light of his family history he decided to refer the man to the local cardiac unit. He explained that he could have referred him to the rapid access angina clinic which would have enabled him to be seen a lot quicker. However, the man did not meet the criteria for this service. He was not experiencing central chest pain when he exerted himself physically. An electrocardiogram (ECG) machine was available in the healthcare centre but the locum GP did not test the man's heart rhythm and include the results with the hospital referral letter.

54. During the consultation, the locum GP prescribed the man diclofenac. It is unclear why this was prescribed and there is no reason detailed in the medical notes. Diclofenac had been issued by previous clinicians. However,

at interview the locum GP was unable to remember why he issued the repeat prescription of diclofenac. The clinical reviewer comments:

“Diclofenac is prescribed in the context of potential heart disease when guidance suggests the use of the lowest effective dose and for the shortest time possible. Diclofenac use has been linked to excess deaths from heart disease. A discussion of alternatives in the context of [the man’s] presenting complaint is not documented”.

55. The locum GP confirmed at interview that he was aware that diclofenac should not be prescribed to those with gastric problems or those with a history of heart disease, but was unable explain why he had prescribed the drug. We make the following recommendation:

**The Head of Healthcare should undertake an audit of diclofenac prescribing to ensure its appropriate use**

56. The clinical reviewer spoke to the locum GP about his clinical experience and comments:

“[The doctor] is a locum doctor whose work since qualification as a GP in 2008 has been predominantly prison based with little or no consistent external work”.

57. The locum GP confirmed that he had never received a specific prison appraisal and had not had a GP appraisal (with the Primary Care Trust) since June 2010. The clinical reviewer advises that GP appraisals should be conducted annually.

58. The clinical reviewer commented in his review that despite a suspicion of heart disease it did not prompt any immediate investigations or recommendations. An ECG was not done and alternative medication was not explored. The clinical reviewer commented that “the consultation with [the man] fell below the expected standard” and we therefore make the following recommendation:

**The Head of Healthcare should ensure that doctors balance their prison work with community practice to allow them to maintain and improve their skills including effective diagnosis of heart disease.**

### **Emergency on the day of the man’s death**

59. The man complained of chest pains during a football match and after speaking to a PEI he was advised to take a seat and rest by the gym door to get some fresh air. It is clear from witness statements that he became very unwell very quickly and his breathing altered. The two PEIs and the PE department manager all have up-to-date Basic Life Support Training. When the man’s condition deteriorated, he was placed in the recovery position. The clinical reviewer comments:

“Basic Life Support guidance does not support the use of the recovery position for patients with abnormal breathing. Witnesses from the gym state this was for only a short period of time (less than a minute) and seemed to improve his breathing. However when nursing staff arrived he was not breathing and had no pulse”.

60. We make the following recommendation:

**The Director should ensure that all gymnasium staff receive the latest Basic Life Support guidance.**

61. When the PEI called the communications room and asked for immediate medical assistance, a call was transmitted over the radio network asking the emergency response nurse to attend the gym. No emergency code was used and, because of this, the nurse was unaware of what equipment to bring. A further nurse arrived a few minutes later carrying the emergency bag containing the defibrillator.

62. The investigator was told that there was no emergency code system in place when the man died. Staff would use the word ‘urgent’ and the designated emergency response nurse would attend an incident. However, we understand that two new emergency radio codes will be introduced; code red and code blue. A leaflet has been issued to staff providing guidance.

63. At the time of writing, the emergency code system had yet to be introduced. The new safer custody manager advised the investigator that, “the process has been agreed in principle”. She also indicated that, “There [will be] a meeting between the head of safer custody and the director of healthcare to finalise a couple of training points prior to its publication”. Because there is no fixed date for the introduction of the new coded system, we make the following recommendation:

**The Director should ensure that an emergency response code system is introduced and that a defibrillator is always taken to a code blue call.**

64. There is no emergency first aid equipment in the gymnasium and PE staff had to wait until the nurses arrived with the defibrillator. Because of this, there was a delay in administering potentially lifesaving treatment. The clinical reviewer comments that:

“In Advanced Life Support, a key element of survival is access to early defibrillation. In this case, the AED [defibrillator] advised the use of shocks which could have been used earlier if there had been faster application of the AED. The emergency bag containing the emergency equipment was located in a building next door to the gym however a number of doors needed to be opened and closed to access and transport this equipment”.

65. We make the following recommendation:

**The Director should ensure that an emergency bag containing a defibrillator is kept in the gymnasium and PE staff trained in its use.**

#### **Next of kin notification**

66. The man was taken by emergency ambulance to outside hospital where he was pronounced dead at 3.50pm on a day in December. After being informed of the man's death, the Duty Director went to the communications room to ensure death in custody contingency plans were followed. The Duty Director had been informed by the officers who had been with the man that hospital staff had made unsuccessful attempts to contact his next of kin.
67. The Duty Director made a telephone call to the man's wife at 5.55pm to break the news of his death. One of the man's brothers, a prison officer at HMP Hindley, was informed of his death in person by the Governor of Hindley. The man's family lived in Bolton, Lancashire and travelling to their home would have taken some time. However, there is no record to show that delivering the news of his death in person was considered, nor any record to explain why it took over two hours for the Duty Director to speak to the man's wife by telephone. The method of delivery and the delay was not good practice.
68. The man's brother said that his family had been surprised by how the prison had contacted his brother's wife to break the news of his death. He thought that this would have been better done in person by the police or a member of staff from a prison local to his family. He acknowledged that there was no easy way to break news such as this, but explained that it had not helped that the person who made the call seemed very panicky about what had happened.
69. While it is good to see that the prison made arrangements to ensure that the man's brother was given the news in person it is disappointing that this was not done for his wife. Prison Service Order (PSO) 2710 describes the action to be taken following a death in custody. The PSO stresses that the preferred way to break news of a death is in person. We make the following recommendation:

**The Director should make every effort to ensure that the news of a prisoner's death is given to the next of kin promptly and in person by someone from the prison. When this is impractical, staff from a nearby prison should be used and, failing that, the police.**

## **CONCLUSION**

70. The man had a family history of heart disease. He complained of symptoms to the prison doctor two days before his death. The day he died he had been experiencing chest pains but had not told staff.
71. The clinical reviewer finds in his review that, although the GP's consultation on 7 December, "fell short of expected standards, it would appear unlikely that any action by this time would have changed the outcome". The GP made a routine referral to cardiology on the same day which would have taken up to 18 weeks. The man did not fit the criteria for a fast track referral and this would not have been different in the community. Even the speedier fast track process would have taken up to two weeks, and would still not have benefited him.
72. After the man's collapse, a defibrillator was used but this was slightly delayed until trained staff brought the defibrillator to the gym. However, the clinical reviewer comments in relation to the man's heart disease that "it is unlikely that [he] would have survived this condition".

## RECOMMENDATIONS

### To the Director

1. The Director should ensure that the PARQ form is improved so that the diseases listed are less prescriptive and cover the range of medical conditions that might raise a concern about participation in physical activity.

National Offender Management Service responded with,

**Accepted** - Every prisoner has a gym induction. Once they have received this their identity card is marked with a 'G'. This allows them access to the gym. They are not allowed in the gym without this mark. The questionnaire that is given to prisoners when they attend the gym will be reviewed from a clinical capacity to see if it needs amending.

2. The Director should ensure that all gym users are warned to report any relevant health issues to PE staff before taking part in physical activity.

National Offender Management Service responded with,

**Accepted** - Posters will be made and displayed around the gym to say 'if you are feeling unwell before, during or after exercise please contact a member of gym staff'.

3. The Director should ensure that all gymnasium staff receive the latest Basic Life Support guidance.

National Offender Management Service responded with,

**Accepted** - G4S Medical Service Lead to pass up to date clinical information regarding medical guidance to Safer Custody for distribution

4. The Director should ensure that an emergency response code system is introduced and that a defibrillator is always taken to a code blue call.

National Offender Management Service responded with,

**Accepted** - The Code Red and Code Blue system has been introduced. The defibrillator is always taken to a code blue response.

5. The Director should ensure that an emergency bag containing a defibrillator is kept in the gymnasium and PE staff trained in its use.

National Offender Management Service responded with,

**Accepted** - New equipment has been ordered by HMP Birmingham to meet this recommendation. The emergency equipment ordered contains a defibrillator as part of the standard kit

6. The Director should make every effort to ensure that the news of a prisoner's death is given to the next of kin promptly and in person by someone from the prison. When this is impractical, staff from a nearby prison should be used and failing that, the police.

National Offender Management Service responded with,

**Accepted** - This will be subject to a public protection risk assessment (relating to victim issues). The prison will demonstrate that every effort is made to contact the family physically. This will be by way of a FLO from the establishment visiting the family. The prison also has a FLO database they can access. If the family live further away they can contact the nearest establishment to complete a home visit on their behalf.

### **To the Head of Healthcare**

7. The Head of Healthcare should ensure that staff request and obtain each newly arrived prisoner's community GP records.

National Offender Management Service responded with,

**Accepted** - There is now a system in place, where all records are requested from the prisoner's GP immediately upon receipt of the prisoner's consent form and subject to the prisoner having a registered GP. The consent and request form is scanned onto SystemOne to ensure the prison has the details of when the request was sent off to the GP.

A weekly secondary check is made by the Administration Manager of any records that have not yet been provided and contact is made with the prisoner's GP to ascertain the issue with the records being forwarded, again this is noted on SystemOne.

Details of any outstanding records will be provided to CGC for clinical advice on a way forward or to confirm no further action is needed.

8. The Head of Healthcare should ensure that where necessary any outstanding outpatient appointments that a newly arrived prisoner has are rescheduled, and consideration of this is documented.

National Offender Management Service responded with,

**Accepted** - Staff try to rebook outstanding appointments, at the earliest opportunity using the five allocated slots per day for external appointments, however, the numbers of appointments needed always outweigh the number of slots available and subsequently healthcare GP's advice on priority of appointments.

In this man's case the outstanding appointment was concerning a longstanding condition of back pain

9. The Head of Healthcare should undertake an audit of diclofenac prescribing to ensure its appropriate use.

National Offender Management Service responded with,

**Accepted** - The lead GP will undertake an audit of diclofenac prescribing to ensure its appropriate use for those inmates with severe heart failure.

However, it should be noted, that the contra-indications for use of diclofenac is in cases of severe heart failure, which was not the case for this man at the time of his appointment and assessment.

10. The Head of Healthcare should ensure that doctors balance their prison work with community practice to allow them to maintain and improve their skills including effective diagnosis of heart disease.

National Offender Management Service responded with,

**Not accepted** - All the GP's in the prison do two or more sessions a week outside of the prison, including the locum GP who was mentioned within the PPO report.

However, all GP's are provided via an agreed contract with Primecare, whose responsibility it is to ensure that those providing services to HMP Birmingham have both relevant experience and regular appraisal, the Head of Primary Care within HMP Birmingham, will regularly check (not less than 6 monthly) with Primecare that all GP's continue to undertake work outside of the prison and have an annual appraisal.

The investigator asked National Offender Management Service for clarification on the response received in regards to recommendation 10. They have not accepted the recommendation despite appearing that they are already doing what has been recommended. The response received was,

“although they [head of healthcare] will check with Primecare that the GP's working in the prison continue to undertake work outside of the prison, they (Birmingham) are not responsible for enforcing this as the management and deployment of the GP's at the prison is contracted out to Primecare”.