

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ian Corns, a prisoner at HMP Birmingham, on 15 April 2017

A report by the Prisons and Probation Ombudsman

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.

The Ombudsman's 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 Ian Corns died on 15 April 2017 of ischaemic heart disease at HMP Birmingham. He was 54 years old. I offer my condolences to Mr Corns' family and friends.

We had to suspend our investigation while the police carried out an investigation into the circumstances of Mr Corns' death and this has unfortunately delayed the completion of this report. (The police decided to take no action following their investigation.)

The clinical reviewer concluded that the healthcare Mr Corns received was of a reasonable standard and equivalent to that which he could have expected to receive in the community. She considered that his death was neither foreseeable nor preventable.

However, I am concerned that when Mr Corns was found unresponsive in his cell on 15 April, prison staff did not radio an emergency code immediately to indicate a medical emergency. As a result, there was a five-minute delay in alerting healthcare staff and calling an emergency ambulance.

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 2020

Contents

Summary	1
The Investigation Process	3
Background Information	4
Key Events	6
Findings.....	8

Summary

Events

1. On 2 March 2016, Mr Ian Corns was remanded to HMP Birmingham charged with sexual offences. On 15 April, he was sentenced to 20 years in prison and was returned to HMP Birmingham.
2. During his initial health screen at Birmingham, a prison nurse noted that Mr Corns had raised blood pressure, was overweight, a moderate smoker and had a family history of heart disease. The nurse used a computerised risk assessment tool test which indicated that he only had a 5.95% chance of developing heart disease in the next ten years. A few days later, Mr Corns' blood pressure had returned to a normal level.
3. Mr Corns had a history of alcohol misuse in the community. The prison nurse referred him to the prison's substance misuse team and he successfully completed an alcohol detoxification program.
4. In the year that followed, Mr Corns had little significant contact with healthcare staff.
5. At 11.40am on 15 April 2017, Mr Corns returned to his cell after lunch. His cellmate said that Mr Corns said he felt cold at about 12.45 pm, and that his breathing then became laboured and he collapsed. At 12.55pm, the cellmate rang the emergency cell bell.
6. At 1.00pm, a prison officer responded. He opened the observation panel and saw Mr Corns face down on the floor with some blood round his mouth. He left the cell and told another officer what he had seen. The officers returned and entered the cell at 1.05pm. One of the officers checked for signs of a pulse or breathing but found none. The other officer radioed an emergency code blue.
7. Healthcare staff arrived and checked Mr Corns for signs of life but could find none. They decided not to attempt cardiopulmonary resuscitation (CPR) because it was clear that Mr Corns was dead.
8. Paramedics arrived at the cell at 1.10pm and pronounced Mr Corns' dead at 1.17pm.
9. The post-mortem examination found that Mr Corns died of ischaemic heart disease caused by coronary artery disease.

Findings

10. The clinical reviewer concluded that the clinical care Mr Corns received at Birmingham was of a reasonable standard and equivalent to that which he could have expected to receive in the community. She considers that Mr Corns' death was neither foreseeable nor preventable.
11. Prison staff did not use an emergency medical code immediately as they should have done when Mr Corns was found unresponsive in his cell on 15 April.

12. The police investigated the actions of Mr Corns' cellmate but found nothing untoward and took no further action.

Recommendations

- The Governor should ensure that all prison staff understand their responsibilities during medical emergencies, including that:
 - where there is a potential risk to life, they should enter a cell immediately, subject to a personal risk assessment; and
 - they should use an emergency medical code promptly to communicate the nature of an emergency effectively.
- The Governor should ensure that a copy of this report is shared with two officers and that a senior manager discusses the Ombudsman's findings with them.

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 him. No one responded.
14. The investigator obtained copies of relevant extracts from Mr Corns' prison and medical records.
15. NHS England commissioned an independent clinical reviewer to review Mr Corns' clinical care at the prison. They jointly interviewed three members of staff in May 2017.
16. Our investigation was suspended while the police completed an investigation into the circumstances surrounding Mr Corns' death.
17. We informed HM Coroner for Birmingham and Solihull of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
18. Mr Corns had not listed any next of kin and there has been no family involvement in our investigation.
19. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

20. HMP Birmingham is a local prison. At the time of Mr Corns' death, it held up to 1,450 prisoners and was managed by G4S. Birmingham and Solihull Mental Health Foundation Trust provided 24-hour healthcare services at the prison and sub-contracted Birmingham Community Healthcare NHS Trust to provide primary care services, including a 15-bed healthcare unit.
21. The prison is currently managed by HM Prison and Probation Service (HMPPS).

HM Inspectorate of Prisons

22. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Birmingham in February 2017, two months before Mr Corns' death. They found that, despite chronic nursing staffing shortages, primary health care services were reasonably good. However, some prisoners waited much too long for routine GP appointments and too many newly arrived prisoners did not receive a timely secondary health screening.
23. The most recent full inspection of Birmingham took place in July 2018. Inspectors noted that health services at the prison had improved and the working relationship between health providers and the prison was good. They also noted that the retention of healthcare staff had improved and that staffing levels were adequate.
24. However, overall the inspectors considered that the prison had deteriorated significantly since their 2017 inspection and was in "an appalling state" and that both staff and managers appeared to have become accustomed to the drop in standards. The Chief Inspector said:

"Against all four of our healthy prison tests – safety, respect, purposeful activity and rehabilitation and release planning – we assessed outcomes as poor, our lowest assessment ... Put simply, the treatment of prisoners and the conditions in which they were held at Birmingham were among the worst we have seen in recent years."
25. As a result, in August 2018, HMIP invoked the Urgent Notification process which committed the Secretary of State to respond publicly to the concerns raised within 28 calendar days. Following the Inspection and the Urgent Notification, HMPPS took over the management of Birmingham on 1 July 2019.
26. In May 2019, HMIP carried out an Independent Review of Progress looking at progress against key recommendations from the 2018 inspection (none involving healthcare). They found that reasonable progress had been made in five of those recommendations, insufficient progress had been made in three and no meaningful progress had been made in one. They noted that the scale of the task to improve the treatment and conditions for prisoners at Birmingham was huge, but that the prison had already made some tangible improvements and had the capacity for further change and improvement if it retained strong leadership and if those responsible for Birmingham at national and regional level provided it with the necessary support.

Independent Monitoring Board

27. 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.
28. In its report for the year to June 2017, the IMB noted that waiting times for GP appointments were comparable to those in the community. However, the Board was concerned that there was a continuing problem with prisoners failing to attend GP appointments because there were insufficient prison staff to escort them remained a problem, and that 20% of hospital escorts were cancelled because of a lack of escort staff.
29. In its latest annual report for the year to June 2019, the IMB noted a reduction in the number of prisoners who did not attend healthcare appointments. They attributed this to the implementation of prisoners acting as healthcare runners and kiosks on the residential units in which prisoners could self-manage their healthcare appointments.

Previous deaths at HMP Birmingham

30. At the time of his death in June 2017, Mr Corns was the 13th prisoner to die at Birmingham since June 2015. Nine of those deaths were from natural causes, two were self-inflicted deaths and one was a drug-related death.
31. There have been 17 deaths since Mr Corns' death. Twelve of those deaths were from natural causes, three were self-inflicted deaths and two were drug-related deaths.
32. We have made recommendations about the failings in the response to medical emergencies following one death in 2016 and five deaths in 2018.
33. In August 2019 we escalated our continuing concerns about this to the Prison Group Director for the West Midlands and asked her to satisfy herself that effective measures had been taken to address Birmingham's continuing failure to ensure that staff enter a cell and radio an appropriate emergency code when there is a potential risk to life. The PGD said in response that she was satisfied that the prison was taking measures to address the problem. She said that the support and assurance visits completed by the West Midlands regional safety team would dip test progress in January 2020.
34. We have not identified concerns about the emergency response since August 2019.

Key Events

35. On 2 March 2016, Mr Ian Corns was remanded to prison charged with sexual offences. He was sent to HMP Birmingham.
36. During his initial health screen at Birmingham, a nurse noted that Mr Corns' blood pressure was raised to 155/89 (a normal adult blood pressure reading is considered to be 120/80 or lower), was overweight, a moderate smoker and had a family history of heart disease. The nurse carried out a QRisk2 test (a computerised assessment tool used to indicate the risk of developing heart disease). The results showed that Mr Corns had a 5.95% chance of developing heart disease in the next ten years (scores above 10% need active primary care intervention).
37. Mr Corns told the nurse prior to being sent to prison, he had been misusing alcohol regularly in the community. He had no other health concerns apart from a rash on his leg, for which he had been prescribed a steroid cream. The nurse referred him to a prison GP for a review, and offered him smoking cessation advice, which he refused. Mr Corns was offered smoking cessation advice on several further occasions, but consistently refused.
38. The following day, a prison GP reviewed Mr Corns. He noted Mr Corns' alcohol misuse and prescribed diazepam (to reduce the effects of alcohol withdrawal) and referred him to the prison's substance misuse team. Mr Corns completed an alcohol detoxification program on 8 March.
39. On 9 March, Mr Corns' blood pressure reading was still borderline and the prison GP advised him about losing weight. On 14 March, healthcare staff rechecked Mr Corns' blood pressure. The reading was 123/78, which indicated that his blood pressure had returned to normal. Mr Corns did not present with any further symptoms to warrant intervention from healthcare staff. However, blood tests that were requested were not completed because Mr Corns failed to attend the appointments. Healthcare staff did not record the reasons for his non-attendance and this was not followed up.
40. On 15 April, Mr Corns was sentenced to 20 years in prison for sexual offences. He returned to HMP Birmingham. Mr Corns had no significant contact with healthcare staff in the year that followed.

Events of 15 April 2017

41. At 11.40am on 15 April 2017, Mr Corns returned to his cell after collecting his lunch. Mr NAME had been sharing a cell with Mr Corns since 13 April. He said that at 12.45pm, Mr Corns told him that he was cold and stood up to close the window in his cell. The cellmate said that when Mr Corns returned to his seat, he noted his breathing had become laboured. Mr Corns began to shake and his right arm dropped down by his side. Mr Corns fell off his chair and landed face down on the floor of the cell. The cellmate saw a small amount of blood coming out of his mouth. He said Mr Corns seemed to be breathing initially. At 12.55pm (about 10 minutes later), he rang the emergency cell bell to alert staff.

42. At 1.00pm, an officer responded to the emergency cell bell. He opened the observation panel and saw Mr Corns face down and unresponsive. He went to find another officer and told him what he had seen. The officer said that when he looked through the hatch, he saw Mr Corns lying “flat on his face with some blood on the floor”.
43. At 1.05pm, both officers entered the cell. An officer checked for signs of a pulse or breathing but he could find none. He also noted the Mr Corns was cold to the touch. An officer radioed an emergency code blue (indicating a prisoner is unconscious or having breathing difficulties).
44. The clinical team leader, and a medical officer arrived at the cell at 1.07pm. They also checked Mr Corns for signs of life, but could find none. They considered that he had been dead for some time and that attempts at CPR would be futile and undignified.
45. At 1.10pm, paramedics arrived at the cell. They also considered that any attempt at resuscitation would be futile as it was clear that Mr Corns had been dead for some time. At 1.17pm, they pronounced that Mr Corns had died.

Post-mortem report

46. The post-mortem gave Mr Corns’ cause of death as ischaemic heart disease caused by coronary artery disease.

Contact with Mr Corns’ Family

47. Mr Corns had not listed a named next of kin. However, during their investigation, the police traced Mr Corns’ ex-wife and informed her of Mr Corns’ death. She thanked them but said that she wanted no further contact on the matter.
48. Mr Corns’ funeral was held on 27 March. The chaplaincy team held a service for prisoners and staff in the prison chapel. The prison paid for the full cost of the funeral in line with national guidance.

Support for prisoners and staff

49. The prison posted notices informing other prisoners of Mr Corns’ 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 his death.
50. After Mr Corns’ death, a senior manager debriefed the staff who were involved giving them the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

Police investigation

51. The police investigated the actions of Mr Corns’ cellmate. They found nothing untoward and took no further action.

Findings

Clinical care

52. The clinical reviewer concluded that the care Mr Corns received at Birmingham was of a reasonable standard and at least equivalent to that which he could have expected to receive in the community.
53. The clinical reviewer noted that Mr Corns arrived in prison with a history of alcohol misuse. Soon after his arrival, he was appropriately referred to the prison's substance misuse team and successfully completed a short alcohol detoxification programme. He received a new patient assessment for heart disease, which revealed nothing of note.
54. The clinical reviewer found that blood tests that were requested were not completed because Mr Corns failed to attend the appointment. Healthcare staff did not record the reasons for his non-attendance and this was not followed up. The clinical reviewer is satisfied, however, that there is now a system in place at Birmingham for active follow up of prisoners who fail to attend appointments and that there is also good documentation to capture the reasons for non-attendance.

Emergency response

55. PSI 03/2013 requires prisons to have a medical emergency response code protocol which ensures that healthcare staff are alerted and an ambulance is called automatically in a life-threatening emergency. It says that all prison staff must be made aware of and understand the protocol and their responsibilities during medical emergencies. Birmingham's local emergency response protocol says that when a member of staff on scene discovers a potentially life-threatening medical emergency, they must call the appropriate emergency code red or code blue.
56. The cellmate rang the emergency cell bell to alert staff to Mr Corns' collapse at 12.55pm. When an officer answered it at 1.00pm, he saw Mr Corns face down on the floor and unresponsive and with blood round his mouth. He then went to seek help from another officer, and they entered the cell together at 1.05pm. It was only then that the officer radioed a code blue.
57. We consider that the officer should have radioed a code blue immediately when he saw Mr Corns unresponsive on the floor. Because he did not do so, there was a delay of five minutes before healthcare staff were alerted and an emergency ambulance was called. Although this does not appear to have affected the outcome for Mr Corns, as it appears he had been dead for some time when he was found, a delay of even a few minutes may make a critical difference in a medical emergency.
58. We are also concerned that the other officer told the investigator that the officer went to him first because officers 'do not enter cells on their own'.
59. Prison Service policy is that the preservation of life must take precedence over normal protocols and that, where there is, or appears to be, immediate danger to life, cells may be unlocked and an individual member of staff may go into the cell

on their own. Staff should not take action that they feel would put themselves or others in unnecessary danger. Before going into a cell, staff should make every effort to get a verbal response from the prisoner. This, together with what the member of staff observes through the panel and any knowledge of the prisoner, should inform a rapid dynamic risk assessment of the situation and a decision about whether to enter immediately or wait for assistance.

60. We do not criticise the officer for not entering the cell immediately: it was a two-man cell, Mr Corns was a large man and the officer could not be sure what had happened. However, we are concerned that he and the other officer appeared to believe that officers can never enter a cell on their own.

61. We make the following recommendations:

The Governor should ensure that all prison staff understand their responsibilities during medical emergencies, including that:

- **where there is a potential risk to life, they should enter a cell immediately, subject to a personal risk assessment; and**
- **they should use an emergency code promptly to communicate the nature of an emergency effectively.**

The Governor should ensure that a copy of this report is shared with both officers and that a senior manager discusses the Ombudsman's findings with them.

The actions of the cellmate

62. When Mr Corns collapsed in his cell on 15 April, the cellmate did not react immediately. In his witness statement to the police, he said that Mr Corns collapsed at about 12.45pm and that he waited about ten minutes before activating the emergency cell bell at 1.00pm. However, prison and healthcare staff said that Mr Corns was cold and appeared to have been dead for some time when he was found at 1.05pm. This suggests that Mr Corns had in fact collapsed some time earlier, perhaps even as early as 11.45am when they were locked in the cell.

63. His delay in alerting prison staff – even if he only delayed by 10 minutes - meant that any attempt to resuscitate Mr Corns would have been futile.

64. The police investigating Mr Corns' death questioned him about his actions. They found nothing untoward and no charges were brought against him. The PPO investigator was told that he had a long history of severe and enduring mental health problems. He also had possible cognitive impairment and limited social skills and insight into others' behaviour. He had been in the prison's inpatients unit but, at the time of Mr Corns' death he was briefly on normal location awaiting a transfer to a secure psychiatric hospital under the Mental Health Act and was transferred shortly afterwards.

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