Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Amerjit Sian a prisoner at HMP Birmingham on 2 February 2019

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 Amerjit Sian died on 2 February 2019 of inflammation of the liver and alcoholic liver disease while a prisoner at HMP Birmingham. He was 57 years old. I offer my condolences to Mr Sian's family and friends.

Mr Sian had only been at Birmingham three days when he became ill and was taken to hospital, where he died two weeks later. I am satisfied that the clinical care Mr Sian received at Birmingham was of an acceptable standard and equivalent to that which he could have expected to receive in the community.

However, I am concerned that Mr Sian's family were not informed that he had been admitted to hospital for 10 days even though he was seriously ill.

I am also concerned that Mr Sian was inappropriately restrained when he was taken to hospital, and that he remained restrained until five days before he died, despite being seriously ill with poor mobility and being assessed as a low risk to others and of escape.

We drew our concerns about the use of restraints at Birmingham to the Governor and Head of Healthcare twice in 2018, and it is disappointing to have to do so again. The Prison Group Director for the West Midlands will wish to assure herself that this issue is properly addressed.

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

Sue McAllister CB
Prisons and Probation Ombudsman **September 2019**

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Summary

Events

1. On 16 January 2019, Mr Amerjit Sian was sentenced to six weeks in prison for drink driving and was sent to HMP Birmingham. Mr Sian had a history of alcohol dependency syndrome, gout and a damaged liver resulting from alcohol misuse.

2. Mr Sian had mild alcohol withdrawal when he arrived at Birmingham, so he was placed in the first night centre and prescribed diazepam to treat the symptoms.

3. On 17 January, Mr Sian was admitted to the prison's inpatient unit because his blood pressure was low and he looked jaundiced.

4. On 19 January, Mr Sian health deteriorated. He was dizzy, had diarrhoea and low urine output. Mr Sian was sent to hospital by emergency ambulance. He was diagnosed with acute alcohol hepatitis and a severe chest infection.

5. On 27 January, Mr Sian's health deteriorated further, and on 31 January, he was placed on the end of life pathway.

6. On 1 February, Mr Sian was transferred to a palliative care unit, where he died on 2 February.

7. The post-mortem report gave the cause of death as inflammation of the liver and alcoholic liver disease.

Findings

8. The clinical reviewer concluded that the care Mr Sian received at Birmingham was of an acceptable standard and equivalent to that which he could have expected to receive in the community. His withdrawal from alcohol was managed in accordance with NICE guidelines, he was adequately monitored, and was transferred to hospital in a timely manner when his health deteriorated.

9. We are concerned that Mr Sian was restrained when he went to hospital on 19 January although he was a seriously ill category C prisoner with poor mobility, serving a six-week sentence, and assessed as a low risk to others and of escape.

10. We are also concerned that the medical section of the escort risk assessment was not completed.

11. Although Mr Sian's health deteriorated further in hospital, he continued to be restrained for another 10 days. We do not consider that this was appropriate.

12. We are also concerned that Mr Sian's family were not told he had been admitted to hospital for 10 days.

Recommendations

- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on

the use of restraints 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.

- The Governor should revise the prison's escort risk assessment form to ensure that it requires:
    - healthcare staff to say whether the prisoner's current state of health has an impact on his mobility; and
    - prison staff to show that they have taken this information into account in assessing the prisoner's current level of risk.
- The Governor should remind the Prison Manager that paragraph 5.2 of Prison Service Instruction (PSI) 58/2010 requires all staff to cooperate fully with all requests from the Ombudsman's staff for information.
- The Prison Group Director for the West Midlands should assure the Ombudsman that she is satisfied that the Governor is taking effective action to ensure that staff understand the legal position on the use of restraints.
- The Governor should ensure that:
    - a prisoner's next of kin is informed when a prisoner is admitted to hospital seriously ill; and
    - a FLO is appointed promptly in these circumstances.

The Investigation Process

13. 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.

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

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

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

17. We wrote to Mr Sian'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.

18. We shared our initial report with HM Prison and Probation Service (HMPPS). They did not identify any factual inaccuracies. They provided an action plan which is annexed to this report.

Background Information

HMP Birmingham

19. HMP Birmingham is a local prison which holds up to 1,450 prisoners. It was managed by G4S from October 2011 to August 2018, when its management was returned to HM Prison and Probation Service (HMPPS). Birmingham and Solihull Mental Health Foundation Trust provides 24-hour healthcare services at the prison and sub-contracts Birmingham Community Healthcare NHS Trust to provide primary care services, including a 15-bed healthcare unit.

HM Inspectorate of Prisons

20. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Birmingham during in July/August 2018, and found the prison to be "fundamentally unsafe", and said that "the treatment of prisoners and the conditions in which they were held at Birmingham were among the worst they had seen in recent years".

21. On healthcare, inspectors found that health services had improved since their last inspection in 2017, but that there were still some areas of concern, including the complaints process. An appropriate range of primary care services met patient need, but 'did-not-attend' rates were very high and the management of long-term conditions required improvement. The inpatient unit provided an impressive environment for up to 30 physically and mentally unwell prisoners.

22. Following the inspection, HMIP invoked the Urgent Notification (UN) process in August 2018, which committed the Secretary of State to respond publicly to the concerns raised within 28 calendar days. In response to the Urgent Notification, the management of the prison was returned to HMPPS in August.

Independent Monitoring Board

23. 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 2018, the IMB reported overcrowded and unfit living conditions, the widespread availability of drugs, and levels of violence which created an unsafe environment. Waiting times to see the dentist or GP had decreased but waiting times were unequal across the wings, and too many hospital appointments were cancelled.

Previous deaths at HMP Birmingham

24. Mr Sian was the fourteenth prisoner to die at Birmingham in the last two years. Eight of these deaths were from natural causes.

25. We made recommendations about the unnecessary use of restraints twice in 2018, in February and September. On both occasions, the prison committed to address these failings by reminding staff of the 2007 High Court ruling on restraints and by ensuring staff had appropriate training.

Findings

The diagnosis of Mr Sian's illness

26. On 16 January 2019, Mr Sian was sentenced to six weeks in prison for drink driving and was sent to HMP Birmingham. Mr Sian had a history of alcohol dependency syndrome, gout and signs of a damaged liver due to alcohol misuse.

27. Mr Sian's reception screening was completed by a nurse. Mr Sian reported ongoing back pain from multiple falls and said he had been drinking 5-6 units of alcohol a day for the past week.

28. The nurse completed an Alcohol Use Disorders Identification Test with Mr Sian. He scored 24, indicating a severe problem with alcohol. Mr Sian scored 5 on a Clinical Institute Withdrawal Assessment (CIWA), indicating mild alcohol withdrawal. Diazapam was prescribed to help any symptoms of alcohol withdrawal and he was referred to the prison's substance misuse team.

29. Mr Sian was located in the first night centre where he could be monitored. Nursing staff observed him overnight and did not note any concerns.

30. On 17 January, an Integrated Drug Treatment Service specialist nurse assessed Mr Sian. He took blood samples to check Mr Sian's liver function. Another CIWA was completed and Mr Sian scored 0, indicating very mild alcohol withdrawal. Mr Sian was referred to the Drug and Alcohol Treatment Team, and was prescribed thiamine and vitamin B.

31. A secondary health screen was completed and, other than alcohol misuse, no significant medical (or family history) was raised. Later that day, Mr Sian was admitted to Birmingham's healthcare unit for observation because his blood pressure was low and he looked jaundiced and generally unwell.

32. On 19 January, Mr Sian's health deteriorated. He reported dizziness, diarrhoea and reduced urine output. A prison GP examined Mr Sian and noted the onset of a tremor, confusion, and a decline in mobility. Mr Sian was transferred to City Hospital, Birmingham via emergency ambulance, and was diagnosed with acute alcoholic hepatitis (a serious and life-threatening illness) and a severe chest infection.

33. Healthcare staff at the prison maintained good contact with the hospital. Mr Sian was treated with antibiotics and his confusion lessened. Blood tests completed on 25 January suggested Mr Sian had liver cirrhosis.

34. On 27 January, a nurse recorded that she had spoken to a doctor at the hospital who said that Mr Sian's condition was worse and potentially 'beyond liver failure'. Mr Sian now needed full help with all aspects of his care.

35. On 29 January, the prison held a Life Limiting multidisciplinary meeting and a Family Liaison Officer (FLO) was appointed. The meeting noted that Mr Sian could die while he was still in custody if his liver function continued to deteriorate. Mr Sian's cuffing arrangements were discussed (although the outcome of the discussion was not recorded).

36. On 30 January, the hospital stopped active management of Mr Sian's condition and focused on making him comfortable because his liver had failed beyond repair.

37. On 31 January, Mr Sian was placed on the end of life pathway, and the prison started the compassionate release process.

38. We are satisfied that healthcare staff appropriately investigated Mr Sian's symptoms, made timely referrals to secondary care providers and monitored his withdrawal from alcohol.

Mr Sian's clinical care

39. On 1 February, Mr Sian was released on temporary licence to receive inpatient care at the Sheldon Unit, a palliative care unit. Mr Sian was accompanied by one prison officer in civilian clothes.

40. On 2 February, it was confirmed that Mr Sian had died.

Mr Sian's location

41. Mr Sian was in Birmingham for three days, before he went to hospital. Mr Sian's illness was recognised quickly and he was transferred first to the prison healthcare unit, then to hospital, as his health declined.

42. We are satisfied that Mr Sian was appropriately located prior to his death.

Restraints, security and escorts

43. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and considers the prisoner's health and mobility.

44. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

45. On 19 January, when Mr Sian was taken to hospital, he was restrained using a single cuff. The escort risk assessment recorded that Mr Sian was a low risk of escape, as well as being a low risk of harm to the public and staff. The medical section of the risk assessment form was not completed, but Mr Sian's medical records for that day noted he was 'frail, mobility poor needing to support himself' and that he left the prison's healthcare unit in a wheelchair.

46. We are concerned that the prison did not conduct a proper assessment of Mr Sian's risk, taking his medical condition into account, as required by the High Court judgement. A prison manager approved the escort risk assessment. The

investigator contacted the prison manager to ask why he had made the decision to restrain Mr Sian using a single cuff but he did not respond.

47. When Mr Sian was in hospital he was restrained using an escort chain for 10 days, although he was seriously ill and his mobility was very poor. On 20 January, the bedwatch log recorded that he was 'very unstable when walking, had to be supported by staff and use a wheelchair' when he needed the bathroom. On 24 January, the log recorded that Mr Sian 'used toilet, assisted by nurse', and on 26 January, 'condition worse than previous. Not very mobile'.

48. At 4.35pm on 29 January, the duty governor authorised removal of the restraints. He recorded in the bedwatch log, 'Big deterioration of health throughout the day. Sister advised cuffs should be removed.' Mr Sian remained unrestrained after this.

49. Whenever restraints are used, the risk assessment must accurately reflect the risk posed at the time to ensure proportionality and to maintain human dignity. Mr Sian was a seriously ill category C prisoner with very poor mobility, serving a short prison sentence and assessed as a low risk of escape and a low risk of harm to others. We make the following recommendations:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints 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.

The Governor should revise the prison's escort risk assessment form to ensure that it requires:

- **healthcare staff to say whether the prisoner's current state of health has an impact on his mobility; and**
- **prison staff to show that they have taken this information into account in assessing the prisoner's current level of risk.**

The Governor should remind the Prison Manager that paragraph 5.2 of prison Service Instruction (PSI) 58/2010 requires all staff to cooperate fully with all requests from the Ombudsman's staff for information.

The Prison Group Director for the West Midlands should assure the Ombudsman that she is satisfied that the Governor is taking effective action to ensure that staff understand the legal position on the use of restraints.

Liaison with Mr Sian's family

50. Prison Rule 22 says that if a prisoner dies, becomes seriously ill, sustains any severe injury or is removed to hospital on account of mental disorder, the governor shall inform the prisoner's spouse or next of kin at once. PSI 64/2011, *Safer Custody*, says that prisons must ensure that arrangements are in place for an appropriate member of staff to engage with the next of kin or prisoners who are terminally or seriously ill.

51. Although Mr Sian was not diagnosed with a terminal illness when he was taken to hospital on 19 January, he was diagnosed with a potentially life-threatening illness and his condition deteriorated in hospital. We consider that the prison should have informed his family that he had been admitted to hospital and was seriously ill. We also consider that the prison should have appointed a Family Liaison Officer (FLO) at this point.

52. Mr Sian's family were not told he was in hospital until 29 January, 10 days after his admission, when the prison were informed that Mr Sian might lose consciousness. The contact numbers that the prison had on record, provided by Mr Sian, did not work. The duty governor called West Midlands Police, who gave him two other numbers, but no one answered the calls. He spoke to the police again, and they sent officers to Mr Sian's wife's address at about 8.00pm. The duty governor provided the bedwatch officers with a list of approved visitors and briefed them that they were to have unrestricted access to Mr Sian.

53. Mr Sian's wife and his daughter visited Mr Sian in hospital that evening. The bedwatch officers did not allow Mr Sian's daughter to see him.

54. On 30 January, the prison clarified that Mr Sian's daughter was allowed to see her father and apologised to the family for the confusion the night before, and informed them that a FLO had been appointed. She contacted Mr Sian's wife.

55. On 2 February, when Mr Sian died, his wife, daughter and brother-in-law were with him. The FLO was informed of Mr Sian's death and contacted his wife while she was still in the hospital. The FLO offered to come to the hospital but Mrs Sian declined. The FLO arranged to visit her at her home the following Monday.

56. Mr Sian's funeral was held on 14 February. The FLO attended. The prison contributed to the cost of the funeral in line with national instructions.

57. We make the following recommendation:

The Governor should ensure that:

- **a prisoner's next of kin is informed when a prisoner is admitted to hospital seriously ill; and**
- **a FLO is appointed promptly in these circumstances.**

Compassionate release

58. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months.

59. The hospital stopped active management of Mr Sian's condition on 30 January and he was placed on the end of life pathway on 31 January. The prison started the compassionate release paperwork on 30 January and asked the hospital consultant for a letter confirming Mr Sian's prognosis. This was received on 1 February, giving Mr Sian's prognosis as a few weeks, but Mr Sian died before the compassionate release application could be made. However, on 1 February, Mr

Sian was released on a temporary licence to the Sheldon Unit, West Heath Hospital, Birmingham, so his family could visit him freely.

60. We are satisfied that the prison started the compassionate release process promptly and we make no recommendations.

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