Prisons &
Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Christopher Joyce a prisoner at HMP Birmingham on 8 December 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*

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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 Christopher Joyce died on 8 December of meningitis at HMP Birmingham. Mr Joyce was 52 years old. I offer my condolences to Mr Joyce's family and friends.

The clinical reviewer is satisfied that staff appropriately assessed Mr Joyce and, as he did not have classic meningitis symptoms, his death was not preventable. However, I have some concerns about the emergency response, including staff having problems with equipment and a failure to call an ambulance straight away.

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 **July 2017**

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Summary

Events

1. On 23 November 2016, Mr Christopher Joyce was sentenced to 16 weeks imprisonment for theft and breach of a criminal behaviour order and was sent to HMP Birmingham.

2. Mr Joyce's initial health screen highlighted his heavy alcohol abuse, liver problems and gastric ulcers.

3. On 7 December at 4.00pm, a nurse assessed Mr Joyce in his cell as he had complained that he did not feel right and his hands were tingling. The nurse took his blood pressure, pulse and oxygen saturation levels, which were all normal. The nurse gave him some paracetemol and officers gave him more that evening.

4. The officer who did the roll count the next morning at 6.15am did not recollect anything unusual but when another officer from the Drug and Alcohol Team went to visit Mr Joyce at approximately 8.40am, she found him half naked on the floor of his cell which was in a state of disarray. Mr Joyce did not respond when she called his name and as she was nervous about entering the cell on her own, she went to get colleagues from the wing office to assist.

5. When officers arrived and entered his cell, they tried to get a response by shaking Mr Joyce and tried to find his pulse. After these attempts failed, an officer called a code blue emergency (which indicates that a prisoner is unconscious or not breathing) at 8.55am. Healthcare staff attended promptly but staff in the control room did not call an ambulance immediately, as they asked for more information about Mr Joyce's condition before calling emergency services at 8.58am.

6. A nurse tried to revive Mr Joyce and, when his colleague arrived, insert an airway. However, rigor mortis was present preventing this. The nurses started cardio pulmonary resuscitation anyway and applied a defibrillator (which advised one shock and none further) until paramedics took over. The paramedics stopped shortly after and, at 9.13am, they pronounced Mr Joyce dead.

Findings

7. The clinical reviewer considered that the care Mr Joyce received at Birmingham was equivalent to that he could have expected to receive in the community. She considered that Mr Joyce did not exhibit some of the symptoms more commonly associated with meningitis, such as having a stiff neck or a fever and that he had risk factors (being an older man with a history of alcoholism), which reduced his chances of survival. We agree with the clinical reviewer that Mr Joyce's death was neither predictable nor preventable. She considered that the resuscitation attempt in the light of the presence of rigor mortis was unnecessary.

8. We are concerned that the officer who was the first on scene was unclear whether she had a radio with her because radios were frequently not charged. We are concerned that control room staff failed to call an ambulance immediately on hearing the code blue emergency code.

Recommendations

- The Director should ensure that sufficient staff are able to obtain charged radios at the start of their shifts.
- The Director should ensure that the prison's emergency response protocol ensures that when a code red or blue is called, staff in the control room call an ambulance immediately.
- The Director and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is inappropriate.

The Investigation Process

9. 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.

10. The investigator obtained copies of relevant extracts from Mr Joyce's prison and medical records.

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

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

13. Mr Joyce did not supply contact details for his next of kin when he arrived in Birmingham and the prison, probation service and coroner's office were unable to trace them. As a result, we have not been able to contact his next of kin to explain the investigation and to ask if they had any matters they wanted the investigation to consider.

14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly. We note that the prison has accepted all our recommendations. However, their action point in relation to charged radios addresses accessibility to radios and their coverage. It also mentions that the radios display how charged a particular unit is, but we wish to reiterate that when staff come on duty they should have access to one that has already been charged.

Background Information

HMP Birmingham

15. 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 15 bed healthcare unit.

HM Inspectorate of Prisons

16. 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. Patients with complex, acute or chronic needs had access to well-organised inpatient units staffed by caring nurses and officers. External health appointments were rarely cancelled for security reasons. Inspectors noted that the healthcare centre had a new palliative care room and waiting times to see the doctor were less than 48 hours.

Independent Monitoring Board

17. 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 healthcare staff sickness levels had had a negative impact on the prison regime, particularly when multiple unlock was required. However, there continued to be a high level of prisoner satisfaction with the service provided by the healthcare department.

Previous deaths at HMP Birmingham

18. Mr Joyce is the sixth prisoner to die of natural causes at Birmingham since January 2016. There has been one subsequent natural cause death. We have made recommendations about emergency response procedures before and noted issues with charging radios.

Key Events

19. On 23 November 2016, Mr Christopher Joyce was sentenced to 16 weeks imprisonment for theft and breach of a criminal behaviour order and was sent to HMP Birmingham.

20. On arrival at Birmingham, a nurse completed Mr Joyce's initial health screen. Mr Joyce told the nurse he drank more than 100 units of alcohol a week and used cocaine and butane gas. The nurse noted that Mr Joyce had a rash on his chest that might be scabies, that he had liver problems and gastric ulcers (coughing up fresh blood) although he was receiving treatment for these.

21. The nurse arranged for Mr Joyce to see a doctor and made a Wellman Clinic appointment. Wellman appointments are routinely offered to men over fifty and provide a range of health checks including lifestyle, circulatory and respiratory issues. Mr Joyce saw a prison GP the same day and he prescribed various medications for Mr Joyce's conditions including the rash. Mr Joyce had a secondary health screen with a nurse on 24 November.

22. On 7 December at approximately 4.00pm, a prisoner called a prison manager to Mr Joyce's cell. When he got there, Mr Joyce was sweating but saying he was freezing and banging his head with the heel of his hands. He said his face did not feel right and his hands were tingling.

23. A nurse came to Mr Joyce's cell. Mr Joyce said that felt sick, dizzy and generally unwell. The nurse took Mr Joyce's pulse, blood pressure and blood oxygen saturation levels, which were all normal. His pupils were also normal size. The nurse gave Mr Joyce two paracetemol and told him to call healthcare again if his headache persisted. The nurse noticed that there appeared to be vomit in Mr Joyce's sink, but Mr Joyce denied he had been sick.

24. At 10.00pm, an officer spoke to Mr Joyce briefly at his cell door after Mr Joyce called out to him. Mr Joyce said that he had asked for some more paracetemol but was still waiting for them. As they were having this conversation, the officer brought Mr Joyce some paracetamol tablets. After giving Mr Joyce the tablets officers left Mr Joyce in his cell. As Mr Joyce was not recognised as being seriously ill, no plans were put into place to check on Mr Joyce overnight.

25. The next morning at approximately 5.40am, an officer started the roll check. He got to Mr Joyce's cell at approximately 6.15am but does not remember anything out of the ordinary.

26. At approximately 8.40am, an officer from the Drug and Alcohol Recovery Team went to visit Mr Joyce. She looked through the observation panel but it was too dark to see much so she unlocked the door. Mr Joyce was lying on the floor, half naked, and she described his cell as 'trashed' with items all over the floor. He did not respond to her calling his name from the doorway. She locked the door and went to get officers from the wing office. She did not go into the cell because she was nervous about Mr Joyce's presentation and the state of the cell, which made her feel unsafe. She was aware of the prison's emergency codes and in what circumstances they are appropriate. She thought she might not have called an emergency code because it was possible that she did not have a charged

radio. She said it was not unusual for her to start her shift and find that the radio batteries have not been charged overnight.

27. Another officer accompanied the officer to Mr Joyce's cell, went in and called Mr Joyce's name but he did not respond. He shook Mr Joyce by the arm and checked for a neck pulse. He could not feel a pulse but Mr Joyce's neck was warm so he thought he might still be alive although the rest of his body was cold. He called a code blue emergency code (which indicates that a prisoner is unconscious or not breathing) on his radio at 8.55am. A nurse responded to the code blue and put a call out for any other available nurses to also attend.

28. Staff in the control room asked for more information about Mr Joyce's condition and when it was confirmed he was not breathing they called an ambulance. The ambulance was called at 8.58am.

29. The nurse arrived at Mr Joyce's cell at approximately 8.58am. He put Mr Joyce in the recovery position and asked officers to bring the emergency 'blue' bag (a bag kept on each wing, which contains life saving equipment including a defibrillator and a ventilator). An officer brought one quickly. The nurse started chest compressions and then attempted to insert an airway into Mr Joyce's mouth when another nurse arrived (at approximately 9.05am). However, Mr Joyce's jaw had locked as rigor mortis had set it in. The nurse set up the defibrillator and administered one shock, as advised, which had no effect. The nurses continued chest compressions until paramedics arrived.

30. Paramedics arrived at the cell at approximately 9.03am and took over chest compressions but stopped shortly after, declaring Mr Joyce's death at 9.13am.

Contact with Mr Joyce's family

31. On arrival in Birmingham, Mr Joyce said that his mother was his next of kin but he did not give correct contact details for her. On the day of his death, the prison appointed an officer to break the news of his death to his next of kin. She visited three addresses found within Mr Joyce's prison record but was unable to locate anyone with a connection to him. She sought assistance from the police, probation service and coroner's office but they were also unable to trace Mr Joyce's next of kin.

32. Mr Joyce's funeral was held on 20 February 2017 and the prison arranged and paid for it, in line with national instructions.

Support for prisoners and staff

33. On 8 December, a prison manager 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.

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

Post-mortem report

35. The post-mortem report concluded that Mr Joyce died of acute pyogenic meningitis (Streptococcus pneumoniae).

Findings

Clinical care

36. The clinical reviewer considered that the care HMP Birmingham gave Mr Joyce was equivalent to that he would have received in the community. He was appropriately assessed when he first arrived at the prison and he did not exhibit any of the clinical signs more commonly associated with meningitis, such as a stiff neck and or an actual fever.

37. Streptococcus pneumoniae carries a mortality rate of 30%, especially in older adults and those with significant other health problems. Chronic alcoholism is also a known risk factor associated with poor outcomes from bacterial meningitis. The clinical reviewer considered that Mr Joyce's death was not predictable or preventable.

Emergency response

38. Prison Service Instruction (PSI) 03/2013 requires prisons to have a medical emergency response code protocol, which should ensure that an ambulance is called immediately when a medical emergency is called. There should be no requirement for control room staff to check with managers, healthcare staff or others at the scene before calling an ambulance, but they should wait for updates and keep the ambulance service informed. The PSI notes that it is better to act with caution and request an ambulance that can be cancelled later if it is not needed.

39. In this case, the officer did not call a code blue when she found Mr Joyce because she said it was possible she did not have a charged radio with her. She told us that it was common to find that radio batteries have not been recharged overnight.

40. Although she could not be sure if she had the radio or not, we note that during the course of a previous emergency response at the prison (only a month before Mr Joyce's death), the officer who was first on scene went to use her radio to broadcast an emergency code but could not do so because its battery was flat. The short duration from discovering Mr Joyce to alerting other officers did not delay the emergency response and did not affect the outcome for him. However, as this issue has occurred at least twice in a month and that it could have a serious implication in the future, we make the following recommendation:

    The Director should ensure that sufficient staff are able to obtain charged radios at the start of their shifts.

41. The officer did not enter Mr Joyce's cell when she found him, as she felt unsafe to go in on her own and wanted colleagues to help her. We feel her actions were reasonable and did not impact on Mr Joyce's chances of survival, as colleagues were close by and Mr Joyce had probably been dead for some time.

42. We note that staff in the communications room did not call an ambulance as soon as the officer broadcast the code blue. They made further enquiries about Mr Joyce's condition before doing so.

43. HMP Birmingham’s emergency code protocol is confusing. It says that once staff in the communications room receive a code red or blue they will automatically call 999 and ask for a blue light emergency ambulance to attend the prison. However, later on in the protocol, it says that communications room staff will need to establish if the patient is breathing or conscious, what is perceived to be wrong with them, if trained medical staff are with them, the patient’s name and date of birth ‘in order to successfully send for an ambulance in an urgent time frame’. It is apparent that there was a three minute delay in calling an ambulance. While this did not affect the outcome for Mr Joyce, a similar delay could be vital in the future. We make the following recommendation:

The Director should ensure that the prison’s emergency response protocol ensures that when a code red or blue is called, staff in the control room call an ambulance immediately.

44. The clinical reviewer has also pointed out that from the description of Mr Joyce’s body it is highly likely that he had been dead for some time before anyone discovered him. We understand the wish to attempt and continue resuscitation until death has been formally recognised but staff should understand that they are not required to carry out cardiopulmonary resuscitation in all circumstances. Guidance issued by the Royal College of Nursing says that nurses are expected to start the resuscitation process where a death is unexpected unless the circumstances not to do so are justified. The fact that in this instance nurses could not insert an airway should have alerted them to the fact that rigor mortis had set in and therefore resuscitation attempts should have stopped. We make the following recommendation:

The Director and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is inappropriate.

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