PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the circumstances surrounding the death of a man in November 2011, at outside hospital, while in the custody of HMP Birmingham

Report by the Prisons and Probation Ombudsman for England and Wales

May 2012

Ashley House, 2 Monck Street, London SW1P 2BQ Tel: 020 7035 2876 Fax: 020 7035 2012
E-mail: mail@ppo.gsi.gov.uk www.ppo.gov.uk

This is the investigation report into the death of a man who was in the care of HMP Birmingham when he died of natural causes in November 2011. He was 73 years old. A post mortem report concludes that he died from pneumonia (a serious lung infection). I offer my condolences to the man's friends and family.

The investigation was carried out by one of my investigators with the cooperation of Birmingham prison.

The Heart of Birmingham Primary Care Trust (PCT) appointed a clinical reviewer to review the man's clinical care and I am grateful for that clinical review which is essential to my conclusions.

The man arrived at HMP Birmingham in poor health, although he was at first able to be cared for in the prison. He became increasingly unwell and needed to visit hospital on a number of occasions. The clinical reviewer indicates that although the man was seen regularly by healthcare staff the prison did not have a system for formal structured reviews to monitor the treatment of those with chronic conditions in line with current best NHS practice. Recommendations are made about this as well as the need for more responsive family liaison, and fully informed risk assessments for those subject to restraints.

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 **May 2012**

CONTENTS

SUMMARY

1. The man appeared at a Crown court on 20 January 2011, when he was sentenced to four years imprisonment (with an extended four year licence period) and sent to HMP Birmingham. On arrival, he had a first reception healthscreen with a nurse and disclosed a number of medical conditions, including diabetes and chronic obstructive pulmonary disease (COPD - a term used for a number of conditions; including chronic bronchitis and emphysema). He also said he had hearing problems and was registered blind.

2. He initially lived on a prison wing reserved for prisoners regarded as vulnerable usually because of the nature of their offence but, following staff concerns about the man's ability to cope, he was moved to the healthcare centre. He remained there for several weeks before being well enough to return to his wing. He remained relatively stable, until 14 July when his health deteriorated and he was readmitted to healthcare for a few weeks. He returned again to his wing but, after a few minor falls and increasing concern by wing staff, he was readmitted to the prison healthcare centre on 10 August and subsequently admitted to outside hospital the following day.

3. During his hospital admittance the man was diagnosed with cor pulmonale (enlargement of the right side of the heart caused by increased blood pressure in the lungs). He was discharged back to the prison on 16 August where he remained until a further admittance to outside hospital on 27 August, when his health again deteriorated. Following cardiac monitoring and

an improvement in his condition, he returned to the in-patient unit of Birmingham prison healthcare centre on 31 August.

4. Over the next few months, the man became frailer, suffered from some incontinence and had mobility difficulties. On 28 October, his condition worsened again and he was re-admitted to outside hospital. Initially he was stabilised and plans were made for his discharge back to the prison but, on a day in November, the oxygen levels in his body declined and his condition deteriorated. He died at 12.15am the following day.

5. The prison did not appoint a family liaison officer (FLO), until two days after the man's death as its only trained FLO did not work at weekends. There was no contingency plan to ensure immediate contact was made with his family. Once appointed, the FLO had difficulty making contact with his family, although once established, support was provided in line with Prison Service guidance.

THE INVESTIGATION PROCESS

6. The investigation was opened on 14 November 2011, when an Assistant Ombudsman visited HMP Birmingham and arranged for all the relevant documents about the man to be sent to the investigator. He met the head of healthcare, head of safer custody, the prison's family liaison officer and visited the prison's healthcare centre. In advance of this visit, notices were issued announcing the investigation to staff and prisoners. No staff or prisoners came forward in response.

7. The investigator was not able to visit Birmingham until 6 January to interview staff, due to holidays and difficulties in arranging a specific day for interviews. During this visit she interviewed five members of staff. She met the Director of the prison immediately after her interviews and updated him about the investigation. Written initial feedback was sent to the Director on 16 January 2012.

8. In the written feedback to the Director, the investigator requested verification of the time the request was made for an ambulance on 28 October. Despite further requests made via the liaison officer, and an e-mail sent directly by the investigator to the Head of Security and Operations Manager on 25 January, no response was received from Birmingham. Therefore, the investigator contacted West Midlands Ambulance Service who were able to provide written verification of the contact they had with the prison.

9. Heart of Birmingham Primary Care Trust (PCT) asked a clinical reviewer to review the man's clinical care on their behalf. He was provided with all relevant documentation to assist this review.

10. The investigator contacted Her Majesty's Coroner for Birmingham to inform him of the nature and scope of the investigation and request a copy of the post mortem report. The completed investigation report will be sent to the Coroner to assist his enquiries.

11. One of the office's family liaison officers contacted the man's sister on 6 December 2011 to inform her about the investigation and to allow the family to ask questions or raise concerns about their relative's care at Birmingham. His family raised the following issues:

- What date was their relative admitted to hospital and for what reason?

- Why were they not told until the day before his death that their relative had been admitted to hospital?

- Why was there a lack of family support from the prison? The man's sister commented that she did not hear from the prison until after her return home from Birmingham following her brother's death, and met prison staff for the first time on the day of the funeral.

- The man told his family that he was always cold while in prison. Was it ever recorded that he mentioned this to staff?

12. The investigator has sought to address the issues raised by the man's family in the report. His sister received a copy of the draft report as part of the consultation process. Having considered the investigation findings she commented that the care her brother received was wholly insufficient as a blind person of an elderly age. She added that her brother should not have been placed in a prison setting. She explained he would have been unfamiliar with his surroundings and therefore his care should have been more appropriately and better managed. In addition, she remained unhappy with the time taken by the prison in making contact to inform her of her brother's illness. The sentencing of the man to imprisonment is not a matter for the investigation. However, the concern regarding the contact with the man's family following his admittance to hospital has been addressed and resulted in a recommendation.

HMP BIRMINGHAM

13. HMP Birmingham is a large local prison serving the courts of Birmingham and much of the West Midlands. It holds up to 1,450 adult male prisoners, both on remand and sentenced. The prison has undergone significant improvement over the last few years, including the building of a new healthcare centre. Birmingham is the first public sector prison to be transferred to the private sector. G4S assumed responsibility for Birmingham on 1 October 2011 and will manage the contract for the next 15 years.

Person Escort Record (PER)

14. This is a form that accompanies prisoners on all journeys from and between prisons, police and hospital. It serves as a communication tool about risks a prisoner poses on escort or transfer. It also provides a chronological record of the escort, e.g. meals served, times journey started etc.

Escort risk assessments/restraints

15. On each occasion when a prisoner is escorted outside the prison to hospital, a risk assessment considers the risk to the public, potential for escape and likelihood of outside assistance. The assessment informs the decision about the number of escorting officers and the type of restraint to be used (single cuffs or two metre long escort (closet) chain with a cuff at either end). It also determines the circumstances and the authority required for the restraints to

be removed. The risk assessment is reviewed by prison managers each day that a prisoner is in hospital and amended where necessary.

Categorisation

16. Prisoners are risk assessed when they come into prison and given a category based on their offence and the risk that they pose to the public should they escape. There are four levels of category: A, B, C and D, with category A prisoners being the most dangerous. This man was a category C prisoner, which are prisoners who cannot be trusted in open conditions, but who do not have the resources and will to make a determined escape attempt.

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board (IMB) whose members are appointed by the Secretary of State for Justice from members of the community. Their role is to satisfy themselves that the prisoners are treated humanely and justly and that there are adequate programmes for preparing prisoners for release. In their 2011 annual report the IMB noted that members had observed healthcare staff providing a good level of care to prisoners and that the in-patient facilities had been refurbished.

HM Inspectorate of Prisons

18. HM Chief Inspector of Prisons' last published report related to an unannounced full follow-up inspection of the prison in December 2009. The Chief Inspector noted that:

> " … there was still a considerable amount to do to ensure a safe, decent and effective prison. Relationships between staff and prisoners were found to be a considerable weakness… Inspectors found that healthcare provision at the prison was mostly satisfactory. It was largely delivered from a modern, purpose-built unit by three distinct groups of staff working in primary care, in-patient care and visiting specialists. Relationships between healthcare staff and prisoners were identified as good, particularly on the in-patient wards. All the in-patients had a care plan and a named nurse and officer."

Previous deaths in custody at Birmingham

19. There has been one other death at Birmingham in the previous year. The investigator reviewed the Ombudsman's report into this death and she found no issues in common between the two deaths. There have been two subsequent deaths at the prison since that of this man. His death was the 36th death to have occurred at Birmingham since April 2004 when the office began investigating all deaths in prison custody in England and Wales. Twenty of the previous deaths were due to natural causes; there has been one murder, one drug overdose and the remainder were self-inflicted

KEY EVENTS

20. The man was born in September 1938. Prior to coming into custody, he lived in the Erdington area of Birmingham. He was retired, having been employed as an HGV driver, but had not worked since 1999. Following his arrest, he appeared at a magistrates' court on 19 March 2010 for serious sexual offences, was remanded in custody and taken to HMP Birmingham. He was granted conditional bail and released on 14 April 2010, however, following a breach of bail conditions, he was sent back to Birmingham on 23 November 2010.

21. On arrival at Birmingham on 23 November, the man had an initial healthscreen where he disclosed to a nurse that he was registered blind, was Type 2 diabetic (which results from insulin resistance and occurs mainly in people aged over 40 and is often managed by diet, weight control and physical activity). He had been diagnosed with chronic obstructive pulmonary disease (COPD is a term used for a number of conditions; including chronic bronchitis and emphysema. COPD leads to damaged airways in the lungs, causing them to become narrower and making it harder for air to get in and out of the lungs.) Despite this, he continued to smoke. He had some mobility difficulties, so was located where he did not need to use the stairs, and was referred to the prison GP due to the complexity of his health issues.

22. The man's blood pressure was not recorded during this assessment but was noted on 2 December by a prison doctor as 104/64 (the normal range for blood pressure is 100/70 to 140/90, although the pressure varies throughout

the day depending on the individual's activities. A blood pressure reading of greater than 140/90 is classed as high and a reading of 90/60 or below is classed as low). The man reported that he felt well, although had breathing difficulties and he was encouraged to stop smoking. His medication upon reception was recorded as:

- Salmeterol (also known as sretide, for asthma and COPD)
- Salbutamol (for asthma and COPD)
- Furosemide (a diuretic for those with heart failure)
- Perindopril (for blood pressure)
- Tiotropium (used for management of COPD)
- Spironolactone (a diuretic – diuretics are used to treat heart failure and promote excretion of fluid from the body)
- Simvastatin (to help reduce cholesterol)
- Omeprazole (reduces acid in the stomach)
- Digoxin (for heart failure, digoxin strengthens the force of the heartbeat)
- Citalopram (for depression) – the reason this was prescribed was not established and its continuation not reviewed.
- Aspirin (to reduce the risk of a stroke)
- Metolazone (a diuretic)
- Metformin (for diabetes)
- Glimepride (for diabetes)

23. After spending his first night on the induction wing the man went to P wing on 24 November. On 14 December, a nurse observed that he was quite breathless, although he did not complain of feeling unwell. The nurse referred him to the Disability Liaison Officer (DLO) for further assessment. Following

this assessment on 24 December, he was referred for a full nurse review and was seen the next day by a nurse. His blood pressure was normal (110/73), and the nurse recorded that he appeared breathless and that his medications should be brought to his cell by staff, to ensure he was reviewed each day and she referred him to the prison doctor. The man disclosed to the nurse that the young prisoner sharing his cell kept moving his belongings which caused him difficulty because of his poor sight. As a result his cell mate was moved to another cell.

24. On 28 December, a nurse recorded that the man was much happier since his cell mate had been moved although observed that his breathing was laboured. (Wing staff and other prisoners had raised concerns that the man was not coping and rarely left his cell.) The same day a prison doctor reviewed his medication and later he was examined by a nurse. Despite the man's frailty, as he was supported by staff and other prisoners it was collectively agreed that he would remain on the wing. He was referred to the prison doctor for a routine check.

25. The next day a nurse recorded that the man's blood pressure was high (128/105), but that he was alert and steady on his feet. The following day, he failed to attend a GP appointment and after assessment by nursing staff on the wing he was moved to the inpatient unit in the healthcare centre after staff on P wing expressed concern about his ability to care for himself properly. He was experiencing bouts of incontinence and was observed to be short of breath. He was examined by a prison doctor on 31 December and diagnosed with hypotension (low blood pressure) and COPD. He was prescribed

antibiotics for a chest infection and vitamin drinks. Blood tests were all normal, although his blood glucose was raised.

26. Over the next six weeks the man remained in the healthcare centre. He was regularly checked and assisted with his daily living, personal hygiene and encouraged to associate with other prisoners.

27. The man appeared at a Crown court on 20 January, when he was sentenced to four years in prison with four years on licence. Following his return to Birmingham prison, he was assessed by healthcare staff and no concerns were raised about his mental health. His physical health improved and on 15 February 2011, he was assessed as fit enough to return to his wing and he moved to a shared cell on 25 February. Care plans, shared with healthcare staff for P wing, were formulated to manage his diabetes, pulse rate and impaired sight. Over the following months the man was regularly reviewed and staff reported that he was managing well on the wing with few problems.

28. On 30 June, the man was examined by a prison doctor and told him that he was not able to lie flat, was retaining water and had swollen ankles. His diuretic medication was varied and blood tests were requested. On 7 July, a further prison doctor reviewed the man who reported that his breathing was still problematic but that he was more stable. The doctor advised him that his symptoms were as a result of heart failure and COPD and encouraged him to stop smoking.

29. A week later on 14 July, following concerns from P wing staff a nurse examined him in his cell and observed that he was short of breath and that his feet were very swollen. He was admitted to the in-patient unit in the healthcare centre the same day due to his deteriorating physical health. He was examined by a prison doctor. His blood pressure was recorded as a little high (133/92) and he was prescribed antibiotics for a chest infection. The next day, he was examined by a nurse who noted that his stomach was distended. Later the same day, he was reviewed by a prison doctor who noted that he was settled and that his breathing was stable.

30. On 16 July, the man's blood pressure was recorded at 2.54pm by a nurse as low (97/67) and the nurse referred him to see the doctor the following day. There is no record that the man saw the doctor on 17 July, although he was regularly monitored by healthcare staff. The next day the same nurse recorded at 10.23am that the man's blood pressure was a little high (123/91) and he had a raised pulse of 98bpm. She noted that his ankles were still swollen, but his slippers were not as tight as they had been which suggested that the swelling had reduced.

31. Over the next few days, the man continued to be regularly monitored. On 26 July, he was reviewed by a prison doctor and, due to his improved condition, he was assessed as fit for return to the wing. He attended an appointment at outside hospital on 28 July for an ultrasound scan on his abdomen to check that a previous operation to repair an abdominal aortic aneurysm (a swelling in the main artery due to a weakening of the wall) was in good condition. He

was observed overnight in healthcare and returned to P wing the following day.

32. A vascular multi-disciplinary team meeting (MDT - where all those involved in decision making regarding treatment attend) was held on 2 August. The man was referred for a CT scan (computerised tomography – computer equipment is used to take pictures of the body) as the ultra sound scan undertaken on 28 July was inconclusive and they wanted to establish if the stent (an artificial repair) fitted for his aneurysm was still working. This CT scan was subsequently completed but there is no record in the prison medical record when this was undertaken.

33. On 10 August, the man was assessed on the wing by a nurse. His blood pressure was recorded as a little low (101/68) with a normal pulse of 72bpm. The man complained of feeling dizzy. In addition, his cell mate told the nurse that the man had fallen recently and was incontinent. The nurse gave the man glucose as he had low blood sugar levels and arranged for him to be admitted as an inpatient to the healthcare centre where he had a formal assessment to see how he could cope with routine tasks to look after himself. This assessment established that he needed assistance with hygiene and being made comfortable in bed. A prison doctor examined him and his blood pressure was noted as low (97/74). It was also noted that he experienced shortness of breath and had swollen legs. The doctor requested an ECG (an electrocardiogram which measures the electrical activity of the heart to help with diagnosis) for the following day.

34. A prison doctor examined the man the next day and diagnosed that, due to heart failure, there had been a general decline in his health. He was short of breath, had swollen ankles, could not walk well and was doubly incontinent. The doctor concluded that the man was too unwell to be managed in the prison healthcare centre and arranged for him to be taken to outside hospital, where he was admitted to the medical assessment unit (MAU). A risk assessment was completed that authorised a two officer escort and the use of restraints to be removed for emergency treatment purposes only, with the duty manager's approval.

35. Over the next few days, the man remained in the MAU. He suffered bouts of diarrhoea but ate and drank normally. He was diagnosed with cor pulmonale (an enlargement of the right side of the heart caused by increased blood pressure in the lungs) as a result of COPD. On 15 August, an ECG showed that there was right sided bundle branch block (BBB – when transmission of electrical impulses to the heart are delayed) and a chest x-ray was requested. A meeting attended by the ward manager, clinical lead, primary care manager and a staff nurse discussed the man's case the same day to ensure that he was appropriately supported on his return to Birmingham prison.

36. The man returned to the prison healthcare centre on 16 August where his medication was revised. He was assessed by a physiotherapist and encouraged to ask staff for help to get about. Over the next few days his condition remained stable, his blood pressure and blood sugar were regularly monitored and he ate and drank normally.

37. A further multi-disciplinary meeting of prison healthcare staff took place on 22 August. It was agreed that the man no longer needed to have his blood sugar monitored daily, but needed ongoing help with daily living activities. It was also decided that he was to remain in the healthcare centre due to the diagnosis of multi organ failure. The man's diabetic tests were within normal range. However, there is no evidence that his medication or diet was considered, as part of a structured chronic illness review.

38. The prison movement record states that the man attended an outside hospital appointment on 23 August. His medical records do not indicate the purpose of this appointment but there is a record that he left the prison at 11.17am and returned at 12.56pm.

39. On 25 August, the man fell when he was trying to go to the toilet during the night. Officers assisted him back into bed and recorded that there were no injuries. The next day at 4.10am, a nurse found him sitting on the floor. The cell was unlocked and he was assisted back to bed. He had no injuries but appeared confused. A prison doctor examined him later that morning and a nurse created a care plan to prevent future falls. A further nurse found the man at 9.40pm standing by his toilet. He had suffered a significant bout of faecal incontinence. A response team in protective clothing attended, opened his cell and assisted him in cleaning himself and they put him back to bed. He was regularly checked throughout the remainder of the night.

40. The next day on 27 August, the man was examined by the in-patient ward manager. His blood pressure was recorded as low (94/68) at 9.50am but this

had increased to a normal level (104/73) by 11.25am. Healthcare staff were concerned about his deteriorating health and asked a prison governor if the man's cell could be left unlocked, during the day and night, to ensure staff were able to assist him quickly if necessary. The governor decided that the risk was too great at that time, but they should discuss it again following an assessment by the doctor. During interview, the in-patient ward manager told the investigator that she was satisfied that healthcare staff were given quick access to the man when necessary during the night, and that this decision did not compromise his health or safety and was not therefore followed up.

41. The man's condition deteriorated during the day. His blood pressure remained low, he had another bout of faecal incontinence and he was again admitted to outside hospital. A nurse was told by the hospital that the man's blood sugar level was erratic and showed signs of kidney failure. However, she was told that he had no further episodes of diarrhoea and further tests were being completed.

42. The same nurse visited the man in the MAU at outside hospital on 29 August, where he remained subject to cardiac monitoring. His blood pressure had improved and his oxygen level was stable. A vascular MDT meeting held on 30 August confirmed that a CT scan showed that the stent was working fine and that he should be reviewed in 12 months.

43. The man gradually improved. He returned to Birmingham prison on 31 August, and reviewed by a prison doctor on 1 September. His medication was amended following discharge from outside hospital and he was regularly

monitored by nursing staff. The in-patient ward manager noted that the man was being treated for Methicillin-Resistant Staphylococcus Aureus (MRSA - a species of bacterium commonly found on the skin) which was located in his nasal area. Staff ensured the appropriate protective equipment was used to prevent the infection spreading to staff and other prisoners.

44. Over the next few days, the man remained stable, but continued to have bouts of incontinence and needed regular assistance from staff. On 4 September, a nurse completed a falls risk assessment tool (FRAT) and identified that he would need occupational therapy and physiotherapy and that he should be referred to the falls clinic. His blood pressure remained low but his condition was stable. A prison doctor said the swelling on his legs had reduced significantly.

45. The man remained in the healthcare centre. His blood pressure remained low and he was assisted daily by staff with his personal hygiene, mobilisation and encouraged to request help when necessary. On 12 September, a nurse recorded that the man “fell gently” in his cell during the night while staff were observing him. His cell was unlocked and he was assisted back into bed and his blood pressure was recorded as low (77/60) with a low pulse (45bpm). He was examined by a prison doctor and his blood pressure medication was stopped. Over the next few days his blood pressure fluctuated but generally remained low.

46. On 13 September at 11.15pm, a nurse noted that the man had been incontinent. Oscar 2 (the assistant duty prison manager) unlocked his cell

and he was washed and made comfortable. The next day the falls referral was faxed to Birmingham East and North (BEN) falls clinic (The falls clinic specialises in the prevention of falls in older people. It assesses and looks at reducing risk of falling, and fall-related injury). A member of staff at the clinic telephoned a nurse at the prison to explain that the man was probably outside their area (because of his home address) but that they would forward the referral to the appropriate service. He was also reviewed by the physiotherapist and given advice on using a rollator frame for supporting him when walking. He was told to request staff assistance when required. An application was made for a rollator frame for his personal use, which was later provided to him.

47. Although the man continued to experience daily bouts of incontinence, his health remained stable and on 16 September, when he was examined by a prison doctor, he reported that he generally felt better. The doctor noted that his legs were less swollen but they were purple which indicated that he had poor circulation. On 19 September, a third negative test for MSRA was received. The next day a member of staff from the BEN falls clinic telephoned a nurse at the prison to confirm that they would accept the man into their clinic. However, they were not able to confirm when he would be assessed and he was placed on the waiting list.

48. During his review with the physiotherapist on 21 September, the man reported that he felt well and had not had any dizzy spells that week. He said that he did not feel that he needed to use the rollator frame, although he was encouraged to do so. Over the next few days, his blood pressure increased

slightly. He told staff that he was worried that he would go totally blind. On 25 September, a nurse found the man on the floor and Oscar 1 (the duty prison manager) came to unlock the cell and he was assisted back into bed. The following morning, he was examined by a nurse and his blood pressure was recorded as a little low (119/66) with a low pulse (58bpm). He was later seen by a podiatrist (a specialist in diagnosing and treating conditions of the foot and ankle), and she noted that the man's feet were cold and red.

49. A prison doctor examined the man on 27 September and noted that that his legs and feet were very swollen and his left foot was red. The doctor wrote that he should be treated for cellulitis (a common skin infection caused by bacteria) and prescribed antibiotics. A further doctor reviewed the man on 30 September. His blood pressure was recorded as normal (110/73) with a slightly raised pulse (82bpm). Following a physical examination, the doctor detected an abdominal mass and referred him for an urgent ultra sound scan. Over the next few days, he was regularly checked by healthcare staff and, on 2 October, a personal hygiene care plan was created to ensure he had increased assistance.

50. Over the next few days, the man complained of occasional abdominal pain but ate and drank well. He was reviewed by the physiotherapist and was noted to walk sufficiently well, but still had swollen feet. On 5 October an appointment was received for the man to see a heart specialist at outside hospital on 10 October. This appointment was re-arranged to 7 November by an administrator in healthcare, although the reason for the change is not explained on the record.

51. On 8 October, the man advised the ward manager that he had an “upset tummy”. He said his stomach was a bit painful but that he had not had diarrhoea. He linked this to his diabetes saying that he often woke at night and felt hungry. He was given some cereal and bread and butter to eat and told the ward manager that his stomach felt better. Following a MDT review on 10 October, a prison doctor examined him and noted that his stomach was distended and soft. However, he wrote that no masses could be felt so there was no obvious aneurysm and that he would wait for the ultra sound scan that had already been requested.

52. The BEN falls clinic requested that the prison complete an ECG. This was undertaken on 14 October by a prison doctor and he returned the results to the falls clinic. The results of the ECG showed that there had been an old anterior-inferior infarction (a heart attack) but no further action was necessary.

53. The man remained in the healthcare centre. Over the next few weeks, he remained compliant with his medication, was assisted with his hygiene and ate and drank reasonably well, although he was physically weak. On 25 October, he attended outside hospital for his ultra sound scan and returned to the prison the same day.

54. On 27 October, at 12.15am, a nurse observed that the man was short of breath. His cell was unlocked and his observations were taken which were within normal range. The nurse helped him change his position, as he appeared uncomfortable because his abdomen put pressure on his

diaphragm, which restricted his breathing. The man told her that he was comfortable and he slept for the rest of the night. During the day, he remained in his cell. He was assisted with his personal hygiene and, although he did eat and drink, he told staff that he did not feel well. A nurse recorded at 4.33pm that the man was examined by a doctor (although there is no supporting entry from the doctor in the medical records). She wrote that he would be reviewed by a doctor daily, but that if his condition worsened he would be sent to outside hospital. He was encouraged to tell staff if he felt increasingly unwell.

55. The following day, on 28 October, a nurse recorded that the man was doubly incontinent during the previous night, but told staff that he felt well and was not in any pain or discomfort. A prison doctor examined him. He made an entry on the electronic medical record at 11.13am that the man had experienced increased shortness of breath, had a large abdominal mass and 'creps' (a sign of fluid or infection in the lungs). He queried whether the man could have cancer and made the decision to send him to outside hospital.

56. The investigator requested the communications log for 28 October from the prison to establish the exact times when the ambulance arrived and departed from the prison. Despite several requests, Birmingham did not provide this information.

57. A nurse has made an entry at 12.15pm to note that the man was monitored and wrote: " … he will be sent to outside hospital as a matter of urgency". It is

unclear from the electronic medical record what time the ambulance was initially requested. An entry made by the nurse at 2.07pm states:

> "Spoke to control room [the area in the prison that deals with such requests] to book ambulance as requested by GP referral. Spoke with [person] from the ambulance service with regards to [the man's] condition"

58. The nurse recorded that the member of staff from the ambulance service told her the ambulance would be at Birmingham 'within 2 hours'. The nurse made a number of subsequent entries detailing the care provided to the man and the regular observations that she took.

59. West Midlands Ambulance Service (WMAS) verified that an ambulance was initially requested at 1.37pm. At 4.15pm, the nurse again contacted the control room to request an emergency 'blue light' ambulance as the man's condition had deteriorated. According to the WMAS records, the ambulance arrived at Birmingham at 4.23pm. The paramedics examined and assessed him and he was transported to outside hospital at 5.18pm.

60. A risk assessment was completed and the man was subject to an escort chain restraint with a two officer escort. The restraints were to be removed for emergency treatment purposes only with the duty manager's approval. However, this risk assessment was based solely on the man's offending history. The factors relating to his health, mobility and how these would affect the level of actual risk were not considered.

61. The man was admitted to the MAU at outside hospital. On 29 October, a nurse contacted the outside hospital for an update on his condition. She was advised that he had been prescribed antibiotics, his diuretics were increased and he would be discharged back to Birmingham in two days if he stabilised. Birmingham healthcare remained in contact with the hospital and the ward manager and a colleague visited him on 31 October. Escort staff explained to the ward manager that the man could walk with a walking stick. The ward manager met the doctor who was treating him and the physiotherapist who told her that he would be discharged back to Birmingham the following day. A CT scan of his abdomen would be done later as an outpatient.

62. A letter was received by Birmingham healthcare on 1 November, which informed them of an urgent appointment for an echocardiogram (also known as a cardiac ultrasound, standard ultrasound techniques are used to produce images of the heart) on 3 November. A healthcare administrator contacted outside hospital to advise that the man was an inpatient there. During this contact, the healthcare administrator spoke to the bed watch staff who told her that the man was unable to maintain his oxygen levels and was not yet fit enough to be discharged.

63. A nurse contacted outside hospital on 2 November. She was told that the man was confused and was due to have a scan later in the week. He would remain in hospital until the results were known and what intervention had been agreed. Later the same day, the nurse was told that the man's oxygen levels had reduced and his blood test results were poor. She arranged to visit the hospital the following day.

64. The next day, the nurse visited outside hospital and recorded in the electronic medical record that the doctor treating him explained the man would require 24 hour oxygen, but that his heart failure was under control. The nurse spoke with the man who appeared “confused”, but was reassured and encouraged to continue to use his oxygen. The nurse ensured that the prison security department were aware that he would require 24 hour oxygen and a mobility assessment, prior to his discharge.

65. On 4 November, a nurse contacted outside hospital at 1.51pm and was told that the man was very poorly and that he was due to have a CT scan later that afternoon. His restraints were removed for this purpose and, because of the deterioration in his condition, the Director authorised the permanent removal of restraints at 2.10pm, unless the man’s condition improved. A further nurse recorded at 5.56pm that she contacted the hospital with regard to notifying the man’s next of kin. She noted that his sister’s contact details were not on the prison system and the hospital agreed to arrange for the local police to notify her that his condition had deteriorated. The investigator found that the correct next of kin details were recorded, but was unable to establish why they were not able to be found at the time his condition became very serious.

66. A prison custody officer (PCO), one of the escort bed watch staff, recorded at 7.55pm that the consultant indicated that the man’s condition was so poorly that only palliative care was to be offered (the form of healthcare that focuses on relieving and preventing the suffering of patients). His life expectancy was

24 - 48 hours. Neither the prison nor the hospital were able to contact the man's sister as the number recorded did not connect. At 8.25pm, the ward manager at outside hospital contacted police, who agreed to attend his sister's address to alert her to her brother's condition and request that she contact the hospital.

67. Over the next few hours, the man's breathing became more laboured. His sister contacted the outside hospital and was told about her brother's deteriorating health. The man stopped breathing and the bed watch staff immediately alerted the nursing staff. He was pronounced dead at 12.20am. During interview, a member of the escort bedwatch staff said:

> "He [the man] seemed to pass away really peacefully. He just stopped breathing."

Liaison with the man's family

68. Hospital staff notified the man's sister of his death, although there is no record of the specific time this contact was made. The prison had not appointed a family liaison officer (FLO) and the prison officers at the hospital were asked to wait for his sister to arrive at the hospital, as she had indicated that she would be travelling up immediately.

69. The officers responsible for the bed watch remained at the hospital but at 5.10am the man's sister contacted the hospital to let them know that she

would not travel to the outside hospital immediately and the officers were given permission to return to the prison.

70. Following the man's death, the prison's family liaison officer was appointed. The family liaison officer does not work weekends and was not on duty at that time. She attempted to contact the man's sister on 7 November when she was next at work, but was unable to speak to her until 11 November as at that time his sister had travelled to Birmingham to identify her brother. During their initial conversation, the family liaison officer told the man's sister about the role of the prison family liaison officer, the Coroner and the Prisons and Probation Ombudsman investigation. She also offered a contribution towards funeral expenses, which was accepted. The funeral was conducted on 30 November, and attended by the FLO and Deputy Head of Safer Custody. The man's property was returned to his family on 8 December.

Support for prisoners

71. Prisoners were informed of the man's death in a notice from the Director expressing condolences on the day he died. The notice reminded prisoners of available support, from wing staff, the prison chaplaincy and Listeners (prisoners trained by Samaritans to offer confidential support their peers). A memorial service was held in the healthcare centre on 14 November, for those who wished to attend.

Support for staff

72. The duty director held a hot debrief with the bed watch officers (a meeting immediately after an incident to discuss issues and any lessons learned following serious events such as deaths in custody. The meeting focuses on reassurance, information sharing and how staff can support each other) who were with the man when he died. Staff in the healthcare centre who had looked after him did not hear of his death until 6.30am the next morning when they were told the news by a healthcare colleague working in another area of the prison.

73. Support was made available to the prison uniform staff through the prison's care team. Staff confirmed that they were contacted by a member of the care team and were aware that, if they chose to, they could contact them at any point for ongoing support, although in interview healthcare staff said that they were not approached by the care team and were supported informally by their peers and manager.

Post-mortem

74. A post mortem was undertaken on 11 November. It concluded the cause of death was due to pneumonia. There were no significant findings in the toxicology report.

ISSUES

Clinical care

75. A clinical reviewer was commissioned by Birmingham Primary Care Trust to review the medical care that the man received in prison custody. His clinical review looks at the care and treatment he received at Birmingham prison and considers whether it was appropriate and comparable to that which is available in the community.

76. The man received some good care from healthcare staff and the records show regular interaction. Despite the level of daily care and intensive interventions, the clinical reviewer has outlined some concerns that checks were not carried out consistently and systematically. The clinical reviewer also notes that it does not appear that the clinical team at the prison were fully aware of his medical history and that some assumptions were made in respect to his medications, which were subsequently varied during his time at Birmingham. The clinical reviewer states in his report:

> "[The man] had a number of chronic conditions. There appears a paucity of evidence of formal reviews of the following in line with the current Outcomes Quality Framework (sic) in General Practice:
>
> - Medication review including reducing medication.
> - Diabetes review including retinal screening, peripheral neurology testing

- Heart failure annual review
- COPD review including spirometry and reassessment of the suitability of his inhalers.
- Atrial fibrillation

These reviews would take place in an organised NHS GP practice and are common in the majority of practices since the advent of QOF. It is not entirely clear that these structured reviews took place so I conclude that the care was not equitable to NHS primary care."

77. Following a discussion with the investigator, the clinical reviewer explained that Birmingham does not have the QOF so a direct comparison of service cannot be made, and that his conclusion was based on current NHS practice. He said that the reviews undertaken by Birmingham were "not bad practice" but that he hoped the QOF would be adopted.

The Head of Healthcare should adopt a system of review for chronic medical conditions in line with the NHS Quality Outcomes Framework and ensure that the clinical team are aware of the full medical history of those with chronic health issues and review repeat medications every six months.

78. An ambulance was requested following the deterioration of the man's health on 28 October. He was regularly observed in the healthcare centre when a decision was made later to request an emergency ambulance as he had not

improved. The clinical reviewer concludes that there was no undue delay in admitting him to outside hospital.

Temperature in the prison

79. The man's family asked the PPO family liaison officer if he had ever complained to staff about being cold, as he had often told them that he was cold in prison. The investigator found no evidence that he had spoken to staff about this, and he made no formal complaints. Nevertheless, it is likely that an older man with his condition would feel the cold more than others and this is something that prison staff need to be vigilant about when caring for older people.

Restraints

80. The man was subject to restraints when he visited hospital. The removal of restraints can only be authorised by a senior prison staff member or in emergency situations (such as if hospital staff demand their removal to enable them to provide treatment). The assessment of the risk the man posed and the level of restraint was reviewed on a number of occasions. The decision to remove restraints was made on 4 November at 2.10pm, when the hospital confirmed that the man's life expectancy was very short.

81. The investigator considered whether the restraints should have been removed earlier, given the man's deteriorating health and the risk he posed of escape or further offending, while also subject to a two person escort. It is

understandable that, due to the nature of his offences, the man was originally made subject to restraints when taken to hospital. However, there is no evidence that the prison took into account, and kept under review, the man's medical condition, the physical surroundings of the hospital or any other information; it was based solely on his offences.

82. 'Section One - Medical Assessment' of the escort risk assessment had not been completed. No consideration was given to the man's level of mobility or how his deteriorating health would affect the actual level of risk posed at the time of the escort, and there is no evidence that a medical opinion had been sought. Prisons have a responsibility to balance safety to the public with dignity for the prisoner. Given the context of the man's deteriorating health and mobility, the decision to remove the restraints should have been made earlier.

The Director should ensure that all relevant sections of the escort risk assessment are completed each day a prisoner is in hospital, so that full account is taken of a prisoner's health and physical condition and the impact this has on his actual risk.

Notifying the man's family

83. The man's sister asked why she was not informed about his admission to hospital before 4 November. Prison Rule 22 requires governors to inform the prisoner's spouse or next of kin when a prisoner 'becomes seriously ill'. His

condition was sufficiently serious for the prison to have called an emergency ambulance on 29 October and we would have expected his family to have been notified at that stage.

84. During his time at the hospital there is no evidence that prison staff asked the man if he wanted to use the telephone, or if he wanted them to contact anyone on his behalf. No consideration was given to contacting his family until a very late stage on 4 November, when doctors indicated that his condition was life-threatening. We do not consider that the prison met its responsibilities by taking so long to contact his family.

85. When Birmingham prison and the hospital attempted to contact the man's sister the recorded telephone number did not connect. The police were contacted and a request was made for them to go and visit her to request that she contact outside hospital. She did contact the hospital, and was advised by nursing staff of her brother's condition.

The Director should ensure that next of kin are notified as soon as possible when a prisoner becomes seriously ill.

Contact with family following the man's death

86. The man's sister was advised of her brother's deteriorating condition by the hospital for the reasons outlined earlier, and was subsequently advised over the telephone by them that he had died. If the news is broken in this way, then an early follow up by the prison, in person, should be a priority.

87. The guidance for liaison with bereaved families following a death in custody guidance in PSO 2710 (Follow up to deaths in custody) states:

> "4.3 The Governor (or delegated supervisor) is responsible for deploying a Family Liaison Officer immediately following a death. The Family Liaison Officer may be from the establishment where the prisoner has died or from elsewhere within the area (or, if the family lives some way away, from another area). The Governor should record the rationale for a particular officer being deployed to an individual family.
>
> "4.9 The family should be informed face to face as soon as possible after the death. Wherever possible, this should be done by a dedicated Family Liaison Officer working alongside the Chaplain or Governor or most senior individual available together with the Chaplain…If a dedicated Family Liaison Officer is available for deployment, the duty governor can remain in charge at the scene. This option is recommended because it is what families and agencies that work closely with them say they prefer and expect; it shows that the death is being taken seriously by the prison...If face-to-face prison notification is not possible, there should be swift face-to-face follow-up.
>
> "4.10 If distance from the prison presents a problem, a dedicated Family Liaison Officer or chaplain based in the area nearest the family home could inform the family face to face...This individual must give the family

contact details at the establishment where the death occurred and the visit should be followed up by that establishment as soon as possible."

88. Birmingham only has one trained FLO, who does not work weekends (the man died in the early hours of Saturday morning). When it was thought that his sister was travelling to the hospital, the prison should have sent someone to the hospital to meet her, rather than rely on the officers who had been guarding him at the hospital. When it was known that she was not travelling to Birmingham, the prison should have considered contacting the nearest prison to the man's sister to make arrangements for them to attend her home address.

89. Despite making a number of attempts to contact the man's sister by telephone, the prison FLO was not able to speak to her until 11 November. The delay in the first contact by the prison is not good practice; although this is not a criticism of the individual member of staff acting in the FLO role. Birmingham should have considered appointing a FLO on 4 November as soon as it was apparent that the man was dying so that there would be a consistent point of contact with the prison. The Director told the investigator that following this incident a number of staff have been identified for this important role and are waiting for training.

The Director should ensure that there are a sufficient number of trained family liaison officers.

The Director should ensure that a family liaison officer is appointed when a prisoner is assessed as seriously ill and that appropriate and timely arrangements are made for early contact with families.

90. Despite the early difficulties in making contact with the man's sister, consistent with Prison Service guidance, funeral expenses were offered and accepted. It is positive to see that the prison also provided financial assistance to enable his sister and her husband to travel to Birmingham.

Support for staff

91. The investigator was unable to verify exactly why healthcare staff were not informed immediately of the man's death. There is some uncertainty surrounding these events, but it is a concerning omission that healthcare staff who had been involved in looking after the man were not told at the earliest opportunity.

92. Healthcare staff received informal support from their manager and from each other, but did not have the opportunity to attend a debrief which they told the investigator they would have welcomed.

93. Giving staff the opportunity to discuss an incident collectively and reflect on all aspects of how it was managed is fundamental to providing the prison with feedback on any issues that need to be addressed (or indeed good practice). It also provides those directly involved with an opportunity to process events. It is unclear if the prison care team approached any members of the

healthcare staff involved. While we understand that healthcare staff involved were supported by their manager, advised of the employee support telephone line and were informally supported by their peer group, the prison had a duty of care for the well-being of all staff involved.

The Director should ensure that all relevant staff are invited to a debrief shortly after the death of a prisoner.

Record keeping

94. There are a number of examples of inadequate recording in the electronic medical records. All staff, irrespective of grade, including agency staff, have a duty to ensure that accurate and comprehensive records of contacts with patients are entered on the computerised record. Record keeping has been identified as a problem in previous investigation reports into deaths at Birmingham and the prison undertook that this would be remedied. It is regrettable that this is still an issue.

The Head of Healthcare should ensure that all healthcare staff comply fully with the requirements for accurate and contemporaneous record keeping in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council.

95. The most essential documents were available to the investigator in order for us to complete our enquiries. However, despite several requests, the communications log for the 28 October, when an ambulance was requested,

was not provided. It is vital that all documents for a prisoner are available and accessible to provide an accurate chronology of events, and to show the prison are trasparent about interactions regarding prisoners in their care.

The Director should ensure that all documentation relating to a prisoner is available if requested during the course of any investigation.

CONCLUSION

96. The man entered custody with a number of chronic health conditions. Due to this he required careful monitoring. Healthcare staff were regularly involved with him and lots of effort was made to ensure that he was comfortable. However, the clinical reviewer has raised concern that there is no clear evidence that some of his conditions and medications were regularly monitored and reviewed. Although there is no suggestion that this affected the quality of his overall health treatment, the prison needs to ensure that there are processes to review prisoners with similar life long conditions which need regular monitoring, particularly as there are rising numbers of older people in prison.

97. Better arrangements are needed to ensure timely and supportive contact with prisoners' families when they are seriously ill and die. More active reviews of risk assessments for prisoners in hospital are needed to demonstrate the security arrangements are proportionate.

RECOMMENDATIONS

1. The Head of Healthcare should adopt a system of review for chronic medical conditions in line with the NHS Quality Outcomes Framework and ensure that the clinical team are aware of the full medical history of those with chronic health issues and review repeat medications every six months.

   Accepted - *The long term condition nurse will review all prisoners against quality guidelines. They are due to be in post in July 2012. Target for completion November 2012*

2. The Director should ensure that all relevant sections of the escort risk assessment are completed each day a prisoner is in hospital so that full account is taken of a prisoner's health and physical condition and the impact this has on his actual risk.

   Accepted - *The escort risk assessment is a prison escort document and relates to escape risk and security concerns. With the exception of a blue light emergency and overriding clinical needs, a Section One medical assessment will be completed prior to discharge of a medical escort.*

3. The Director should ensure that next of kin are notified as soon as possible when a prisoner becomes seriously ill.

Accepted - *This will be subject to a public protection risk assessment (relating to victim issues). If it is established that there are no issues about this, then the next of kin will be notified as soon as possible.*

4. The Director should ensure that there is a sufficient number of trained staff to undertake the role of a family liaison officer.

Accepted - *Two additional FLO's have now been trained with an additional three training places requested.*

5. The Director should ensure that a family liaison officer is appointed when a prisoner is assessed as seriously ill and that appropriate and timely arrangements are made for early contact with families.

Accepted - *The Duty Director on the day would take advice from the Hospital about whether the prisoner/patient is classed as seriously ill. If it is established that they are seriously ill, then appropriate and timely arrangements will be made for early contact with families.*

6. The Director should ensure that all relevant staff are invited to a debrief shortly after the death of a prisoner.

Accepted - *All relevant staff will routinely be invited to both the Hot de-brief and Critical Incident de-brief with immediate effect.*

7. The Head of Healthcare should ensure that all healthcare staff comply fully with the requirements for accurate and contemporaneous record keeping in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council.

Accepted - *Director of healthcare has reiterated requirements to all staff (this will be reissued every six months).*

8. The Director should ensure that all documentation relating to a prisoner is available if requested during the course of any investigation.

Accepted - *Death in custody documentation will be made available to: Police, Coroners, Prisons & Probation Ombudsman and Prison staff.*