



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at HMP
Birmingham in May 2013**

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 report of an investigation into the death of a man, who died of chronic obstructive pulmonary disease (COPD) at HMP Birmingham in May 2013. He was 69 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received at the prison was undertaken. Birmingham cooperated fully with the investigation. The investigation was suspended until a criminal investigation concluded and I am sorry that this has delayed the issuing of this report.

The man had already been diagnosed with the most severe form of COPD when he arrived at Birmingham in November 2012. His condition was relatively stable for much of the time, although his mobility became worse because he had increasing pain in his hip. At the beginning of May 2013, he reported having a cold and his oxygen saturation levels were lower than expected. Otherwise, there was little to suggest deteriorating health.

I am satisfied that the man's COPD was managed well at Birmingham, although the investigation found that his oxygen saturation levels should have been monitored more frequently. His cellmate claims that he told an officer on 26 May that the man was not breathing well, but no action was taken. The officer denied this. The investigation has been unable to establish what happened that evening, but it is important that all prison staff take appropriate action when alerted to concerns about a prisoner's wellbeing. Prison staff responded quickly when the cellmate told them that the man was very unwell on the morning of his death. However, they did not use the appropriate emergency code or begin basic life support until qualified help arrived. While I am satisfied that neither of these factors affected the outcome for him, in other circumstances a quick and effective emergency response could be crucial.

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

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SUMMARY

1. On 26 November 2012, the man was sentenced to 28 months in prison and taken to HMP Birmingham. He had significant health problems, including the severe chronic obstructive pulmonary disease (COPD), which meant that he very quickly became short of breath.
2. The man lived on J wing at Birmingham, a special unit for older prisoners. The prison's specialist respiratory nurse frequently reviewed him. The man's mobility deteriorated because of increasing pain in his hip and, from spring 2013, he used a wheelchair to get about.
3. On 14 May, the man told a nurse that he was unwell with a cold. His clinical observations were mostly normal, but his oxygen saturation level was below the normal range. The nurse noted that the man's oxygen levels should continue to be monitored, but they were taken only once more, the next day, when they were still below the normal range.
4. On 26 May, the man told prison nurses that he still had a cold. A nurse saw him at 7.30pm and recorded that his only symptoms were a runny nose and slightly high temperature. Other clinical observations were normal, but the nurse did not check his oxygen saturation levels. The nurse told the investigator that she had no significant concerns about the man.
5. Around an hour later, the man's cellmate pressed the cell call bell. He said that he had told the officer who responded that the man was not breathing well, but the officer had said that there was nothing he could do about it as there was no longer a nurse on duty. The officer told the investigator that the cellmate had pressed the bell to ask for a toilet roll. The officer said that he had asked the cellmate to press the cell bell in the night if the man's condition got worse, as he knew that he had been unwell.
6. At around 8.00am, the man's cellmate pressed the bell for help as he thought that the man looked very unwell. The officer checked the man, who did not appear to be breathing. He called to another officer to radio the first response nurse to attend. They did not use an emergency medical code and there was a delay of around four minutes until the duty manager arrived and requested an ambulance. No one attempted to resuscitate the man until the nurse arrived. Shortly after paramedics arrived, they pronounced him dead, at 8.28am. The prison informed his next of kin of his death at 2.00pm that afternoon.
7. The clinical reviewer concluded that the man's COPD was managed appropriately in prison, although there should have been better monitoring of his oxygen saturation levels. We do not know what happened on the evening of 26 May but, if the man was as unwell as his cellmate described, then medical help should have been sought at that stage. Officers did not follow appropriate emergency procedures and it took too long to inform his family of his death. We make four recommendations.

THE INVESTIGATION PROCESS

8. On 30 May 2013, the investigator issued notices to staff and prisoners at HMP Birmingham about the investigation and inviting anyone who had relevant information to contact him. No one responded.
9. The investigator and a colleague went to Birmingham on 3 June. They visited J wing, where the man lived for most of his time at the prison and spoke to prisoners who knew him. They met the Director and the duty manager who had informed his next of kin of his death. They also met the police investigators. They interviewed seven members of staff on 8 July.
10. In accordance with the Ombudsman's terms of reference, our investigation was suspended on 9 July, while West Midlands Police conducted a criminal investigation into the man's death. The suspension was lifted on 20 October 2014. The police gave us statements from prison staff and prisoners and the transcript of an interview with the officer who responded to the cellmate ringing the cell bell the night before he died.
11. NHS Shropshire and Staffordshire commissioned a clinical reviewer to review the man's clinical care at the prison. She joined both investigators for the interviews on 8 July.
12. One of the Ombudsman's family liaison officers spoke to the man's nephew, his nominated next of kin, on 20 June, to explain the investigation process. He did not have any specific concerns for the investigation to address. The family received a copy of the draft report. They did not make any comments.

HMP BIRMINGHAM

13. HMP Birmingham is a large local prison, principally serving the West Midlands courts. It holds up to 1,450 remand and sentenced men. G4S Care and Justice Services have managed the prison since October 2011.
14. The prison consists of 11 wings. The man lived on J wing, a smaller unit for older prisoners, those with poor mobility or those who need extra help with aspects of social care. A weekly nurse-led clinic is held on the wing.
15. Birmingham and Solihull Mental Health Foundation Trust provide 24 hour healthcare services. Primary care services are subcontracted to Birmingham Community Healthcare NHS Trust. There is a 15 bed inpatient unit for prisoners with physical health conditions. Prison doctors hold 21 GP surgeries a week. There is an out of hours service. A senior nurse has responsibility for older prisoners.

HM Inspectorate of Prisons

16. HM Inspectorate of Prisons last inspected Birmingham in March 2014. They found that prisoners were generally satisfied with health services and there were a wide range of clinics and GP surgeries. Inspectors found that J wing offered very good support for older prisoners and those with social care needs.

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that all prisoners are treated fairly and decently. In their annual report for 2012-13, the IMB reported that J wing operated very successfully due to the hard work and attitude of unit staff and managers. The IMB noted that they had received a number of complaints relating to patient/doctor relationships. A number of the complaints were about doctors prescribing alternative medications to those considered 'tradable' within the prison.

Previous deaths at HMP Birmingham

18. The man was the eighth prisoner to die at Birmingham since April 2011. In one of the previous investigations, we recommended the introduction of an emergency code system to identify medical emergencies. In another investigation, we found that the man's numerous chronic diseases – including COPD – were not monitored in line with national guidance.
19. Since the man's death we have investigated five other deaths at Birmingham. In two of those investigations, we found that emergency response procedures were not carried out in line with national guidelines.

KEY EVENTS

20. The man was convicted and sentenced to two years and four months imprisonment on 26 November 2012, and arrived at HMP Birmingham that evening. This was his first time in prison.
21. The man's medical history included grade four chronic obstructive pulmonary diseases. (COPD is a term which encompasses a number of lung diseases including chronic bronchitis and emphysema. Patients with this diagnosis have trouble breathing due to long-term damage to the lungs. Grade four is the most severe form of the disease.) This meant that he very quickly became short of breath and, with the help of a stick, could walk for 20 yards at the most. He had recently seen a specialist due to swollen, discoloured and painful feet, for which no cause had been found.
22. Reception staff identified the man's medical history at a reception health screen and initially allocated him to a cell in the prison's inpatient healthcare unit because of his limited mobility. He spent a week living in the inpatient unit while he waited for a space on J wing, a specialist unit for older prisoners, to become available. During this time a physiotherapist gave the man some exercises to do to help his swollen feet. The prison's specialist respiratory nurse reviewed him.
23. After the man moved to J wing, a nurse completed a needs assessment for older prisoners to determine what help he required and whether he needed any adjustments to help with his daily living. The assessment found that the man was independent and did not need additional help, although staff made some small adjustments (such as a raised toilet seat) to his cell.
24. The man saw the specialist respiratory nurse at the weekly J wing clinic on 11 December. He reported no significant health concerns. The nurse created a care plan to help him manage his COPD. This included reminding him to use his inhalers as prescribed, to walk around the wing each day and to tell wing staff if he thought his COPD was worsening.
25. The man reportedly settled in well on J wing. In January 2013, his feet became more swollen and painful and a GP prescribed an antibiotic and medication to improve his blood flow. Later in the month, he saw a podiatrist (foot specialist), who noted that his feet were getting better.
26. In March, the man told a prison doctor that he had experienced hip pain for around four to six weeks and could only manage a few steps with a walking frame. The doctor prescribed a course of tramadol, a strong painkiller for moderate to severe pain. Another prisoner was employed to help the man with everyday tasks such as collecting his meals and cleaning his cell.
27. In early April, the man said that his painkiller was not sufficient. A GP prescribed paracetamol in addition to the tramadol and asked for an X-ray of his hip. This showed severe degenerative changes in the left hip. By now, staff had given him a wheelchair to help him move around the wing.

28. On 26 April, the man told wing staff that he had had a cold for three days. A nurse went to see him in his cell and advised him to drink plenty and tell staff if he felt worse. Around a week later, he told another nurse that he still had a cold. The nurse made an appointment with a prison doctor for the next morning (3 May). The doctor told us that the man's chest was clear, he had no temperature and he seemed comfortable, although he said he had recently experienced headaches. The doctor concluded that he had a persistent cold and prescribed ibuprofen as an additional painkiller.
29. The man's cellmate told wing staff on 9 May that the man was not feeling well. A nurse went to see him and he said he was bringing up a lot of mucus and had headaches nearly every day. The nurse spoke to a doctor, who prescribed an antihistamine as he thought the symptoms suggested the man had hay fever. The man said he was pleased to have this particular antihistamine, as it had worked for him in the past.
30. The specialist respiratory nurse assessed the man on 14 May, after his cellmate had again said he was unwell. He said he had been unhappy about a recent delay in receiving a new inhaler, but this had now been resolved. The nurse recorded that the man had a runny nose and eyes and a cough. She checked his blood pressure, temperature and respiratory rate, all of which were within the normal range. The man's oxygen saturation level (a measure of the amount of oxygen carried in the blood) was 84 per cent, lower than the normal level of at least 95 per cent which he had previously registered. The nurse told us that this might have been caused by him not having an inhaler for several days. She noted that, now he was using his inhaler regularly again, his oxygen saturation levels should be monitored to ensure that they returned to normal levels. Consideration needed to be given to referring the man to a specialist if this did not happen. The nurse told us that she had wanted to admit him to the healthcare centre inpatient unit for further assessment, but he refused as he preferred to stay on J wing.
31. The man saw a doctor the next day. He noted that the man's symptoms were persisting, although he appeared relatively well. The doctor checked the man's oxygen saturation level, which had improved to 89 per cent. He prescribed a course of antibiotics, because of the man's medical history and the length of time he had had his current symptoms and referred him to hospital for a chest X-ray. (This had not taken place before he died.)
32. On 16 May, at the weekly J wing clinic, the man told a nurse that he felt better than he had recently. There were no further entries in his medical record until 25 May, when a nurse reported that he still had a blocked nose.
33. A nurse reviewed the man on 26 May. He told her that he felt unwell due to tiredness and a runny nose, and he had spent the morning in bed. The nurse took his blood pressure and pulse, which were both normal, although he had a high temperature. She told us that he was not breathless and had no chest pain at the time. She gave him some paracetamol for his temperature and noted that he should be reviewed the next morning.

34. At around 7.30pm, a senior primary care nurse examined the man in his cell. She checked his temperature, which had reduced from earlier, but was still a little high. She told us that his only symptom was a runny nose. He had no chest symptoms, was not short of breath and had no chest pain or headache. The nurse said she had no significant concerns at the time and, as her shift was about to end, she passed on her observations to the night nurse.
35. In a statement to the police, the man's cellmate said that his breathing became heavier after the nurse left the cell. After around an hour, he pressed the cell call bell for help. (The call bell record shows that the bell was pressed at 8.28pm and an officer arrived at the cell and reset it 32 seconds later.) The cellmate said that he told Officer A that the man was not well and was breathing strangely. He said that the officer replied, "there is nothing I can do, the nurse is gone and there is no nurse on duty".
36. Officer A told West Midlands Police that, when he answered the call bell, the cellmate had asked for a toilet roll. He said that the man was lying on his bed and appeared asleep. He thought that there was nothing unusual about this and he had no cause for concern. Because he knew that the man had not felt well that day, he said he had told the cellmate to press the cell bell again if he thought the man needed to see a nurse during the night. The officer said that the cellmate said nothing about the man's breathing and that he did not tell the cellmate that he could not call a nurse. He finished his shift shortly afterwards.
37. The cellmate said that when he went to bed at around 10.40pm, the man was lying in the same position and making the same noise when he breathed as he had been earlier when he had rung the cell bell. He tried to ask the man if he was alright, but he did not respond. The cellmate woke at some time during the night, and said that the man was no longer making a noise. He therefore thought he was asleep.
38. During the night an operational support officer was the night patrol officer on J wing. In a statement to the police, she said that she was not called to the man's cell during the night and heard no noise from its two occupants. At around 6.00am, she carried out a roll check to ensure that the correct number of prisoners were on the wing. She recalled seeing the man lying in bed at the time. Her shift finished at 7.00am.
39. The man's cellmate woke at around 7.00am. As the man usually slept until later, he said that he did not initially pay any attention to him. After a while, he noticed that the man looked white and pressed the cell bell for help. Records show that this was 8.08am.
40. Two prison officers were detailed to work on J wing that morning. At around 8.00am, Officer B left the wing to carry out tasks elsewhere in the prison. While he was away, Officer C, who usually worked on D wing, covered his duties. Officer C told the investigator that he had covered full shifts on J wing several times before and knew the man and his cellmate.

41. Officer C responded to the cell bell. (The records show that he arrived at the cell 38 seconds after it had been pressed.) The cellmate told him that the man did not look well. Officer C unlocked the cell immediately and examined the man, who was very pale and cold, with just a little warmth on his back. Officer C said there was no indication that the man was breathing and he could not feel a pulse.
42. Officer C then left the cell and shouted to Officer D to radio for the first response nurse. He said that he did not consider asking him to radio a code blue emergency which should have prompted healthcare staff to respond urgently and the control room to call an ambulance.
43. Officer D radioed for the response nurse to attend J wing immediately. The communications room log (which notes all significant radio communications) records that this call was made at 8.10am. While waiting for the response nurse to arrive, he brought an emergency bag (containing resuscitation equipment, including a defibrillator) which was stored on J wing. At around the same time, Officer A and the duty manager arrived on the wing. The duty manager radioed to request an emergency ambulance. This message was recorded at 8.14am. The response nurse arrived within a few seconds of this message. None of the staff present began any basic life support before she arrived.
44. The nurse said that the man's body was warm when she first examined him, but his face was discoloured and she could not find a pulse. She considered that he was dead. She attached the defibrillator, which found no shockable heart rhythm and she began cardiopulmonary resuscitation. An ambulance crew arrived at the prison at 8.21am (the time they arrived at the cell is not recorded). They took over emergency treatment but quickly stopped. They pronounced the man dead at 8.28am.
45. The safer custody manager debriefed the staff involved in the emergency response later that morning and offered them the support of the prison's care team. An officer spoke to the cellmate to tell him that the man had died and to offer support. Officers also spoke individually to all other residents of J wing.
46. At around 2.00pm, the deputy Director and the safer custody manager visited the man's nephew at his home to tell him that his uncle had died. The prison contributed to funeral expenses in line with national instructions.

ISSUES

Clinical care

47. Before he went to prison, the man had been diagnosed with grade four COPD, the most severe form of the disease. The clinical reviewer considered that he had received appropriate medication in prison for his condition. She compared the decisions of clinical staff, when he presented as unwell in May 2013, against National Institute for Clinical Excellence (NICE) guidelines for managing COPD. She noted that the man's symptoms in the last few days and weeks of his life amounted to a runny nose and, latterly, a temperature. These do not meet the NICE definition of a deterioration of COPD, which includes worsening breathlessness, a cough, and increased sputum production. She concluded that the man did not meet the criteria for hospital admission or other additional treatment.
48. The clinical reviewer was satisfied that the man had frequent access to a specialist nurse, general nurses and doctors and that the management of his COPD in prison was at least equivalent to that expected in the community.

Monitoring oxygen saturation levels

49. The man reported that he was unwell on 14 May, and described cold-like symptoms. The specialist respiratory nurse took clinical observations and found that his oxygen saturation levels were 84 per cent, lower than the normal range (these had been in the normal range when previously measured at the prison). She attributed this to him being without his inhaler for several days, but told us that he appeared relatively well. She asked for his oxygen saturation levels to be monitored.
50. A doctor checked the man's oxygen saturation levels at his clinic the next day. By then, they had risen to 89 per cent. Although this was an improvement, it was still below the normal level of at least 95 per cent. However, no one checked his oxygen saturation levels again after that.
51. The specialist respiratory nurse had noted in the man's medical record that his oxygen saturation levels should be checked, but it does not appear that she passed on this request to healthcare staff by any other means. Prison nurses saw the man at the weekly J wing clinic on 16 May (but not on 23 May) and on several other occasions, but did not check his saturation levels at any of these reviews. We cannot know whether his oxygen saturation levels returned to normal. The clinical reviewer noted that if they had been checked and remained low the man should have been referred to the prison doctor to consider further management. We make the following recommendation:

The Head of Healthcare should ensure that nurses are clearly briefed to carry out observations as required and note these in the clinical record.

Evening leading up to incident

52. The man's cellmate said that he had told Officer A, the night before the man died, that he was not breathing well. A nurse had assessed him an hour earlier and found that he had no symptoms other than a runny nose and slightly high temperature. The cellmate said that the man had got worse after the nurse left, but the officer had told him that there was nothing he could do as there was no nurse on duty.
53. Officer A had a different version of events and said that the cellmate's reason for pressing the call bell was to ask for a toilet roll. He said that the man appeared to be asleep at the time and he had no cause for concern. He said that he was aware that the man had not been well that day and he had told the cellmate to press the cell bell if the man appeared unwell again during the night and needed to see a nurse.
54. We note that the cellmate said that the officer told him that there was no nurse on duty. While the nurse had left for the day, there were nurses on duty in the prison who could have been called if necessary so it is not clear why he would have said this, as the cellmate claimed.
55. Officer A's account of what was said differs substantially from the cellmate's version and there is no other evidence available to corroborate either account. Therefore, it has not been possible for this investigation to establish exactly what happened that evening. We make no judgement about which version of events is correct, but we consider it would be a reasonable learning point to remind officers how they should respond in such situations. We therefore make the following recommendation:

The Director should ensure that all prison staff understand the need to satisfy themselves of a prisoner's wellbeing when they are alerted to a potentially significant health problem, and seek healthcare advice if necessary or call an emergency code as appropriate.

Emergency response

56. Prison Service Instruction (PSI) 03/2013 *Medical Emergency Response Codes*, issued in February 2013, sets out the actions staff should take in a medical emergency. It contains mandatory instructions for governors to have a protocol to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It stipulates that if an emergency code is called over the radio, an ambulance must be called immediately. Staff should ensure there are no delays in calling an ambulance and that it should not be a requirement for a member of the healthcare team or a manager to attend the scene before an ambulance is called. These instructions are reflected locally at Birmingham by Operational Instruction 004/2012.

57. When the man's cellmate raised the alarm on 27 May, Officer C promptly opened the cell and Officer D quickly radioed for medical assistance. However, the call was for the response nurse to attend J wing immediately and neither officer used an emergency code. Local instructions at Birmingham require that the emergency call sign 'code blue' be used when a prisoner is unconscious or has serious breathing difficulties. The man was unresponsive at the time and an emergency code should have been used to help the response nurse understand the nature of the emergency.
58. We are concerned that none of the prison staff who initially responded began basic life support or were trained in cardiopulmonary resuscitation. This did not begin until the nurse arrived around four to five minutes after the alarm was first raised. In this case the delay was not significant as the chance of successful resuscitation was extremely unlikely. Nevertheless, it is important that staff have these skills, as the chances of successful resuscitation decline very quickly and it is important that it begins as soon as possible when someone is found unresponsive.
59. National and local instructions also require staff in the communications room to call an ambulance as soon as an emergency code is broadcast. In the absence of a code blue message, an ambulance was not requested until about four minutes after the initial radio call. While it does not appear that the lack of an emergency code affected the outcome for the man, in other circumstances this could be crucial. We make the following recommendation:

The Director should ensure that all prison staff use an appropriate emergency code in a life threatening situation which results in an ambulance being called immediately and initiate basic life support as needed until health care staff arrive.

Breaking the news of the man's death to his next of kin

60. Prison Rule 22 requires prisons to inform the next of kin immediately if a prisoner dies. PSI 64/2011 gives a mandatory instruction that, wherever possible, this must be done in person by prison staff.
61. The deputy Director and the safer custody manager visited the man's nephew to break the news of his death, and arrived at his home at around 2.00pm. The safer custody manager told us that they were delayed as they had some difficulty finding the address.
62. The man's nephew lives 40 miles from the prison. Even allowing for some delays, it was five and a half hours after his uncle's death before prison staff informed him of such. While we appreciate the difficulties faced by staff when a prisoner dies unexpectedly, we consider that this should have been done more quickly, in line with the Prison Rules and Prison Service Instructions. We make the following recommendation:

The Director should ensure that, in line with national instructions, that prison staff inform the next of kin as soon as possible after a prisoner's death.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that nurses are clearly briefed to carry out observations as required and note these in the clinical record.
2. The Director should ensure that all prison staff understand the need to satisfy themselves of a prisoner's wellbeing when they are alerted to a potentially significant health problem, and seek healthcare advice if necessary or call an emergency code as appropriate.
3. The Director should ensure that all prison staff use an appropriate emergency code in a life threatening situation which results in an ambulance being called immediately and initiate basic life support as needed until health care staff arrive.
4. The Director should ensure that, in line with national instructions, that prison staff inform the next of kin as soon as possible after a prisoner's death.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and Function Responsible
1	The Head of Healthcare should ensure that nurses are clearly briefed to carry out observations as required and note these in the clinical record.	Accepted	Any observations/ interventions that need to be completed are placed on the H2 list for action. This list is then allocated out to nurses to complete the action. At the end of the day the night nurse ensures all prisoners have been seen that day. This is a secondary check to ensure all prisoners are seen and actions noted on the patient's record.	Completed Head of Healthcare
2	The Director should ensure that all prison staff understand the need to satisfy themselves of a prisoner's wellbeing when they are alerted to a potentially significant health problem, and seek healthcare advice if necessary or call an emergency code as appropriate.	Accepted	Notice to staff will be published with regard to avenues to access medical/clinical interventions.	14/01/2015 Safer Custody
3	The Director should ensure that all prison staff use an appropriate emergency code in a life threatening situation which results in an ambulance being called immediately and initiate basic life support as needed until health care staff arrive.	Accepted	Notice to staff to be republished on the use of appropriate emergency codes. Operational Order in place regarding actions to be taken.	14/01/2015 Safer Custody
4	The Director should ensure that, in line with national instructions, that prison staff inform the next of kin as soon as possible after a prisoner's death.	Accepted	Next of kin will be informed as soon as possible following a death in custody, once necessary security checks have been completed.	Completed Safer Custody