

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Leslie Hammond a prisoner at HMP Birmingham on 12 August 2017

A report by the Prisons and Probation Ombudsman

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141



© Crown copyright 2017

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

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 Leslie Hammond died from heart disease, on 12 August, at HMP Birmingham. He was 50 years old. We offer our condolences to Mr Hammond's family and friends.

We agree with the clinical reviewer that some aspects of Mr Hammond's care at Birmingham fell below that which he could have expected to receive in the community. Healthcare staff missed two opportunities to assess his risk factors for cardiovascular disease. We are concerned that there are no facilities at Birmingham for healthcare staff to obtain readings of urgent ECG tests outside normal working hours.

The investigation found that prison staff did not immediately use an emergency code when they found Mr Hammond unresponsive. Although this did not affect the outcome, quick and effective communication of an emergency underpins the resuscitation process and could be vital in similar circumstances in the future.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman

June 2018

Contents

Summary	1
The Investigation Process.....	3
Background Information.....	4
Key Events.....	5
Findings	7

Summary

Events

1. On 15 April 2016, Mr Leslie Hammond was remanded to HMP Birmingham for drug offences. An initial health screen identified no physical or mental medical conditions and he had no serious health problems over the next 16 months.
2. During the evening of 12 August 2017, Mr Hammond reported chest pains. The nurse team leader thoroughly examined him and checked his vital signs, which showed raised blood pressure. He gave Mr Hammond medication to try to relieve his pain and booked an appointment for a further review the next day.
3. At 9.10pm, an officer went to check Mr Hammond. She saw him lying motionless on his cell floor and called for assistance. A nurse and prison staff performed chest compressions and applied a defibrillator, which advised one shock. Two ambulance crews continued the resuscitation attempts. At 9.50pm, the paramedics confirmed Mr Hammond's death.

Findings

4. The investigation found that Mr Hammond missed a secondary health screen and the reason was not recorded. In addition, healthcare staff did not investigate a scan result in December 2016 which revealed a fatty liver. The clinical reviewer considered that the missed health screen and further exploration after the scan might have identified Mr Hammond's risk factors for cardiovascular disease.
5. We are satisfied that the nurse who assessed Mr Hammond on 12 August made a good attempt to diagnose and treat the cause of his chest pains, but we are concerned that there are no facilities for healthcare staff at Birmingham to obtain urgent ECG reviews out-of-hours.
6. Staff did not comply with the requirement to use an emergency code immediately on discovering Mr Hammond. Although this led to a delay of a few minutes in calling an emergency ambulance and bringing essential first aid equipment, it did not affect the outcome for Mr Hammond.

Recommendations

- The Head of Healthcare should ensure that all new prisoners are offered a general health assessment, in line with Prison Service Order 3050. Staff should follow up non-attendance and record the reasons in their Systmone medical record.
- The Head of Healthcare should ensure that healthcare staff are fully aware of the risk factors for cardiovascular disease and appropriately investigate any diagnosis of fatty liver.
- The Head of Healthcare should ensure that there is a process for obtaining urgent reviews of ECG readings when prisoners report chest pains.

- The Director and Head of Healthcare should ensure that staff use an emergency response code to communicate the nature of a medical emergency, in line with national and local instructions.

The Investigation Process

7. 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.
8. The investigator obtained copies of relevant extracts from Mr Hammond's prison and medical records.
9. NHS England commissioned a clinical reviewer to review Mr Hammond's clinical care at the prison.
10. The investigator and clinical reviewer interviewed three members of staff at Birmingham on 5 October. The investigator subsequently conducted telephone interviews with two additional staff on 23 October and 1 November.
11. 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.
12. One of the Ombudsman's family liaison officers contacted Mr Hammond's son, his next of kin, to explain the investigation. Mr Hammond's son asked the investigation to consider the following matters. A prison manager had told him that after his father had reported chest pains on 11 August, a nurse had found that his blood pressure was high. He was concerned that his father had returned to work as a cleaner the next day and questioned whether this was appropriate. He also asked whether Mr Hammond's treatment and diagnosis on that day was fair, in line with that in the community and whether staff should have taken any other action to prevent his death the following day.
13. As there were no records to indicate that healthcare staff had examined Mr Hammond on 11 August, the Ombudsman's family liaison officer contacted Mr Hammond's son to clarify the date. Mr Hammond's son insisted that the prison managers who broke the news to him and the prison's family liaison officer had told him about an incident on 11 August.
14. Mr Hammond's son received a copy of the initial report. He did not make any comments.
15. We shared the initial report with HM Prison and Probation Service (HMPPS) and they found no factual inaccuracies. The HMPPS action plan has been annexed to this report.

Background Information

HMP Birmingham

16. HMP Birmingham is a local prison 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. The prison has two 15-bed healthcare wards, one for prisoners with physical health issues and the other for those with mental health issues.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Birmingham was in February 2017. Inspectors reported that although health interactions were good, there were severe shortages in the primary care team, which had caused difficulty in meeting the high level of demand. A shortage of prison officers to escort prisoners to the healthcare department had led to very high non-attendance levels for internal appointments. Inspectors also noted that a significant number of prisoners did not receive a secondary health screen due to complex unlocking arrangements and a lack of capacity among healthcare staff. Around a third of operational staff were trained in first aid and ambulances were called promptly for emergencies.

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 2017, the IMB reported that healthcare managers had reviewed practices and liaised with prison managers to resolve some of the problems caused by a shortage of staff. Waiting times to see a GP were comparable to those in the community.

Previous deaths at HMP Birmingham

19. Mr Hammond was the tenth prisoner to die of natural causes at Birmingham since January 2016. There have been two subsequent deaths. We have made previous recommendations to Birmingham about the use of emergency response codes.

Key Events

20. On 15 April 2016, Mr Leslie Hammond was remanded to HMP Birmingham, following convictions for conspiring to produce and supply controlled drugs. (He was subsequently sentenced to four years in prison). It was his first time in prison.
21. At his initial health screen, a nurse noted that Mr Hammond had no physical or mental health problems. Mr Hammond did not attend a Wellman new reception appointment booked for 18 April. The reason was not recorded.
22. Most of the entries in Mr Hammond's medical record were for minor ailments, with the exception of a benign cyst on his right kidney. This was detected by an ultrasound scan in December 2016, which also revealed fatty changes in Mr Hammond's liver. There was no further investigation of this abnormality.
23. During the evening of 12 August 2017, Mr Hammond reported chest pains to wing staff. At around 6.30pm, the clinical team leader for primary care nurses, examined him in his cell. Mr Hammond found it hard to describe the pain, but said it was burning and stabbing and had moved from the central area to the right side. The clinical team leader noted no discolouration, history of chest pain, or family history of cardiac problems and that Mr Hammond was breathing normally and speaking calmly in full sentences. He took blood pressure, pulse and oxygen saturation readings and tested his blood glucose level. There was a steady pulse, but raised blood pressure.
24. The clinical team leader gave Mr Hammond glyceryl trinitrate spray (GTN spray – used to treat angina) which did not alleviate the pain. He then thought it might be a stomach problem, so gave him medication for indigestion and heartburn. He advised wing staff to contact him again if Mr Hammond's condition worsened. At 7.55pm, just before he finished his shift, the clinical team leader went back to review Mr Hammond, but decided not to disturb him as he was sleeping. He checked with an officer that there had been no further problems and booked an appointment to recheck Mr Hammond's blood pressure the following day.
25. Officer A started her night shift at around 8.50pm. At the handover, day staff informed her of Mr Hammond's chest pains earlier in the evening. Between 9.05pm and 9.10pm, Officer A went to his cell to check if he was feeling better. When she looked through the observation panel, she saw Mr Hammond lying face down on the floor, unresponsive. She immediately radioed for the emergency nurse and staff assistance, stating that Mr Hammond was not breathing. Officer A was unable to break the seal of the pouch containing the cell key for night emergencies, so she also asked staff to bring keys. She twice shouted Mr Hammond's name, but there was no response.
26. Nurse A heard a radio call to attend the wing immediately. She saw a large amount of blood on the cell floor and around Mr Hammond's face. The night manager and Officer B also attended. Officer A and Officer B helped to turn Mr Hammond over and the night manager radioed the control room to request an emergency ambulance. Mr Hammond's lips were cyanosed (bluish discolouration) and his face swollen. There were no signs of life. Nurse A asked another nurse to get the emergency blue bag containing a defibrillator, oxygen

and airways and she started chest compressions until it arrived. Prison staff then performed cardiopulmonary resuscitation (CPR) in rotation while Nurse A attached the defibrillator and inserted an airway.

27. The first paramedics arrived at the prison at 9.22pm. They asked the prison staff to continue CPR while they administered adrenalin intravenously. Shortly afterwards, the defibrillator advised a shock, but there was no effect. Another ambulance crew arrived at 9.35pm and took over the resuscitation attempts. At 9.50pm, the paramedics confirmed that Mr Hammond had died.

Contact with Mr Hammond's family

28. At 10.30pm, two prison managers went to the address listed for Mr Hammond's son, his next of kin. They found that he no longer lived there and attempts to telephone him were unsuccessful. The two managers then went to the addresses given for Mr Hammond's adult daughter and his sister, but they had also moved home. They contacted the police, who were also unable to trace Mr Hammond's son. When they returned to the prison in the early hours of 13 August, one of them noted that he was due to visit his father at 8.30am. The two managers met Mr Hammond's son at the prison visitors' centre, before he entered the prison, to break the news of his father's death and offer condolences and support.
29. The prison appointed a family liaison officer. She telephoned and visited Mr Hammond's son to explain the procedures in more detail and gave continuing support. In line with national instructions, the prison contributed to the costs of Mr Hammond's funeral, which was held on 1 September.

Support for prisoners and staff

30. After Mr Hammond's death, the night manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising and to offer support. She also offered the support of the staff care team.
31. The prison posted notices informing other prisoners of Mr Hammond's death and offering support.

Post-mortem report

32. The report of the post-mortem examination concluded that the cause of Mr Hammond's death was:
 1. Ischaemic heart disease
 2. Coronary artery narrowing by atherosclerosis.

Findings

Clinical care

Secondary health screen and investigation of ultrasound scan

33. Prison Service Order (PSO) 3050 - *Continuity of healthcare* requires prisons to offer prisoners a general health assessment during the first week after their arrival. We note that during an inspection in February 2017, HM Inspectorate of prisons found that a significant proportion of prisoners missed such examinations and recommended that, "...all prisoners should receive a secondary health screening within seven days of their arrival in prison".
34. When Mr Hammond arrived at Birmingham on 15 April 2016, an initial health screen identified no physical or mental health issues. A more detailed Wellman examination booked for 18 April did not take place. As staff did not record the reason, we do not know why. The clinical team leader told the investigator that there was a significant backlog of Wellman examinations, as prisoners often missed appointments due to a shortage of staff to escort them to the healthcare centre.
35. In December 2016, an ultrasound scan to examine a lump in Mr Hammond's abdomen showed that he had a fatty liver. The clinical reviewer suggested that healthcare staff should have investigated this further, due to the association between a fatty liver and cardiovascular disease.
36. The clinical reviewer considered that a secondary health screen (the equivalent of a new patient check at a GP surgery) and investigation of the ultrasound result might have identified key risk factors for heart disease, such as high blood pressure and high cholesterol levels. This would have given staff the opportunity to help address those risks. We agree with the clinical reviewer that these aspects of Mr Hammond's care were not equivalent to that which he could have expected to receive in the community. We make the following recommendations:

The Head of Healthcare should ensure that all new prisoners are offered a general health assessment, in line with Prison Service Order 3050. Staff should follow up non-attendance and record the reasons in their Systmone medical record.

The Head of Healthcare should ensure that healthcare staff are fully aware of the risk factors for cardiovascular disease and appropriately investigate any diagnosis of fatty liver.

Examination of Mr Hammond's chest pain

37. Mr Hammond's son believed that his father had first reported chest pains on 11 August and that, in spite of this, he had continued to work as a cleaner the next day. The investigation found no documentary evidence to indicate that healthcare staff examined Mr Hammond on that day. During interviews and enquiries of staff, no one could recall him saying he felt unwell the day before he died.

38. When Mr Hammond complained of chest pain on 12 August, the clinical team leader examined him and tried to assess whether the pain was due to a gastric or cardiac problem. He concluded that it was probably an abdominal problem that did not warrant admission to hospital, and gave him some medication. The clinical team leader checked on him a little later and arranged to review him the next day, as his blood pressure was raised.
39. At interview, the clinical team leader explained that if he had believed the problem was a cardiac issue he would have sent Mr Hammond to hospital for an electrocardiogram (ECG – a test to check the heart’s rhythm and electrical activity). As this took place on a Saturday, a prison doctor would not have been available to read and review an ECG result until Monday morning and the prison had no facilities to send an ECG recording to hospital for advice. He added that the prison was looking into ways of facilitating urgent ECGs.
40. We agree with the clinical reviewer that the clinical team leader conducted a thorough examination of Mr Hammond. However, we share her concern that, unlike some other prisons, there was no process to obtain out-of-hours ECG readings. We make the following recommendation:

The Head of Healthcare should ensure that there is a process for obtaining urgent reviews of ECG readings when prisoners report chest pains.

Emergency response

41. Prison Service Instruction (PSI) 3/2013 requires prisons to have a medical emergency response code protocol to ensure that an ambulance is called automatically in a life-threatening medical emergency and to enable staff to bring equipment relevant to the nature of the emergency. The PSI also says it should not be a requirement for a member of healthcare staff or a manager to attend the scene before the emergency services are called. Birmingham’s local instruction to staff, issued on 12 June 2017, confirmed the requirement to use an emergency code in potentially life-threatening situations.
42. Officer A radioed for immediate assistance at 9.10pm. Although she indicated that Mr Hammond was not breathing, she did not use an emergency code. The control room log noted that at 9.11pm, the night manager, Nurse A and three named prison officers were asked to attend D4 landing immediately. Shortly after Nurse A arrived at the cell, she asked another nurse to collect the emergency bag. At 9.13pm, the night manager called a code blue and one minute later the control room requested an emergency ambulance.
43. We are satisfied that the failure to promptly use an emergency code and the consequent delay in requesting an ambulance and obtaining the emergency bag did not affect the outcome for Mr Hammond, but in other emergencies such a delay could be critical. We make the following recommendation:
- The Director and Head of Healthcare should ensure that staff use an emergency response code to communicate the nature of a medical emergency, in line with national and local instructions.**
44. The clinical reviewer considered that staff performed the resuscitation process effectively and we agree.

**Prisons &
Probation**

Ombudsman
Independent Investigations