Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Kenneth Handley, a prisoner at HMP Birmingham, on 4 October 2020

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 Kenneth Handley died of heart disease on 4 October 2020 while a prisoner at HMP Birmingham. He also had chronic obstructive pulmonary disease (COPD) which contributed to but did not cause his death. He was 66 years old. I offer my condolences to his family and friends.

The clinical reviewer was satisfied that the healthcare that Mr Handley received at Birmingham was of a high standard and equivalent to that which he could have expected to receive in the community. However, Mr Handley did not have a cardiovascular care plan.

I am concerned that healthcare staff did not complete a new order to reflect Mr Handley's changed position when he decided that he wanted to be resuscitated. While it did not affect the outcome for Mr Handley as the hospital consultant considered that he was in too poor a condition to resuscitate, nursing staff gave the consultant incorrect information that Mr Handley did not want to be resuscitated. In another emergency, this could be critical information.

I am also concerned that the officers who found Mr Handley unresponsive did not radio a medical emergency code blue. This led to a six-minute delay in calling for an 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 **October 2021**

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Summary

Events

1. On 24 July 2020, Mr Kenneth Handley was remanded to HMP Birmingham, and was transferred from hospital to the prison's inpatient wing. He had several health conditions, including cardiovascular disease, asthma, chronic obstructive pulmonary disease (COPD, a chronic lung condition) and hypertension.

2. On 27 July, a nurse noted that Mr Handley had told hospital staff that he did not want to be resuscitated if his heart or breathing stopped and that he had signed an Order to that effect. Mr Handley told the nurse that he now wanted to be resuscitated. The nurse noted in Mr Handley's medical records that he should have 'active treatment'.

3. On 15 September, Mr Handley was sentenced to two years and three months in prison for breaching a criminal behaviour order.

Events of 4 October

4. At about 4.00pm on 4 October, an officer saw Mr Handley sitting on his bed in his cell, with a vape in his hand. At about 4.20pm, the officer saw that he was lying on his back on the floor. The officer went into the cell, opened Mr Handley's mouth, checked his airway and heard him breathe. He turned him onto his side, called to his colleagues and asked an officer to call the nurses and to bring oxygen.

5. The officer radioed the emergency response nurse. Another officer went into the cell but was unable to find a pulse. Nurses started cardiopulmonary resuscitation (CPR). At 4.29pm, a custodial manager (CM) went to the cell and radioed a medical emergency code blue (which indicates that a prisoner is unconscious or not breathing and triggers the control room to call an ambulance immediately).

6. At 4.32pm, ambulance paramedics went to Mr Handley's cell and took over emergency care. At 5.27pm, the paramedics left Birmingham and took Mr Handley to hospital.

7. A hospital consultant telephoned a nurse at Birmingham and asked if Mr Handley had signed an Order not to be resuscitated. The nurse told the consultant that she had found an Order dated 24 July in the hospital discharge letters in Mr Handley's medical records. The consultant told the nurse that because Mr Handley was in a very poor clinical condition, they would not try to resuscitate him. At 8.40pm, Mr Handley died from heart disease.

Findings

Clinical care

8. The clinical reviewer found that the clinical care that Mr Handley received at Birmingham was of a high standard and was equivalent to that which he could have expected to receive in the community. However, the clinical reviewer said that healthcare staff should have completed a care plan to address Mr Handley's history of cardiovascular disease.

Resuscitation order

9. The clinical reviewer considered that when Mr Handley changed his mind and said that he wanted to be resuscitated, the nurse should have completed another order to confirm his decision to be resuscitated if his heart or breathing stopped.

Emergency response

10. The officers who responded to Mr Handley's medical emergency failed to radio a code blue. This led to a six-minute delay in calling an ambulance.

Recommendations

- The Head of Healthcare should ensure that healthcare staff put appropriate care plans and risk assessments in place for prisoners with a history of cardiovascular disease.
- The Head of Healthcare should ensure that healthcare staff are trained to record decisions about resuscitation clearly and accurately on the appropriate form rather than solely in the medical records.
- The Governor should ensure that prison staff understand their responsibilities during medical emergencies, including that they know when to use an emergency medical code and that they communicate the nature of the emergency effectively.

The Investigation Process

11. 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.

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

13. The investigator interviewed three members of staff by telephone on 21 December. The interviews were conducted by telephone because of the COVID-19 restrictions.

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

15. We informed HM Coroner for Birmingham and Solihull of the investigation. She gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

16. The Ombudsman's family liaison officer wrote to Mr Handley's next of kin to explain our investigation. They did not respond.

17. We shared the initial report with the Prison Service. There were no factual inaccuracies.

Background Information

HMP Birmingham

18. HMP Birmingham is a local prison which holds up to 1,450 prisoners. 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

19. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Birmingham in July 2018. They noted a dramatic deterioration in the prison's overall performance since the previous inspection. They judged outcomes for prisoners to be 'poor' against all four of their healthy prison tests – safety, respect, purposeful activity, rehabilitation and release planning. They issued an Urgent Notification to the Secretary of State for Justice, seeking immediate improvements.

20. Notwithstanding their overall judgement of the prison, 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. They found that record keeping by healthcare staff was of a good standard. However, they noted that while the environment in the healthcare centre was generally good, many of the wing-based clinical rooms were dirty and failed to meet infection control standards.

21. At their subsequent Independent Review of Progress in May 2019, HMIP reported that prison leaders at Birmingham had made progress against many of their recommendations, with significant work done to restore order to the prison.

22. HMIP also carried out a scrutiny visit of HMP Birmingham (a shortened inspection during the pandemic) in November 2020 and January 2021. Inspectors reported that COVID-19 had created significant challenges for leaders at the prison and that the prison had experienced three outbreaks of the virus. Inspectors reported that there was effective communication between staff and prisoners throughout the period of COVID-19 restrictions and frontline staff were visible when prisoners were unlocked. Healthcare was good but prisoners waited too long to see a GP.

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 2020, the IMB reported that healthcare provision was generally good, with inpatient wards being particularly well run, offering treatment for a range of conditions. They also noted that healthcare and prison staff worked well together.

Previous deaths at HMP Birmingham

24. There were four deaths, all from natural causes, at HMP Birmingham in the two years before Mr Handley's death. Four prisoners have died from natural causes at Birmingham since Mr Handley's death, including one from COVID-19, and there has been one self-inflicted death. There are no significant similarities to the findings in our investigation of these deaths.

Key Events

25. On 24 July 2020, Mr Kenneth Handley was remanded to HMP Birmingham, and was sent there from hospital. At his initial health screen, a nurse noted that Mr Handley had several pre-existing conditions, including cardiovascular disease, hypertension, asthma and COPD.

26. Mr Handley told a nurse that he had gone to hospital after he fell over and that he had a catheter fitted for urinary retention.

27. Mr Handley lived in the prison's inpatient wing, where healthcare staff took daily observations and gave him a nebuliser and inhalers for asthma and COPD when he needed them.

28. Healthcare staff created care plans for COPD, COPD infection protection, catheter use, low body mass index, nutrition, blood pressure, skin care and falls risk.

29. On 27 July, a nurse noted that Mr Handley had said in hospital that he did not want to be resuscitated if his heart or breathing stopped and signed an Order to that effect. Mr Handley told her that he had changed his mind and now wished to be resuscitated. She noted in his medical records that he was now for 'active treatment'.

30. On 15 September, Mr Handley was sentenced to two years and three months in prison for the breach of a criminal behaviour order.

31. Mr Handley was a challenging prisoner to manage because of his behaviour, which included swearing, spitting and random verbal outbursts at staff and he was not always compliant with healthcare treatment.

Events of 4 October

32. At about 4.00pm on 4 October, Officer A carried out the ward medication round with two nurses. He walked Mr Handley to the clinic, where he took his medication, and he went back to his cell. Another officer made Mr Handley a cup of tea which he placed on the observation panel flap. Officer A saw that Mr Handley had pressed his cell bell. Mr Handley asked him where his tea was and asked him for something to eat. Officer A said that his tea was on the hatch and that there was no more to eat. Officer A saw that he was sitting on his bed, with a vape in his hand.

33. At about 4.20pm, when the medication round was finished, a nurse told Officer A that she had to carry out Mr Handley's nebuliser treatment. Officer A went back to Mr Handley's cell, looked in and saw that he was lying on his back on the floor. He saw that there was tea and a chewed biscuit on the floor. He went into the cell, opened Mr Handley's mouth, checked his airway and extended his head and neck. He said he heard Mr Handley breathe, so he turned him onto his side. He left the cell and called to his colleagues for assistance and, because Mr Handley was grey and ashen in colour, he asked another officer to call the nurses and to bring oxygen.

34. Officer A also radioed the emergency response nurse. Another officer went into the cell and was unable to find a pulse. A nurse turned Mr Handley onto his back and started CPR with a colleague. At 4.29pm, a CM went to the cell and radioed a medical emergency code blue. Healthcare and prison staff went to Mr Handley's cell, and continued resuscitation attempts until ambulance paramedics arrived.

35. Paramedics went to Mr Handley's cell at 4.32pm as they were already at the prison. They took over emergency care. At 5.27pm, they took Mr Handley to hospital.

36. A hospital consultant telephoned a prison nurse and asked her if Mr Handley had signed an Order not to be resuscitated. She told him that she had found an Order not to resuscitate Mr Handley, dated 24 July, in his hospital discharge letters. He told the nurse that in any case, they would not try to resuscitate him because Mr Handley was in a very poor clinical condition. At 8.40pm, Mr Handley died.

Contact with Mr Handley's family

37. On 4 October, the Duty Governor appointed the Head of Reducing Reoffending as the family liaison officer. At 6.30pm, she telephoned Mr Handley's sister and told her that Mr Handley was seriously unwell and in hospital. When Mr Handley's health deteriorated, she telephoned his sister to tell her that she should go to the hospital, but she said that she was too unwell to visit. At 8.51pm, she telephoned Mr Handley's sister, told her that Mr Handley had died and offered her condolences.

38. Mr Handley's funeral took place on 28 October. The prison contributed to its cost in line with national instructions.

Support for prisoners and staff

39. After Mr Handley's death, the Duty Governor 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.

40. The prison posted notices informing other prisoners of Mr Handley'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 Handley's death.

Post-mortem report

41. A post-mortem examination established that Mr Handley died of ischaemic heart disease. He also had chronic obstructive pulmonary disease which contributed to but did not cause his death.

Findings

42. The clinical reviewer concluded that the clinical care that Mr Handley received at Birmingham was of a high standard and was equivalent to that which he could have expected to receive in the community.

43. However, the clinical reviewer said that it would have been best practice if healthcare staff had completed a care plan to address Mr Handley's history of cardiovascular disease. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff put appropriate care plans and risk assessments in place for prisoners with a history of cardiovascular disease.

Resuscitation orders

44. Mr Handley arrived at Birmingham from hospital, where he had signed an order not to be resuscitated if his heart or breathing stopped. When Mr Handley changed his mind about being resuscitated on 27 July, a nurse should have completed another order to confirm Mr Handley's resuscitation wishes. The clinical reviewer also noted that the words 'for resuscitation' should have been made clear in Mr Handley's medical records. Instead, the nurse used the words, 'for active treatment', which was not sufficiently clear.

45. Although prison and healthcare staff did try to resuscitate Mr Handley, the clinical reviewer said that the failure to complete a new Order could have caused a misunderstanding and a member of staff may not have known that Mr Handley had changed his mind and referred to the previous order completed in hospital.

46. The clinical reviewer also said that on 4 October, when Mr Handley went to hospital, it would have been best practice for a new Order to resuscitate him to have gone with him. This did not happen. When the consultant treating Mr Handley telephoned Birmingham and spoke to a prison nurse to clarify the resuscitation position, he was given the incorrect information that Mr Handley had a Do not Resuscitate Order in place. In the event, the consultant decided that, as Mr Handley was in a very poor clinical condition, no further resuscitation attempts would be made. Nonetheless, we make the following recommendation:

The Head of Healthcare should ensure that healthcare staff are trained to record decisions about resuscitation clearly and accurately on the appropriate form rather than solely in the medical records.

Emergency response

47. Prison Service Instruction (PSI) 03/2013 on medical emergency response codes and Birmingham's local policy set out the actions staff should take in a medical emergency. The PSI includes mandatory instructions on communicating the nature of a medical emergency so that staff take the relevant equipment to an incident and that there are no delays in calling an ambulance. It says that all prisons must have a medical emergency code protocol and that staff must understand their responsibilities during medical emergencies.

48. The medical emergency codes are normally called ‘code blue’ (which should be used when a prisoner is having chest pain, difficulty in breathing, is unconscious, choking, fitting or concussed, or is suffering a severe allergic reaction or a suspected stroke) and ‘code red’ (which should be used for severe blood loss or burns or a suspected fracture). Prison staff are not expected to be able to make medical diagnoses and the PSI says that staff must understand that if they are in any doubt about the nature of an injury, they must call a code and that “it is better to act with caution and request an ambulance that can be cancelled if it is later assessed as not required”.

49. When Officer A found Mr Handley, he was unresponsive, and it was clear that he was seriously unwell. The officer did not radio a medical emergency code blue, and instead called to his colleagues and asked nursing staff to bring oxygen, because he said that he saw Mr Handley breathing. When another officer realised that Mr Handley was not breathing, the officers still did not radio a medical emergency code blue but radioed for the emergency response nurse to come to Mr Handley’s cell. It was not until the CM arrived at Mr Handley’s cell six minutes later that she radioed a code blue medical emergency, which triggered the control room to call an ambulance.

50. As it happened, ambulance paramedics were already in the prison, so the delay in calling a medical emergency code did not delay the arrival of an ambulance. However, we are concerned that at interview the officers were not clear about when they should call a medical emergency code. In other cases, this could cause delay and prevent life-saving treatment. We make the following recommendation:

The Governor should ensure that prison staff understand their responsibilities during medical emergencies, including that they know when to use an emergency medical code and that they communicate the nature of the emergency effectively.

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