PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in March 2013 at hospital while in the custody of HMP Featherstone

Our Vision

‘To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision’

This is the investigation report into the death of a man, a prisoner at HMP Featherstone, who died in March 2013 at hospital. He was 29 years old. A post-mortem examination found that his death was caused by a bleed on his brain. I offer my condolences to his family and friends.

An investigation into the clinical care the man received at the prison was conducted. Featherstone and Birmingham prisons cooperated fully with the investigation.

The man had been in prison since September 2012 and had been held at a number of prisons before arriving at Featherstone on 1 February 2013 from Birmingham prison. In March he collapsed while exercising with another prisoner. He was taken to hospital and died the next day, after his life support machine was switched off.

On 4 January, when the man was at Birmingham prison, he had been accidentally hit on the head by his cell door when it was opened by an officer. His family was concerned that his brain haemorrhage could have been triggered by this incident. Although I am concerned that he was not examined by a member of healthcare staff at the time and monitored for possible concussion, the pathologist who conducted the post-mortem examination found that this injury did not contribute to his death.

The clinical reviewer concludes that the care the man received was of an equivalent standard to that he could have expected to receive in the community and I am satisfied that his sudden and unexpected death could not have been predicted or prevented by the prison. However, I am concerned that an ambulance was not called as quickly as it should have been when he collapsed and that restraints were used, albeit briefly, when he was at best barely conscious.

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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **February 2014**

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SUMMARY

1. The man died in March 2013 at hospital. He was 29 years old. He had been admitted to hospital the previous evening after he collapsed while exercising at HMP Featherstone.

2. The man had been in prison since 6 September 2012 and arrived at HMP Featherstone from HMP Birmingham on 1 February 2013. During his time in prison, he had been involved in two fights, had banged his head against the wall of his cell during a period of poor behaviour and, on 14 January 2013, had been hit on the head by a cell door when it was opened unexpectedly. He had refused to comply with his transfer to Featherstone and had transferred from Birmingham restrained and accompanied by four officers.

3. One evening in March, the man was exercising with another prisoner when he collapsed. A member of staff called for assistance and healthcare staff attended. An ambulance was not called until over ten minutes after he collapsed. Paramedics took him to hospital where he arrived at 8.20pm. He was escorted by two officers and restrained by an escort chain. The chain was removed at around 10.30pm at the request of a hospital doctor and was not reapplied. Tests confirmed that he had suffered a brain haemorrhage. Doctors advised the escort officers that he would remain on life support to enable his family to see him before he died. He died the next day. His family was with him at the time.

4. A post-mortem examination found that the man's death was caused by a subarachnoid haemorrhage (in which blood leaks from blood vessels over the surface of the brain).

5. The clinical reviewer considered that the standard of care given to the man was equivalent to that he could have expected to receive in the community. We make three recommendations about the treatment and recording of head injuries at Birmingham and the emergency response and the use of restraints at Featherstone.

THE INVESTIGATION PROCESS

6. The investigator issued notices at HMP Featherstone and HMP Birmingham, informing staff and prisoners of the investigation and asking anyone who had relevant information to contact him. No responses were received.

7. NHS England commissioned a clinical reviewer to assess the man's clinical care in prison.

8. The investigator visited Featherstone on 11 March and met the Governor and spoke to staff involved in the man's care. He also spoke to the man's cellmate. He obtained the man's relevant prison and medical records. He interviewed staff and prisoners at Featherstone and HMP Oakwood on 2 and 22 April. He gave initial feedback to the security manager at Featherstone, and followed this up in writing to Featherstone and Birmingham prisons. At the draft report stage, the National Offender Management Service (NOMS) responded to the recommendations. That response is included below the recommendations at the end of this report.

9. HM Coroner for South Staffordshire was informed of the investigation and provided the results of the toxicology and post-mortem reports in August 2013. Our investigation was suspended until the post-mortem and toxicology reports became available. The Coroner has been sent a copy of this investigation report.

10. One of the Ombudsman's family liaison officers contacted the man's family to explain the purpose of the investigation and invite them to raise matters they wished the investigation to consider. They were concerned about a head injury he had received at HMP Birmingham, whether this had had any impact on his death and whether he had received adequate treatment for this. His family asked whether he had made any complaints about his head injury. They wanted to know the sequence of events after his collapse and whether there were any delays to the emergency response. They received a copy of the draft report. The solicitor representing the family wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor

HMP BIRMINGHAM

11. HMP Birmingham is a large local prison serving the courts of Birmingham and the West Midlands run by G4S. It holds up to 1,450 adult male prisoners, on remand and sentenced. Healthcare is provided by NHS Birmingham and Solihull. The prison healthcare centre operates 24 hours a day.

HM Inspectorate of Prisons

12. The last published report on Birmingham by HM Inspectorate of Prisons followed an inspection in January 2012. Inspectors found that there was a good range of clinical services, although prisoners' views about the quality of health services were relatively poor. Inspectors noted that healthcare staff were well-qualified and primary care services were delivered professionally.

Independent Monitoring Board

13. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. In their latest published annual report for 2012, the IMB noted the difficulties experienced by the prison after its transfer to private sector management, including issues relating to staff morale. The IMB reported that there were fewer nursing shortages and that agency staff were usually familiar with the prison. The IMB confirmed that they had no direct dealings with the man while he was at the prison.

HMP FEATHERSTONE

14. Featherstone is a category C[1] adult male training prison near Wolverhampton. It holds up to 687 prisoners. Houseblock 5, where the man lived, is the induction unit for newly-arrived prisoners. Healthcare services are provided by Staffordshire and Stoke on Trent Partnership NHS Trust. There is no inpatient facility.

HM Inspectorate of Prisons

15. The latest published report on Featherstone by HM Inspectorate of Prisons (HMIP) followed an inspection in November 2011. The report found that the prison had made progress since the previous inspection in 2008. Healthcare services had improved. Almost all of the healthcare recommendations made by HMIP in 2008 had been achieved. The report of a more recent inspection in November 2013 has not yet been published.

Independent Monitoring Board

16. In their latest published annual report, for the year ending October 2012, the Independent Monitoring Board (IMB) noted that healthcare services had improved. They were particularly positive that medication was now dispensed

[1] Category C prisoners are those who are not judged ready for open conditions but who are unlikely to escape and do not require high security.

on each house unit, so that healthcare staff were able to familiarise themselves with prisoners and were better able to give advice.

17. The investigator spoke to a member of the IMB at Featherstone. The IMB member was positive about the prison and the professionalism of staff. The IMB had not had any contact with the man.

Previous deaths at Featherstone

18. The Ombudsman has investigated six deaths at Featherstone. None of the previous investigations raised any issues which are pertinent to the man's death.

KEY EVENTS

19. The man was remanded to prison by a Magistrates' Court on 6 September 2012. He arrived at HMP Birmingham the same day. This was not his first time in prison.

20. At a health screen later that day, it was noted there was a suicide warning note from the courts stating that the man made threats to harm himself. He assured a nurse that the comments were taken out of context, and the nurse recorded that he had no history of self-harm or attempted suicide. He then saw a prison doctor, who prescribed ibuprofen.

21. While he was at Birmingham, the man had several altercations with other prisoners. On 30 October, he was involved in a fight when it was recorded that he "came off worse" but did not want to press charges. A nurse noted that he had two cuts inside his mouth, but no loose teeth and no head injury. He said the cuts were due to a punch. He told a doctor that afternoon that he was unsure what had happened. He refused to move his jaw and flinched when touched on either side of his jaw or on any part of his head.

22. On 13 November, at Crown Court, the man was convicted of conspiracy to supply Class A drugs. He was sentenced to four years imprisonment on 23 November and went to HMP Hewell, at Redditch as Birmingham prison was full.

23. On 24 November, the man was constantly observed under suicide and self-harm prevention procedures after he flooded his cell and set fire to tissue paper. An entry in his prison record indicated that he started to bang his head and was crying and shaking.

24. On 27 November, the man returned to Birmingham prison after another court appearance. The suicide and self-harm monitoring ended the next day when it was assessed that he no longer posed a risk to himself. On 29 November, he threatened an officer and refused to go to court.

25. On 18 December, an officer spoke to the man, who agreed that his behaviour had been unacceptable. He said he intended to "keep his head down" and wanted a fresh start. He said that he was being given a chance at proving himself as an equalities representative and wanted to be seen by staff as a good prisoner.

26. On 27 December, the man transferred to HMP Oakwood, but came back to Birmingham prison again on 3 January 2013 after a further court appearance where he was sentenced to 23 weeks imprisonment for making threats to kill.

27. According to his medical records, the man was given 16 paracetamol tablets and 12 ibuprofen tablets on 2 January for back pain. Another suicide and self-harm monitoring plan was opened on 7 January after he told staff that he had taken an overdose of his medication. He was taken to hospital but later told

staff that he had taken only two paracetamol and said he had claimed to have taken an overdose to prevent a planned move to HMP Stafford.

28. At around 4.30pm on 14 January, the man was hit on the head when an officer opened his cell door when he was bending down near it. In a statement for the investigator, she said that she had gone to the cell to look for his cellmate. She did not see him when she looked through the observation panel and opened the door. She then saw him holding his head. He told her that she had hit him with the door. She said she had asked him twice if he was all right and he had said he was, although he was rubbing his head. She said she made an entry in the wing observation book about the incident and completed an accident report form.

29. The officer wrote in the observation book, "Had bump to head from cell door, stated he was alright". There was no entry in the man's prison record and there is no record of an accident report form. The investigator and the police both contacted the cellmate about the incident. He said that the man had vomited soon after the accident and had complained of having a headache for a few days.

30. A prisoner, who had been a cleaner on the wing, told the investigator that the officer did not look through the observation panel before opening the door. He said he had heard the door hit the man and his reaction. He said that the man's cellmate was in his cell at the time and that the officer had apologised. He said that he went to check on him to see how he was a few minutes after the incident. He said he had been sick in his sink and that he appeared a "bit woozy" for the rest of the day. He recalled that he of having a headache over the next few days but otherwise appeared fine.

31. According to the officer's statement, the man spoke to her on the afternoon of 16 January and said that his head was still sore but healthcare staff at the medication hatch would not give him pain relief. He told her that he had asked to see a nurse earlier, but no one had come to see him. In her statement, she said that she had agreed to ask a nurse to see him and that this had happened later that same day. However, there is nothing recorded in either his prison or medical records to indicate that a nurse saw him on 16 January or that he was given any pain relief medication that day. The suicide and self-harm monitoring plan was closed that day.

32. On 18 January, a nurse noted that she had seen the man at his request. She recorded that he had said that he had banged his head on the cell door and had subsequently had headaches on regular basis. She booked a GP appointment for him. Three days later, on 21 January, he saw a nurse, who recorded that he was not vomiting and did not have a headache. His blood pressure was recorded as normal.

33. A nurse saw the man on 25 January and noted that he had told her he had been having blackouts for a week after the accident. She could not see any signs of wounds or marks when she examined him. A doctor also saw him that day and noted that he had been dazed by the accident and had experienced

headaches, dizziness and a few episodes of vomiting. His Glasgow Coma Score[2] was 15 which indicated normal functioning. The doctor found no evidence of a serious head injury but diagnosed post-concussion syndrome[3] and prescribed strong pain relief. There were no other references to headaches or other related symptoms while he was at Birmingham.

34. Two days later, on 1 February, the man was due to be transferred to HMP Featherstone. A nurse recorded that, after refusing to transfer, he put a jumper around his neck and tried to pull it tight so he could not be taken from the holding cell. He was restrained and handcuffed. He was then taken out of the holding cell to a taxi accompanied by four officers. The nurse made the following entry in the medical record: "I escorted the process and no injury noted". According to statements from the escort staff at the start of the taxi journey, he was still quite irate and tried to attack staff. The officers held him down, but after around ten minutes he calmed down and was allowed to sit up. When he arrived at Featherstone, a nurse recorded that he had "redness to both wrists and chest wall that appear to concur with the correct control and restraint techniques being used".

35. On 21 February, the man saw a nurse, who recorded that the toe nail on his left foot had come off and was throbbing. The nurse issued 12 ibuprofen tablets for pain relief. This was the last occasion he saw healthcare staff before he collapsed in March. He did not mention the incident with the cell door at Birmingham.

36. When interviewed, the man's cellmate said that he thought that he was "pretty healthy". He recalled that he complained of having light migraines on a couple of occasions and was given ibuprofen by healthcare staff. They trained together in the cardiovascular (CV) room on Houseblock 5. He said they trained between two or three times a week with two rest days between sessions.

37. In her statement, an officer said that she had seen the man while she had been on duty on 4 March and they had spoken on a number of occasions. She said that he appeared to be in good health and did not complain of any physical pain.

March 2013

38. In his statement, a Senior Officer (SO) said that one afternoon in March, the man told him that that he had wanted to submit an application for enhanced prisoner status and wanted him to look at it. The SO said that they could

[2] The Glasgow Coma Scale (GCS) is a reliable, objective method to determine the conscious state of a patient. Three types of response are measured (eye, verbal and motor), and are added together to give an overall score. The lowest possible score is 3/15, which indicates deep coma or death.
[3] Post-concussion syndrome (PCS) describes a collection of symptoms that can persist after concussion. Symptoms usually resolve within two weeks but can last for several months and include nausea, headaches, dizziness, impaired concentration, memory problems, extreme tiredness, intolerance to light and noise, and can lead to anxiety and depression. There is no specific treatment but treatment of individual symptoms such as headaches or depression can be given.

discuss it on 10 March when he was next on the houseblock. In his statement, he said that he appeared fit and well at the time.

39. According to CCTV footage, at 6.00pm, the man collected his evening meal and returned to his cell at around 6.15pm. Soon after, Prisoner A entered the CV room. At around 6.30pm, the man also went into the CV room and started exercising with the prisoner. In his police statement, the prisoner said that at around 6.45pm, as they were reaching the end of a set of repetitions with a medicine ball, he stopped, bent over and looked as though he was about to lean against the wall when he missed it and fell over. He shouted for assistance and put him in the recovery position. Another prisoner who was in the CV room went to the spur office and told an officer, who immediately went to the CV room and radioed a code blue emergency (a code used to indicate an emergency where someone is having trouble breathing or is unconscious). The officer was soon joined by three officers, a senior officer and two nurses.

40. Prisoner B told the investigator that he usually trained with Prisoner A and the evening of the incident had been the first time they had been joined by the man. He said that the man was exercising on the spot, doing curls with a medicine ball when he collapsed. The prisoner said that he had reached out to steady himself when he fell to his left into the wall. He said that he then went to inform staff that the man had collapsed. Prisoner A declined to be interviewed. There was no CCTV coverage of the exercise room.

41. In her statement, an officer wrote that when she arrived at the CV room she saw two officers trying to get a response from the man. He did not respond, although he was breathing. Nurse A told the investigator that, when she arrived, there were several officers around him. He was lying on his back and was breathing. She said he was conscious throughout, but his Glasgow Coma Scale score was 7 (which was low).

42. Nurse A made an initial assessment. As the man's condition was consistent with a post-seizure state and as his basic observations were stable, she went to collect the emergency bag and to review his medical record in case he had a history of epilepsy. She did not request an ambulance at that point as she wanted to assess whether there were any obvious causes for his collapse. When she returned and found no improvement in his condition, she asked for an ambulance to be called. A custodial manager contacted the communications room to request that an ambulance be called. She estimated it took a couple of minutes for her to reach him, a couple of minutes to make the initial assessment and about five minutes to check the record and return to him with the emergency bag. This is consistent with the communications log of 11 minutes between the first emergency call and request for the ambulance being made.

43. In her statement, Nurse B wrote that when she arrived at the CV room, Nurse A told her that the man had "fixed pin point pupils" and was not responding to her verbally. Nurse B checked his blood pressure, which was a little high. The nurse moved him into the recovery position and Nurse B noticed he was

trembling when she rested her hand on his shoulder. He made several retching sounds.

44. The prison records indicate that an ambulance was called at around 6.59pm and paramedics arrived at the prison at 7.14pm. According to the records from the Ambulance Service, the emergency call was received at around 7.00pm and the ambulance arrived at the prison at 7.12pm. The ambulance staff took over the man's care at around 7.25pm. They assessed him and decided to take him to hospital. The ambulance left the prison at around 7.50pm and arrived at the hospital at around 8.20pm.

45. When the man went to hospital an initial risk assessment concluded that he was a low risk of escape and medium risk to the public and harm to the public (the risk assessment form has three levels of risk: low/medium/high). The medical entry section was scored through, and "medical N/A emergency" written across the form. It was decided that he should be restrained by an escort chain and two officers were to remain with him. At 9.00pm, the restraints were removed while he was taken for a CT scan and they were then reapplied. At 10.30pm, the risk assessment was reviewed by the duty governor after a hospital doctor had asked that the restraints should be removed. He agreed that the restraints could be removed and they were not used again.

46. At around 11.00pm the man was taken for another CT scan, which showed he had suffered a brain haemorrhage. The escorting officers were informed that he would move to the Intensive Care Unit and remain sedated overnight before bringing him round to see if he responded to treatment. The prison was unable to contact his parents by telephone that evening to let them know what had happened, but left a message for them to contact the duty governor.

47. At around 6.00am the next morning, the escort officers were told that the man's condition was terminal and that he was only being kept alive by a ventilator. The hospital staff said that this would not be switched off until his family had arrived. In the morning an operational manager spoke to the man's parents (who were abroad) and told them about his admission to hospital. They said that they would return as quickly as possible and arrived at the hospital at 4.30pm.

48. A hospital doctor certified that the man was dead at 5.44pm. His parents were with him when he died.

49. After the man's death, officers from Staffordshire Police visited Featherstone as they are required to do for all deaths in custody. They found no suspicious circumstances.

50. Featherstone appointed a family liaison officer and he maintained contact with the man's family. In line with national guidance, Featherstone offered financial assistance towards the costs of the funeral, which took place on 12 April. The family liaison officer arranged for his family to visit the prison and for the man's belongings to be returned to them.

51. Officers told other prisoners on the houseblock during the morning of 7 March that the man had died and asked whether they required any additional support or wanted to speak to a Listener (prisoners trained by the Samaritans to offer confidential emotional support to other prisoners in distress). Prisoners being monitored as at risk of suicide and self-harm were reviewed in case they had been affected by his death.

52. After a death, prison managers must hold a "hot debrief" for all the staff involved in a traumatic incident. A debrief was held later that day. No specific issues were identified and the staff were offered the support of the prison's care team.

Post-mortem report

53. The cause of death was recorded as being due to subarachnoid haemorrhage. This is bleeding that arises below a thin covering layer of the brain (the arachnoid) which occurs following injury to one of the major blood vessels supplying the brain. Subarachnoid haemorrhages are mainly caused by defects or weaknesses in the blood circulation system.

54. A specialist in neuropathology examined the man's brain but could not identify the precise source of the bleeding. He excluded a "traumatic cause" of the injury based on the timings of the incident and the description of the events surrounding collapse. The pathologist agreed and suggested that he might have had an underlying connective tissue disorder.

ISSUES

Medical care

55. The clinical reviewer made a number of recommendations in his review. We do not repeat all of these in this report, but the Head of Healthcare at Featherstone will need to consider them.

56. The man's family asked questions about his medical care at Birmingham after the injury to his head when he was hit by the cell door on 14 January. Staff and prisoners have all reported that he did not lose consciousness after the accident but he was said to have vomited and complained of headaches. The officer said that she had arranged for a nurse to see him on 16 January, but there is no record that he saw a member of healthcare staff until four days after the incident, on 18 January.

57. The National Institute of Health and Clinical Excellence (NICE) has published guidelines[4] on the assessment of head injuries. They define a head injury as any trauma to the head, other than superficial injuries to the face. The guidelines recommend the use of the Glasgow Coma Scale in all communication and notes, using the three elements of eye response, verbal response and motor response. The guidelines outline the criteria in which a referral for a CT scan should be made and criteria for hospital admission.

58. When the man was assessed on 18 January, he did not meet the criteria for CT scanning or admission to hospital. His headaches were not persistent or severe. He did not mention the potentially significant symptom of vomiting to the nurses on 18 January or 21 January. On 25 January, he told the GP that he had vomited a few times after the incident, but that this had settled by then. The GP recorded that his Glasgow Coma Scale was 15 and neurological examination was normal.

59. NHS Choices defines Mild Traumatic Brain Injury, or concussion, as 'the sudden but short-lived loss of mental function that occurs after a blow or other injury to the head". It recommends that symptoms are monitored for 48 hours following a head injury.

60. The clinical reviewer finds that the management of the man's head injury was appropriate once he had presented himself to healthcare staff, in line with current guidelines and equivalent to care he would have received in the community. We would also stress that the pathologist has concluded that his fatal brain haemorrhage was not caused by a traumatic event (such as the cell door hitting his head). However, we are concerned that there is no record of an accident report form being completed, and that he was not assessed by a member of healthcare staff at Birmingham until four days after he sustained the injury. Head injuries should always be taken seriously, and appropriate

[4] National Institute of Health and Clinical Excellence (NICE) guidelines: Triage, assessment, investigation and early management of head injury in infants, children and adults. 2007.

medical intervention sought. We make the following recommendation to Birmingham:

The Director and Head of Healthcare at HMP Birmingham should ensure that prisoners with head injuries are assessed promptly by a clinician and that staff submit accident reports in all cases where the injury is the result of an accident.

Connective tissue disorders

61. The clinical reviewer states that connective tissue is a complex mixture of proteins and other substances that provide strength and elasticity to the underlying structures in the body. Connective tissue disorders such as Marfan's syndrome and Ehlers Danlos syndrome are rare inherited disorders that disrupt connective tissue. People with Marfan's syndrome are typically tall with long limbs and high arched palate, and have a number of other skeletal abnormalities such as flat feet or curved spine. In Ehlers Danlos syndrome, people typically have flexible joints and stretchy fragile skin. However symptoms and signs are variable and these features also occur in people without connective tissue disorders. Both syndromes can predispose to arterial dissection and rupture. Diagnosis is complex and looks at the combination of clinical features, family history and genetic testing.

62. Although the pathologist noted some physical signs that could suggest a connective tissue disorder – the man had disproportionately long limbs and a high arched palate – other skeletal or skin abnormalities were not present. There is no previous medical history in the GP or prison medical records that, even in retrospect, would suggest a connective tissue disorder. The clinical reviewer could not see any evidence in the records that indicated that healthcare staff should have been alerted to the possibility of an underlying connective tissue disorder. We are satisfied that his death could not therefore have been predicted or prevented.

The emergency response

63. The man's family asked about the emergency response after his collapse on 5 March. When Nurse A attended the emergency she said that she had asked whether an ambulance had been called but was told that it had not. Both Nurse A and the healthcare manager told the investigator that the local protocol for calling an ambulance is that it should be called at the time the emergency call is put out and only 'stood down' after assessment by a nurse. This did not happen and the nurse assessed him before one was requested. She did not ask for an ambulance to be called immediately as she thought he had a seizure and his basic observations were stable. She looked at his records to clarify if there was an underlying reason for his collapse and but there was not. As his condition had not improved, she then requested an ambulance.

64. The local instruction at Featherstone in operation at the time of the man's death, states that "if a member of staff finds a prisoner in a life threatening situation, it is their responsibility to contact the prison control room to request

an ambulance and, if on site, Healthcare". They should not wait for healthcare staff before summoning an ambulance as this can be cancelled if not required. Although the officer who responded to his collapse asked for medical assistance, he did not request an ambulance be called.

65. Prison Service Instruction (PSI) 03/2013 (Medical Emergency Response Codes), which came into effect on 28 February 2013 just before the man's death, required all prisons to have a Medical Emergency Response Code protocol based on the instruction which gives instructions to staff about communicating the nature of a medical emergency and ensuring there are no delays in calling ambulances. Paragraph 5.4 requires the following mandatory action to be taken:

> *"when the emergency is called over the radio network an ambulance must be called immediately."*

The PSI is clear that "the Communication/Control room automatically calls an ambulance and awaits updates from the scene" as soon as an emergency code is called. As noted above, the local instructions in place when he collapsed were not consistent with the requirements of the PSI 03/2013 as they should have been.

66. This local guidance was replaced on 15 March 2013, and is now aligned with the PSI. The new instruction (NTS 049-2013) states that "when a Code Red or Code Blue is called, the Control Room MUST call an ambulance as part of their contingency plans. The ambulance must be called immediately and must not be left until the arrival of Healthcare staff on the scene to request it". Had this instruction been in place at the time of his death and been followed, there would not have been a delay of over ten minutes before an ambulance was called. The clinical reviewer does not consider that the short delay in bringing emergency equipment and the delay in calling an ambulance would have had any effect in the final outcome for him and judges that in other respects the emergency response was satisfactory. We recognise that the prison has now issued new guidance about emergencies but in order to ensure that the importance of the new instructions is underpinned, we make the following recommendation:

The Governor of Featherstone should ensure that all staff working in the prison are made aware of and understand PSI 03/2013 and NTS 049-2013 and their responsibilities during medical emergencies including efficiently communicating the nature of an emergency, bringing relevant emergency equipment and that an ambulance is called automatically as soon as an emergency code is called.

Restraints

67. The Prison Service has a duty to protect the public when escorting prisoners to hospital, and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the

risk of escape, the risk to the public and which also takes into account factors such as the prisoner's health and mobility.

68. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that medical opinion regarding the prisoner's ability to escape must be considered as part of the assessment process. It deemed that restraining by handcuffs of a prisoner receiving chemotherapy (and by implication, other life saving treatment) was degrading and that such restraint would be likely also to be regarded as inhumane unless justified by other relevant considerations.

69. When the man was found, Nurse A recorded a Glasgow Coma Scale score of 7. A score of 3-8 is indicative of a serious brain injury. We recognise that in most cases in an emergency it will not be possible for a full medical assessment to be completed and it is preferable to get the prisoner to hospital quickly and review the risk assessment later if necessary. However, in this case the information was available but does not appear to have been taken into account in the risk assessment. He was rated as being a medium risk to the public on the basis of his offence, a low risk of hostage taking and a low risk of escape. As he was unconscious at the time and not capable of offending, it is difficult to see how the use of restraints was justified. The assessment was changed two hours after he arrived at the hospital and restraints removed, which we agree was the humane thing to do, However, we note that this was at the request of a hospital doctor rather than a review by the prison after his admission. We make the following recommendation:

The Governor should ensure that risk assessments for escorts to hospital fully take into account the medical condition of the prisoner, are based on the actual risk the prisoner represents at the time and are reviewed promptly after an emergency admission.

RECOMMENDATIONS

1. The Director and Head of Healthcare at HMP Birmingham should ensure that prisoners with head injuries are assessed promptly by a clinician and that staff submit accident reports in all cases where the injury is the result of an accident.

2. The Governor of Featherstone should ensure that all staff working in the prison are made aware of and understand PSI 03/2013 and NTS 049-2013 and their responsibilities during medical emergencies including efficiently communicating the nature of an emergency, bringing relevant emergency equipment and that an ambulance is called automatically as soon as an emergency code is called.

3. The Governor should ensure that risk assessments for escorts to hospital fully take into account the medical condition of the prisoner, are based on the actual risk the prisoner represents at the time and are reviewed promptly after an emergency admission.

ACTION PLAN: HMP Featherstone

No	Recommendation	Accepted/ Not accepted	Response	Target date for completion and Function Responsible
1	The Director and Head of Healthcare at HMP Birmingham should ensure that prisoners with head injuries are assessed promptly by a clinician and that staff submit accident reports in all cases where the injury is the result of an accident.	Accepted	Full training has been given to all senior primary care nursing staff, of which there is always one on duty, in the assessment and management of head injury, including submission of an accident report. It is clear that if there is any doubt about the injury observation on ward one or transfer to an external hospital is indicated.	Completed Head of Healthcare
2	The Governor of Featherstone should ensure that all staff working in the prison are made aware of and understand PSI 03/2013 and NTS 049-2013 and their responsibilities during medical emergencies including efficiently communicating the nature of an emergency, bringing relevant emergency equipment and that an ambulance is called automatically as soon as an emergency code is called.	Accepted	The Security manager has re-issued the previous Notice to Staff 49/13 as a Governors Operational order to ensure all staff are aware and understand their responsibilities during medical emergencies. The Security manager has also spoken to the control room staff to ensure they are fully aware of their responsibilities with regard to calling an ambulance automatically, as soon as an emergency code is called. There is also a large notice in the control room, visible for all control room staff, explaining this.	Completed Security Manager
3	The Governor should ensure that risk assessments for escorts to hospital fully take into account the medical condition of the prisoner, are based on the actual risk the prisoner represents at the time and are reviewed promptly after an emergency admission.	Accepted	The risk assessments for all emergency escorts are now based on a dynamic assessment that includes any advice from the healthcare professionals at the scene (ambulance staff or the prison's medical staff). All operational managers have been briefed about this issue via the morning briefings.	Completed Security Manager