Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Andrew Liddle a prisoner at HMP Birmingham on 7 November 2016

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Andrew Liddle died on 7 November 2016 of a heart attack at HMP Birmingham. Mr Liddle was 46 years old. I offer my condolences to Mr Liddle's family and friends.

I am satisfied that Mr Liddle received a good standard of clinical care for the short time he was at Birmingham, which was equivalent to that he could have expected to receive in the community. I am satisfied that healthcare staff appropriately managed his health conditions and they could not have predicted or prevented Mr Liddle's sudden death. However, I am concerned that appropriate emergency codes were not used when Mr Liddle collapsed, although I recognise that this did not affect the outcome for him.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **May 2017**

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Summary

Events

1. On 1 November 2016, Mr Andrew Liddle received a 26 week custodial sentence for actual bodily harm and was sent to HMP Birmingham.

2. On arrival at Birmingham, a nurse assessed Mr Liddle and he said that he had high blood pressure, depression and Crohn's disease (an inflammatory bowel condition). He also smoked cannabis on a daily basis. The nurse referred him to the Integrated Drug Treatment Service (IDTS). Later that day, a prison GP assessed Mr Liddle and prescribed medication for Crohn's disease, but delayed prescribing medication for his blood pressure until a community GP provided Mr Liddle's past medical history and prescribed medications.

3. On 2 November, an IDTS prison doctor assessed Mr Liddle. He noted that Mr Liddle looked well and did not require detoxification. Mr Liddle refused further intervention from the IDTS team.

4. Later that day, Mr Liddle had a second health assessment. The nurse noted he was very underweight, inactive, a heavy smoker and had raised blood pressure. He was given lifestyle advice, including about smoking cessation. A nutritional supplement was prescribed to increase his weight and weekly appointments to monitor weight gain and blood pressure were booked.

5. On 3 November, the community medical records confirmed Mr Liddle's medical conditions and a list of prescribed medications. The GP prescribed medication for Mr Liddle's Crohn's disease and high blood pressure.

6. On 7 November at 3.19pm, another prisoner found Mr Liddle collapsed on the floor of the toilet and placed him in the recovery position. He alerted an education officer, who noted that Mr Liddle was breathing but unresponsive. She tried to call for medical assistance but her radio battery was flat and she had to use the telephone in the office next door. When a nurse attended at 3.20pm, Mr Liddle's condition began to deteriorate and he stopped breathing. The nurse called a code blue emergency (a code that indicates a prisoner is unconscious, not breathing or is having breathing difficulties) at 3.21pm and carried out cardiopulmonary resuscitation until the paramedics arrived at 3.38pm and took over.

7. At 4.09pm, Mr Liddle was transferred to hospital. Hospital staff queried why Mr Liddle had a large surgical scar on his chest, which would indicate a historic heart condition. Mr Liddle had not disclosed any pre-existing heart conditions and there was no information in the community medical records. Hospital staff continued to deliver cardiopulmonary resuscitation, but their attempts were unsuccessful and they confirmed that Mr Liddle had died at 5.30pm.

Findings

8. We are satisfied that Mr Liddle received a good standard of healthcare at Birmingham, equivalent to that he could have expected to receive in the community. Mr Liddle was promptly referred to the IDTS team for his cannabis

use, and his high blood pressure was monitored appropriately. Mr Liddle's death was sudden and healthcare staff could not have predicted or prevented it.

9. Although it did not affect the outcome for Mr Liddle, the education officer who found him unresponsive did not have a fully charged radio and was unaware that the circumstances justified her to call an emergency code, which would have triggered an immediate request for an ambulance. This did not overly delay the medical response for Mr Liddle but in other circumstances such a delay could be crucial.

Recommendation

- The Director should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including using the appropriate emergency code to effectively communicate the nature of a medical emergency and ensure an emergency ambulance is called immediately.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Birmingham informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

11. The investigator obtained copies of relevant extracts from Mr Liddle's prison and medical records. She also interviewed five members of staff by telephone on 20 December 2016.

12. NHS England commissioned a clinical reviewer to review Mr Liddle's clinical care at the prison.

13. We informed HM Coroner for Birmingham and Solihull of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

14. The investigator wrote to Mr Liddle's wife to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond to our letter.

15. The initial report was shared with the Prison Service. The Prison Service pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Birmingham

16. HMP Birmingham is a local prison, principally serving the West Midlands courts, and holds up to 1,450 men. It is managed by G4S Care and Justice Services. Birmingham and Solihull Mental Health Foundation Trust provides 24-hour health services at the prison and sub-contract Birmingham Community Healthcare NHS Trust to provide primary care services, which includes a 30 bed healthcare unit, split into two wards.

HM Inspectorate of Prisons

17. 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. All prisoners received an initial health screening in reception and a follow up assessment, and GPs in the community were contacted at the beginning of a prisoner's custody to ensure continuity of care. An introductory leaflet about health services was given to prisoners on most wings. The inspectors noted a wide array of nurse-led primary care and lifelong conditions clinics and GP surgeries. Onsite nurses were available out of hours and GPs were on call.

Independent Monitoring Board

18. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to June 2016, the IMB reported that, on arrival, all prisoners are screened by NHS nurses for physical and mental health issues, and attend a Wellman Clinic within 24 hours. The report noted that there continued to be a generally high level of prisoner satisfaction with healthcare provision.

Previous deaths at HMP Birmingham

19. Mr Liddle was the sixth prisoner to die from natural causes at Birmingham since January 2015. There have been three other deaths since. There are no significant similarities with the circumstances of the previous deaths.

Key Events

20. On 1 November 2016, Mr Andrew Liddle received a 26 week custodial sentence for actual bodily harm and was sent to HMP Birmingham.

21. On the same day, a nurse assessed Mr Liddle during his reception health screening. Mr Liddle told him he had high blood pressure, depression and Crohn's disease, and he smoked cannabis daily. He referred Mr Liddle to a prison GP and the Integrated Drug Treatment Service (IDTS). Later that day, a prison GP prescribed azathioprine and dosulepin for Crohn's disease and depression. However, the medication for his high blood pressure was not known, so his community medical records were requested urgently.

22. On 2 November, a prison GP assessed Mr Liddle. He noted he was cannabis dependant but looked fine and did not require detoxification. Mr Liddle refused further intervention. Later that day, Mr Liddle had a second health assessment. A nurse noted that Mr Liddle was underweight, a heavy smoker and had high blood pressure. She gave him smoking cessation advice, prescribed Fortisip (a nutritional supplement for weight gain) and arranged weekly appointments to monitor his weight and blood pressure.

23. On 3 November, Mr Liddle's community medical records arrived with details of his health conditions and prescribed medications. A prison GP prescribed losartan for Mr Liddle's high blood pressure and asacol for his Crohn's disease.

Events of 7 November 2016

24. On 7 November at around 3.10pm, Mr Liddle asked an education officer if he could go to the toilet. A few minutes later, another prisoner went to the toilet, found that Mr Liddle had collapsed and placed him in the recovery position. The prisoner told an education officer, who was teaching in the room opposite, that Mr Liddle had collapsed. She responded immediately and saw Mr Liddle in the recovery position, unresponsive but breathing on the floor. Her radio battery was flat so she ran to the office next door and rang the prison's control room at approximately 3.19pm to ask for medical assistance. The control room asked for healthcare assistance.

25. Two nurses immediately responded to the request for medical assistance with a red medical bag containing a blood pressure machine, blood glucose monitor, pulse oximeter and a tympanic thermometer. Mr Liddle initially had a respiratory output and a pulse. At 3.20pm, a nurse requested the blue medical bag, a larger emergency bag containing a defibrillator (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest), oxygen cylinder, manual suction, more airways and further medication.

26. At 3.21pm, Mr Liddle stopped breathing and had no pulse. A nurse called a code blue emergency, triggering an ambulance to be called, and started cardiopulmonary resuscitation (CPR). Another nurse attended with the blue bag then the nurses applied the defibrillator to Mr Liddle's chest, which advised not to shock. Two nurses continued with CPR for seventeen minutes, managing to get and maintain a pulse until the paramedics attended at 3.38pm and took over.

27. Mr Liddle was transferred to hospital at 4.13pm with his medical notes but a call from the hospital stated these had not been received. The hospital requested a verbal medical background and queried why Mr Liddle had a large scar on his chest. The prison was unable to provide information about the scar as Mr Liddle had not disclosed any information about it and there was nothing in his community medical records. The hospital continued to administer life saving treatment, which was unsuccessful and they confirmed that Mr Liddle had died at 5.30pm.

Contact with Mr Liddle's family

28. At 6.00pm on 7 November, the Director and the Head of Safer Custody met with Mr Liddle's registered next of kin at the hospital. It emerged that she was Mr Liddle's Probation Officer and his next of kin would be his estranged wife. The Director and Head of Safer Custody visited Mr Liddle's wife at her home address at 7.30pm that night to inform her of Mr Liddle's death.

29. At 2.00pm the following day, the prison appointed a trained family liaison officer as the family liaison officer. She discussed Mr Liddle's death with the Probation Officer and they agreed that Mr Liddle's estranged wife should be his next of kin. She called Mr Liddle's wife to introduce herself and arranged to visit the following day. She offered her condolences and ongoing support.

30. Mr Liddle's funeral was held on 30 November. The prison contributed towards the costs in line with national policy.

Support for prisoners and staff

31. After Mr Liddle's death, the Director debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

32. The prison posted notices informing other prisoners of Mr Liddle's death, and offering support. Staff reviewed the prisoner involved and all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Liddle's death.

Post-mortem report

33. The post-mortem concluded that Mr Liddle died from acute left ventricular failure, caused by coronary heart disease. The toxicology report indicated the presence of cannabinoids in his blood and is consistent with the use of cannabis. Mr Liddle had already disclosed that he was a long-term user of cannabis so this result would be expected.

Findings

Clinical care

34. Mr Liddle had been at Birmingham for seven days when he died. In his first few days, healthcare assessments identified that he suffered with Crohn's disease, high blood pressure, cannabis and cigarette consumption, and low weight. An IDTS doctor assessed Mr Liddle promptly. He was given smoking cessation advice and declined further intervention for cannabis use, and his blood pressure and weight was monitored on a weekly basis.

35. The investigation found that there was no evidence that Mr Liddle suffered from symptoms of heart disease, or complained of any symptoms to healthcare staff, in the week before he died. Mr Liddle did not disclose his pre-existing heart condition, which involved an operation to insert a heart valve some years previously and there was no mention of this in his community medical records. Had Mr Liddle mentioned his pre-existing condition it would have given Birmingham the opportunity to make necessary referrals, but was unlikely to have changed the outcome.

36. The clinical reviewer considered that Mr Liddle's death was sudden and unexpected and there was nothing that healthcare staff could have done to prevent it. While his death was unexpected, the clinical reviewer considered that it was not unusual considering his poor health and that his medical conditions all contributed to heart disease. The clinical reviewer considered that Mr Liddle received a good standard of primary care during his short stay at Birmingham.

37. We are satisfied that the prison healthcare team monitored Mr Liddle appropriately in his short time at Birmingham. His care was equivalent to that he could have expected to receive in the community.

Emergency response

38. When the education officer saw Mr Liddle collapsed on the toilet floor and unresponsive, she did not call an emergency code. She tried to alert communications by radio but her battery was flat. She explained that the prison was responsible for charging radios overnight and that she did not realise hers was not charged until she came to use it. While this is concerning, it does not appear to have overly delayed her requesting medical assistance, as it took a matter of seconds to access a telephone in the office next door. On this occasion, the short duration from discovering Mr Liddle to alerting medical staff did not cause a delay to the emergency response. However, we remind Birmingham to ensure that radios are fully charged and are ready for use, as in another situation this could have had a detrimental outcome.

39. Prison Service Instruction (PSI) 03/2013 'Medical Emergency Response Codes', contains a mandatory instruction that prison staff should use a code blue (or code one) for any emergency where a prisoner in unresponsive, has symptoms including chest pain and difficulty in breathing and that they should not delay summoning emergency assistance.

40. When discussing why a code blue had not been called initially, the education officer thought that a code blue was for prisoners who were not breathing. She advised that, as a member of education staff, she had not been trained regarding emergency codes. The prison's local emergency response protocol states that "when a member of staff on scene discovers a potentially life threatening health related scenario, they must use the Code Red or Code Blue prefix over the radio net or telephone system". She told the investigator that, since Mr Liddle's death, she and her peers had now had full training and she was aware that a code blue should be called if a prisoner is unresponsive. She fully appreciated that it should have been called when she found Mr Liddle.

41. The education officer contacted the communications room at 3.19pm for medical assistance. A nurse attended and called the code blue two minutes later. While there was a two minute delay in calling an ambulance, medical staff worked hard to maintain Mr Liddle's condition and pulse for seventeen minutes until the ambulance attended. While the two minute delay did not affect the outcome for Mr Liddle, it could be crucial in other circumstances. We make the following recommendation:

The Director should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including using the appropriate emergency code to effectively communicate the nature of a medical emergency and ensure an emergency ambulance is called immediately.

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