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A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

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**Investigation into the death of a man in April 2014,  
while a prisoner at HMP Birmingham**

## ***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 in April 2014 while a prisoner at HMP Birmingham. He died of multi-organ failure as a result of a brain and neck injury sustained during a fall. He was 72 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received at HMP Birmingham was conducted. The prison cooperated with the investigation.

In June 2012, the man was sentenced to 15 years in prison and sent to HMP Birmingham. His health and mobility was already poor at the time he was sentenced and he often spent time as an inpatient in the prison's health centre. On 24 April 2014, he fell in his cell in the health centre and hit his head. He was breathing but initially unresponsive. Prison healthcare staff treated him until paramedics arrived and took him to hospital. At hospital, tests showed that he had a bleed on his brain and had broken his neck. His condition became critical and he was placed on life support. With the agreement of his next of kin, doctors removed the life support and he died that day.

I am pleased to note that the man was not restrained during his final hospital stay, but I am concerned that the prison used restraints for his previous hospital admission when his health and mobility were very poor and without a fully considered risk assessment to justify their use. The investigation found that there were good care plans to manage his conditions, but these were not always followed and kept up to date. However, this did not affect the outcome for him. The clinical reviewer was satisfied, and I agree, that overall, he received a good standard of care at HMP Birmingham.

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 2015**

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## SUMMARY

1. On 17 May 2012, the man was remanded to HMP Hewell charged with sexual offences. On 14 June 2012, he was convicted and sentenced to 15 years imprisonment and went to HMP Birmingham.
2. The man's health and mobility was poor at the time he was sentenced and his conditions included heart disease. Healthcare staff at the prison saw him frequently to manage his care and often admitted him to the prison's inpatient unit. He had occasional admissions to hospital to treat heart failure and healthcare staff created care plans to manage his heart condition. A physiotherapist saw him occasionally and gave him advice and equipment to help improve his mobility.
3. The man had pedal oedema (a build up and leaking of fluid from his legs) and experienced dizzy spells, a symptom of his heart failure. His dizziness occasionally caused him to fall and healthcare staff assessed him after each fall. Prison doctors prescribed medication to treat these symptoms and drew up care plans to reduce his risk of falling.
4. In March 2014, the man's heart condition deteriorated and he was admitted to hospital between 3 and 13 March. When the hospital discharged him, healthcare staff admitted him to the prison's inpatient unit so they could care for him there. He did not always follow medical advice to help improve his condition and nurses often saw him sitting in his chair during the night, although he had been advised to keep his legs raised to improve his circulation.
5. On 24 April, the man fell in his cell and suffered a head and neck injury. An emergency ambulance took him to hospital where doctors treated him for bleeding on the brain. His condition deteriorated and he died a week later.
6. We agree with the clinical reviewer that the standard of healthcare the man received at HMP Birmingham was equivalent to that he could have expected to receive in the community. While it did not affect the outcome for him, his care plans were not always strictly followed and kept up to date through regular reviews. We are also concerned that, despite his lack of mobility and poor health, he was restrained without a fully considered risk assessment when he stayed in hospital in March 2014. We make two recommendations about these matters.

## THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners at HMP Birmingham informing them of the investigation and inviting anyone with relevant information to contact him. No one responded.
8. NHS England commissioned a clinical reviewer to review the man's clinical care in prison.
9. The investigator obtained copies of the man's prison medical records and relevant extracts from his general prison record. The investigator, clinical reviewer and another investigator interviewed two members of staff at Birmingham on 27 June 2014. The investigator later interviewed another member of staff by telephone.
10. We informed HM Coroner for the City of Birmingham and the Borough of Solihull of the investigation. The investigation was suspended on 18 June and reopened on 22 August, as the coroner was originally unable to provide a cause of death. The coroner held an inquest into the man's death on 8 September and the investigator gave a brief summary of the progress of the investigation and findings at that time. The coroner recorded a verdict of natural causes. We have sent the coroner a copy of this investigation report
11. The Ombudsman's family liaison officer tried to contact the man's son via a charity who had assisted him. This was to offer him the chance receive a copy of the draft version of the investigation report. To date we have received no further contact. I hope that the findings of my investigation answer any questions his son may have, should he receive the report in the future.
12. The draft report was issued for consultation with the prison service. There were no factual inaccuracies and the action plan has been added to the end of this report.

## **HMP BIRMINGHAM**

13. HMP Birmingham is a large local prison, principally serving the West Midlands courts. It holds up to 1450 remand and sentenced men. Since 1 October 2011, it has been managed by G4S Care and Justice Services.
14. Birmingham and Solihull Mental Health Foundation Trust provide 24 hour health services at the prison. Primary care services are subcontracted to Birmingham Community Healthcare NHS Trust.

## **HM Inspectorate of Prisons**

15. The most recent inspection of HMP Birmingham was in March 2014. Inspectors noted that health services were generally very good and valued by most prisoners. However, rates of non-attendance at healthcare appointments were too high. There was a reasonable mix of daytime activities for inpatients but no education provision. External health appointments were rarely cancelled for security reasons. Inspectors noted that a palliative care room had been opened in the healthcare centre.

## **Independent Monitoring Board**

16. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that prisoners are treated fairly and decently. In its most recently published report for the year to June 2013, the IMB noted that healthcare provision was available in the prison 24 hours a day, with nurses on duty throughout the night. Doctors were on site every weekday and a locum service provided evening and weekend cover. Prisoners could usually see a GP within a week and almost immediately if urgent. The IMB noted that a palliative care cell was now available for use and appropriate for its purpose.

## **Previous deaths at HMP Birmingham**

17. The man was the fourth prisoner to die from natural causes at HMP Birmingham since July 2012. We have previously raised the issue of the need for fully considered security risk assessments for the use of restraints.

## KEY EVENTS

18. In May 2012, the man was remanded to HMP Hewell charged with serious sexual offences between 1971 and 1984. His health and mobility was poor and he had a history of heart disease and joint problems. He had suffered a stroke two years earlier. A GP at Hewell assessed him and recorded that a referral to a cardiologist should be considered after he had been sentenced and his prison location was known. On 14 June 2012, he was convicted and sentenced to 15 years in prison. He went to HMP Birmingham.
19. At the man's initial health screen at Birmingham, staff recorded that he needed a walking stick and was taking medication for acid reflux and aspirin. Two days later, he told a nurse that he had had a fall just before he had been sent to prison in May and he had been feeling dizzy ever since. The nurse booked an appointment for him to see the prison GP.
20. On 28 June, a doctor examined the man. He noted his history of heart problems and prescribed prochloroperazine for the dizziness. A week later, he reviewed him again and noted that he was still feeling dizzy. The doctor also found some bruising on the left side of his body. He told the doctor that he had fallen from his bed a few days before, but had not told anyone. The doctor admitted him to the healthcare centre so that nurses could monitor him and to identify the cause of his dizziness.
21. On 6 July, a nurse saw the man fall while he was collecting his medication from the hatch. A doctor assessed him and took an electrocardiogram (ECG - a test to check the rhythm of the heart) which showed that his heart was not working properly. He recorded in the medical notes that he had heart failure but his current aspirin prescription was sufficient to treat this for the time being.
22. Over the next few weeks, the man's health deteriorated. On 27 July, a doctor diagnosed atrial fibrillation, an irregular heart rhythm that can cause dizziness and shortness of breath. The GP prescribed digoxin to control irregular heart rhythms and furosemide (a diuretic that prevents ankle swelling.) He adjusted his medication to include bisoprolol (a beta blocker) and ramipril (for high blood pressure) when his heart condition deteriorated. Nurses created a care plan to treat pedal oedema (a build up and retention of fluid in the legs that leads to swelling and is a direct result of heart failure). The plan included regular observations and encouraging him to restrict the quantity of fluids he drank.
23. Medical records show that the man fell a number of times in prison, without suffering a serious injury. Healthcare staff examined him after he fell and referred him to hospital for scans when appropriate. Nurses created care plans to help him manage his mobility and reduce the risk of him falling. They helped him keep his cell tidy to avoid trip hazards. A physiotherapist reviewed him regularly and advised him about improving his mobility and gave him walking aids. Nurses encouraged him to follow a healthier diet and exercise regularly, including using the gym.

24. Healthcare staff reviewed the man frequently to treat and monitor his heart condition and he went to hospital a number of times when his condition deteriorated or he needed specialist treatment. In July 2013, hospital doctors diagnosed him with congestive cardiac failure. They discharged him with advice about controlling the symptoms.
25. Over time, the man's heart condition worsened. On 3 March 2014, a nurse examined him when he appeared unwell. She recorded that he was short of breath, had hypertension and an abnormally high heart rate. She noted that his weight had increased significantly (11kg) since the previous month, when nurses last recorded his weight. (A doctor had asked healthcare staff to record his weight at least twice a week as significant weight gain can indicate deterioration in congestive heart failure.) She consulted a prison GP, who referred him to hospital.
26. Later that day, an ambulance took the man to hospital where scans showed his symptoms were caused by his worsening heart condition. The hospital admitted him for observation. Doctors discharged him on 13 March. Two prison officers escorted him during his stay at the hospital and restrained him using an escort chain. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.)
27. When he returned to the prison, the man was admitted to the healthcare centre as an inpatient. Staff updated his care plan to reflect his deteriorating heart condition and explained his condition and treatment to him. He received oxygen therapy and further diuretic medication to treat his oedema. He had a special air mattress to improve circulation and nurses monitored his heart rate regularly.
28. As the man's health deteriorated, a nurse discussed the possibility of hospice care with him and contacted a palliative care nurse at a hospice in Birmingham. She discussed his condition with a healthcare manager and they decided that he had not yet reached a palliative stage. She referred him to a Community Health Care heart failure team for specialist treatment advice. A specialist heart failure nurse visited him at the prison a few weeks later and advised healthcare staff about his treatment.
29. On 31 March, a cleaner found the man kneeling on the floor of his cell. He told a nurse that he had slid off the air mattress when he sat on the edge of the bed. The nurse arranged for him to have a different type of mattress and referred him for a GP review. A doctor examined him later that day and did not find any serious injuries. The doctor noted that he was leaking a lot of fluid from his legs, because of his worsening heart failure. He told him that he needed to keep his legs raised as much as possible, to improve his circulation and help prevent fluid collecting in his feet. Nurses regularly dressed his legs to help reduce the fluid.
30. On 4 April, a nurse recorded that the man had slept in a chair all night. She asked him to get into the bed and raise his legs several times, but he refused.

Over the next weeks, nurses often saw him sitting on the edge of the bed. Although they continued to explain the importance of keeping his legs raised, he would not follow this advice.

31. On 8 and 11 April, the man had minor falls and nurses recorded that he had slight bruising. On 22 April, a nurse completed a falls risk assessment. She created a care plan to reduce the risk of him falling. This included advice on how to get out of bed safely and to get back up without further injury. It also suggested that he should keep his room tidy and the floor dry so that he would not slip over.
32. On 24 April, shortly after 3.00pm, the man fell while getting dressed. A prisoner cleaner, who saw him fall, alerted a nurse. The nurse went to his cell immediately and found him lying on his left side with his head against the wall. He was breathing, but unresponsive and a small amount of blood was coming from his head. The nurse called for help and two nurses and an officer went straight to the cell. The other nurses began to take his medical observations, while the first nurse brought a hoist to lift him from the floor. When he got back, he asked another nurse to get the doctor while he called an ambulance. He phoned the control room and the ambulance log shows the prison requested this at 3.06pm.
33. A nurse called for the doctor who was on the floor below. At 3.08pm, the doctor arrived at the cell and noted that the man's oxygen levels and blood pressure were low. Nurses gave him oxygen through a breathing mask and he was able to respond to them, but appeared very unwell. An ambulance arrived a few minutes later and a second ambulance arrived at 3.15pm. An ambulance took him to hospital at 3.49pm.
34. At the hospital, a CT scan showed that the man had a subdural haematoma (a bleed on the brain) and a fractured neck. On 25 April, doctors advised one of the officers accompanying him that he was in a critical condition, and suggested they should let his next of kin know. The prison's Head of Safer Custody telephoned the man's son and told him that his father was in hospital. Later that night, he transferred to another hospital for surgery to stop the bleeding on his brain. After the operation, he was sedated and placed on a life support machine.
35. The next morning, the man's son visited the hospital. He met the Head of Safer Custody, who explained his father's situation. He told him that a prison family liaison officer (FLO) would keep in contact him. On 29 April, the FLO tried to speak to him but he was not at home.
36. In the early hours the man's condition deteriorated. At 9.00am, a hospital nurse phoned the man's son and suggested he should come to the hospital urgently. At 11.50am, when he arrived, doctors told him his father's condition was critical. They advised him that they considered they should end the life support. His son agreed, and at 12.15pm, the hospital removed life support. He died at 12.55pm.

37. The prison's family liaison officer arrived at the hospital a short time after the man had died. She met his son and offered her condolences and support. In line with national guidance, the prison offered a contribution to the cost of the funeral, which took place on 19 June.
38. The prison issued notices informing staff and prisoners of the man's death and offering support to anyone affected. A manager debriefed the staff who had been involved in his care and the emergency response and offered them support.

### **Post-mortem**

39. A post-mortem examination, found that cause of death was multi-organ failure with subdural haematoma (bleeding on the brain) and fractured neck of femur in a patient with severe valvular heart disease and atrial fibrillation.

## ISSUES

### Clinical Care

40. The man arrived at Birmingham in June 2012 and had timely health assessments. Throughout this time at Birmingham, healthcare staff saw him frequently to monitor his heart condition. He was often an inpatient in the prison's healthcare centre for treatment or monitoring. Healthcare staff referred him to hospital for treatment when his condition deteriorated. The clinical reviewer concluded that his standard of healthcare in prison was equivalent to that he could have expected to receive in the community.
41. Healthcare staff created a number of care plans aimed at treating the man's deteriorating heart disease and related symptoms. The clinical reviewer commented that these were not reviewed as often as they should have been. In March 2014, a nurse at the prison contacted Birmingham Community Healthcare heart failure team for specialist advice.
42. Birmingham Community Healthcare NHS Trust's Policy for the Prevention and Management of Falls involving Patients and Service Users (issued November 2012) states that *"The Falls Risk assessment must be repeated weekly for patients in bedded units in the Adults and Communities Division and Rehabilitation services, if there is a change in the patient's condition or treatment, or if the patient has a subsequent fall"*. Healthcare staff created a care plan specifically to reduce the man's risk of falling. However, they did not review this regularly, in line with the Trust's policy.
43. One of the man's care plans included regular monitoring of his weight. This was important as changes in weight can indicate worsening heart failure. The medical notes show that there were times when this was not recorded as often as the plans expected.
44. We agree with the clinical reviewer's assessment that the man received care at the prison equivalent to that he could have expected to receive in the community. We are satisfied that he received appropriate support for his health problems and that healthcare staff actively supported him and ensured he was in an appropriate setting for his chronic heart condition. Commendably, they initiated appropriate care plans to manage his conditions, including the risk of falls. However, they did not always follow the plans or review them as frequently as necessary. We do not consider that this would have affected the outcome for him, but it is important to manage patients in line with appropriate care plans. We make the following recommendation:

**The Head of Healthcare should ensure that healthcare staff manage patients in line with agreed care plans, which are reviewed and updated as necessary.**

## Restraints, security and escorts

45. When prisoners have to travel outside prison, such as to a hospital, a risk assessment is conducted to determine the nature and level of any security arrangements, including any restraints.
46. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity and maintain their dignity. The level of restraints used should be necessary in the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes account of factors such as the prisoner's health and mobility. 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 when the same prisoner is suffering from a serious medical condition. The judgement indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process. It said that using handcuffs to restrain a prisoner receiving chemotherapy (and by implication, other life saving treatment) was degrading and would also be likely to be inhumane, unless justified by other relevant considerations.
47. On 3 March, only two months before the man died, he was taken to hospital when his heart condition deteriorated. At the time, he was very ill and his mobility was very poor. Two prison officers accompanied him and used an escort chain to restrain him. His level of security risk was shown as medium, including for risk of escape, risk of hostage taking and risk to public. (We note that his offences had been committed over thirty years earlier when he was much younger and presumably in much better health.) There is no evidence of any healthcare risk assessment and the documentation contains no mention of his poor mobility or congestive heart failure. There was no mention of whether or how his condition impacted on his risk of escape, as the court judgement requires.
48. Public protection is paramount, but security measures must be proportionate to a prisoner's individual circumstances, which must be fully considered, taken into account and balanced against the security risks. The man had a chronic medical condition that meant his mobility was limited and he was prone to falling. Records show that he required a wheelchair or walking frame to mobilise, calling into question the assessment of his risk of escape. We are not satisfied that the use of restraints was justified by fully considered risk assessments that took into account his risk and condition at the time. This is a matter we have raised with Birmingham a number of times before. However, we are pleased to note that he was not restrained when he was taken to hospital as an emergency on 24 April.
49. Ultimately, it is the Director's responsibility to ensure that the process is managed properly, but the Head of Healthcare also needs to ensure that healthcare staff understand their responsibilities and have appropriate and considered input into the risk assessment process. We make the following recommendation:

**The Director and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.**

## **RECOMMENDATIONS**

1. The Head of Healthcare should ensure that healthcare staff manage patients in line with agreed care plans, which are reviewed and updated as necessary.
2. The Director and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

## ACTION PLAN

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible
1	The Head of Healthcare should ensure that healthcare staff manage patients in line with agreed care plans, which are reviewed and updated as necessary.	Accepted	A 'named nurse' process has been put in place on ward one. Each patient admitted to the ward has an allocated nurse who takes responsibility for the care of the patient including, care planning, case reviews and discharge planning. Care plans are revised as required and reviewed through clinical discussions and clinical supervision.	Completed  Head of Healthcare
2	The Director and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.	Accepted	When assessing the needs of patients who present with complex medical needs and are also identified as a high security risk, staff have been reminded that information should be shared between prison and healthcare staff. This will insure that risk assessments are based on available information and that risk is managed in a manner that is proportionate to any perceived risk the patient may pose.	Completed  Director and Head of Healthcare