Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Dominic Birkitt a prisoner at HMP Kirkham on 19 June 2016

A report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

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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 Dominic Birkitt died on 19 June 2016 of a heart attack at HMP Kirkham. Mr Birkitt was 48 years old. I offer my condolences to Mr Birkitt's family and friends.

Mr Birkitt's death was sudden and unexpected. Nevertheless, I agree with the clinical reviewer that healthcare staff at Kirkham and HMP Forest Bank, his previous prison, missed the opportunity to treat his high blood pressure. As a result, Mr Birkitt's healthcare at these prisons was not equivalent to that he could have expected to receive in the community.

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 **March 2017**

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Summary

Events

1. On 3 May 2016, Mr Dominic Birkitt was sentenced to two years and four months in prison and sent to HMP Forest Bank. On 9 June, he moved to HMP Kirkham.

2. After arriving at Forest Bank, a doctor measured Mr Birkitt's blood pressure as 178/86 (high). Mr Birkitt said he had suffered from high blood pressure for twelve months but was not taking any prescribed medication for this. The doctor made an appointment for 6 May to discuss Mr Birkitt's medical conditions but Mr Birkitt did not attend the appointment.

3. On 6 May, a nurse measured Mr Birkitt's blood pressure as 149/88 (high). There are no other blood pressure readings recorded at Forest Bank.

4. At Kirkham, on 10 June, a prison nurse recorded that Mr Birkitt's blood pressure was towards the upper end of the normal range. A prison GP arranged blood tests to check his cholesterol level, diabetes and kidney function but did not discuss Mr Birkitt's history of high blood pressure or offer any treatment options.

5. On 19 June, Mr Birkitt collapsed while he was returning to the wing after participating in a light exercise session. Prison staff gave him emergency treatment and paramedics took Birkitt to hospital by ambulance. Mr Birkitt died from a heart attack shortly after he was admitted to hospital.

Findings

6. When Mr Birkitt arrived at Forest Bank, blood pressure readings indicated he was suffering from high blood pressure. Mr Birkitt told a GP he suffered from high blood pressure but the GP did not did not discuss appropriate treatment with him. After he moved to Kirkham, a further blood pressure reading was towards the upper end of the normal range. Again, a GP did not discuss Mr Birkitt's high blood pressure or create a plan to manage it. While Mr Birkitt's death could not be predicted, we agree with the clinical reviewer that that the management of Mr Birkitt's high blood pressure was not in accordance with clinical guidelines and that the care he received was not equivalent to that he could have expected to receive in the community.

Recommendation

- The Heads of Healthcare at HMP Forest and HMP Kirkham should ensure that high blood pressure is promptly and appropriately investigated and treated in line with current clinical guidelines.

The Investigation Process

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

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

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

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

11. One of the Ombudsman's family liaison officers contacted Mr Birkitt's son and his ex-wife to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They had no specific matters for the investigation to consider.

12. On 2 February 2017, the Coroner's Officer contacted the investigator and provided contact details for Mr Birkitt's brother. One of the Ombudsman's family liaison officers contacted Mr Birkitt's brother and sent him a copy of the Ombudsman's initial report.

13. Mr Birkitt's brother received a copy of the initial report. The family raised a number of comments that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

14. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Background Information

HMP Kirkham

15. HMP Kirkham is an open prison in the North West holding over 600 men. There are 24 living units with single rooms and an admissions unit with double rooms for new arrivals.

16. Lancashire Care Foundation Trust provides healthcare services at the prison. There is a healthcare unit with a part-time doctor and qualified nursing staff. Nurses are on duty between 8.00am and 7.00pm Monday to Thursday and between 8.00am and 4.30pm on a Friday. During the weekend, nurses are on duty between 8.00am and 12.00pm.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Kirkham was in November 2013. Inspectors reported that healthcare services had improved since their last inspection in 2009. Waiting time to see doctors and nurses were short and medicines management was good.

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 December 2015, the IMB reported that prisoners were positive about the healthcare provided. During 2015, the healthcare team introduced 'well man' clinics where men are offered a health check to diagnose potential health issues before they become an issue.

Previous deaths at HMP Kirkham

19. Mr Birkitt was the second prisoner to die of natural causes at Kirkham since January 2014. There were no significant similarities with the circumstances of the previous deaths.

HMP Forest Bank

20. Forest Bank is a local prison in Salford, serving courts in the North West. It holds 1,460 remanded and sentenced men. The prison is privately managed by Sodexo Justice Services. Sodexo provides primary health care services. There is a 20-bed inpatient unit with 24-hour nursing cover. An agency provides GP services with doctors available from 9.00am to 9.00pm Monday to Friday, 1.00pm to 5.00pm Saturday and 9.00am to 12.00pm Sunday. There is out of hours cover at other times.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Forest Bank was in February 2016. Inspectors reported that most areas of health provision were reasonable but some areas required considerable improvement. Some aspects of local governance required attention, including access to staff supervision and emergency equipment checks. Prisoners had access to an appropriate range of

primary care services, with mostly acceptable waiting times, and long-term conditions were well managed.

Independent Monitoring Board

22. 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 November 2015, the IMB reported they were satisfied with the way in which the prison's healthcare responsibilities were provided and there had been no significant issues arising throughout the year.

Previous deaths at HMP Forest Bank

23. Four prisoners have died of natural causes at Forest Bank since January 2014. There were no similarities with the circumstances of the previous deaths.

Key Events

24. On 3 May 2016, Mr Dominic Birkitt was sentenced to two years and four months in prison for theft and sent to HMP Forest Bank. On 9 June, he moved to HMP Kirkham.

25. At an initial health screen at Forest Bank, a nurse noted that Mr Birkitt had a history of gout (a type of arthritis in which small crystals form in and around the joints, causing sudden attacks of severe pain and swelling) and was taking medication for this. She recorded Mr Birkitt's weight as 136kg and his blood pressure as 178/108 (a result over 140/90 is considered to be high). The same day, a prison GP assessed Mr Birkitt and recorded his blood pressure as 178/86. Mr Birkitt said he had suffered from high blood pressure for twelve months and was not taking any prescribed medication for this. The GP made an appointment for 6 May to discuss Mr Birkitt's medical conditions. Nurses contacted Mr Birkitt's community GP to obtain his medical history, although there was no record that healthcare staff received it before he moved to Kirkham.

26. On 6 May, Mr Birkitt did not attend for his appointment with the prison GP. Healthcare staff did not record why. Later that day, Mr Birkitt asked a prison nurse to take his blood pressure. She did not record why Mr Birkitt requested a blood pressure check and noted his blood pressure as 149/88. There were no other blood pressure readings recorded at Forest Bank.

27. When Mr Birkitt arrived at Kirkham on 9 June, a prison nurse noted that he was fit for normal location, work and any cell occupancy. She contacted Mr Birkitt's community GP to obtain his medical history. There was no record that healthcare staff received it before he died.

28. On 10 June, a nurse recorded Mr Birkitt's weight as 126.6kg and his blood pressure as 138/86 (towards the upper end of the normal range). She noted that Mr Birkitt was an ex-smoker and suffered from high blood pressure but was not on any medication for this. She gave Mr Birkitt advice about eating healthily.

29. The same day, a prison GP arranged blood tests to check Mr Birkitt's cholesterol level, haemoglobin level (to screen for diabetes) and kidney function. She received the results on 13 June and noted they were within normal ranges.

Events of Sunday 19 June 2016

30. At approximately 1.50pm on 19 June, Mr Birkitt went to the sports field to participate in a light exercise session. Half an hour later, a custodial manager started to escort prisoners back to the wings.

31. At approximately 2.30pm, a prisoner told the custodial manager that Mr Birkitt had collapsed while pushing a prisoner in a wheelchair. He immediately ran over to Mr Birkitt and found him lying on the ground. At 2.33pm, he radioed an emergency code blue (which indicates a prisoner has symptoms including chest pain and difficulty in breathing) and the control room immediately called an emergency ambulance. He started cardiopulmonary resuscitation (CPR) with assistance from a prisoner. A few minutes later, after travelling from the gymnasium to the sports field, two officers and a custodial manager arrived with

a defibrillator. The custodial manager attached the defibrillator pads to Mr Birkitt's chest and detected a shockable rhythm. He applied four shocks while the officers continued with CPR.

32. At 2.45pm, the paramedics arrived and took control of Mr Birkitt's care. At 3.12pm, the ambulance left the prison. An officer went with Mr Birkitt in the ambulance and did not use restraints. Mr Birkitt was admitted to hospital, but he did not recover and the hospital recorded that he had died at 3.32pm.

Contact with Mr Birkitt's family

33. On 19 June 2016, the prison appointed the Head of Security as a family liaison officer. Mr Birkitt had named his son, who was 17 years old, as his next of kin. Due to his age, the Head queried whether they should inform him personally or contact Mr Birkitt's ex-wife. Senior prison managers decided that they should contact Mr Birkitt's son. At 6.30pm, the Head and a prison chaplain left the prison to visit Mr Birkitt's son. They arrived at 8.20pm, told him Mr Birkitt had died and offered their condolences and support.

34. The next day, the Head spoke to Mr Birkitt's ex-wife on the telephone. He remained in contact with Mr Birkitt's son and ex-wife until his funeral on 4 July. The prison contributed to the costs in line with national instructions.

Support for prisoners and staff

35. After Mr Birkitt's death, the Head of Residential and Safety 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.

36. The prison posted notices informing other prisoners of Mr Birkitt'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 Birkitt's death.

Post-mortem report

37. The coroner concluded that the cause of death was acute myocardial infarction (heart attack). Mr Birkitt also suffered from coronary artery atheroma and cardiac hypertrophy.

Findings

Clinical care

38. When Mr Birkitt arrived at HMP Forest Bank on 3 May 2016, he told a prison nurse he had high blood pressure. The same day, he told a prison GP he had suffered from high blood pressure for the past year but was not on any treatment. The GP took Mr Birkitt's blood pressure and the result was above normal ranges. A further blood pressure test on 6 May was also above normal ranges.

39. After he moved to Kirkham on 9 June, a prison nurse completed an initial health assessment but did not record Mr Birkitt's weight or blood pressure, although this took place the following day. On that date, Mr Birkitt's blood pressure was towards the upper end of the normal range and suggested he was at risk of developing hypertension. When a prison GP saw Mr Birkitt for a routine blood test on 10 June, she did not discuss his history of high blood pressure or discuss treatment options.

40. The clinical reviewer commented that guidance from the National Institute for Health and Care Excellence (NICE) states that if there is a blood pressure reading of 140/90 or higher, a medical professional should take a second reading during the consultation and offer regular monitoring to confirm the diagnosis of hypertension. There was no evidence that healthcare staff at Forest Bank and Kirkham took a second blood pressure reading, offered regular monitoring or discussed appropriate treatment for hypertension. We agree with the clinical reviewer that the management of Mr Birkitt's high blood pressure was not in accordance with NICE guidelines and was not equivalent to that he could have expected to receive in the community. We make the following recommendation:

    The Heads of Healthcare at HMP Forest and HMP Kirkham should ensure that high blood pressure is promptly and appropriately investigated and treated in line with current clinical guidelines.

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