Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr William Billingham, a prisoner at HMP Birmingham, on 19 March 2021

**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.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr William Billingham died on 19 March 2021 of severe chronic obstructive pulmonary disease (COPD) at HMP Birmingham. He was 57 years old. I offer my condolences to Mr Billingham's family and friends.

The clinical reviewer concluded that the care Mr Billingham received at HMP Birmingham was equivalent to that which he could have received in the community.

We found that Mr Billingham missed a hospital appointment for an abdominal ultrasound six weeks prior to his death because of issues about the level of restraints required. We cannot say if this contributed to his death.

We are also concerned that when Mr Billingham was seen unresponsive in his cell on the morning of 19 March, staff did not enter the cell or call a medical emergency code. While this did not affect the outcome for Mr Billingham, prison staff could not have been sure that he did not require medical intervention.

It is disappointing and frustrating that the majority of our recommendations are repeated recommendations. This suggests that action plans created following deaths in 2018, 2019 and 2020 have not been embedded at HMP Birmingham. The Governor will need to ensure that there is renewed focus on the appropriate use of restraints and that staff understand the use of emergency codes and the requirement to consider entering cells at night when there is a potential risk to life.

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

**Elizabeth Moody**
**Deputy Prisons and Probation Ombudsman** **March 2022**

# Contents

# Summary

## Events

1. In February 2018, Mr William Billingham was remanded into HMP Birmingham. In October, he was sentenced to life imprisonment for murder, with a tariff of 27 years.

2. Mr Billingham had been previously diagnosed with chronic obstructive pulmonary disease (COPD – a chronic lung disease). In April 2020, he moved to the prison's isolation wing because he was at high risk if he contracted COVID-19.

3. In December 2020, Mr Billingham was referred for an abdominal ultrasound. He was escorted to hospital for this on 3 February 2021 but arrived late for his appointment because of problems authorising the appropriate level of restraints. As a result, the ultrasound did not go ahead.

4. On 17 and 18 March, Mr Billingham complained that his COPD was worsening. He was seen by nursing staff and a prison GP. On the afternoon of 18 March, the GP recommended that he move to the healthcare unit for observation. Mr Billingham declined, preferring to remain in his cell on the isolation wing.

5. On 19 March, at around 6.00am, Mr Billingham was found by night staff slumped in his chair in his single cell. They called for assistance but did not enter the cell. Healthcare staff arrived about 10 minutes later. They found no signs of life and did not attempt CPR. Paramedics arrived at the prison and at 6.43am, they confirmed that Mr Billingham had died.

## Findings

6. The clinical reviewer concluded that the care that Mr Billingham received at Birmingham was equivalent to that which he could have expected to receive in the community.

7. She did, however, raise concerns about the lack of urgency in rebooking Mr Billingham's ultrasound once his initial appointment had been missed.

8. We are concerned that Mr Billingham could not have his scheduled ultrasound on 3 February because an inappropriate level of restraints had been authorised and it took time for this to be corrected. We cannot say if this had an impact on his death.

9. On the afternoon of 18 March 2021, healthcare staff did not tell prison staff that the GP had recommended that Mr Billingham move to the healthcare unit so his condition could be monitored, and that Mr Billingham had declined. As a result, prison staff could not consider whether they should observe Mr Billingham more frequently overnight.

10. We are concerned that when Mr Billingham was seen slumped in his chair and unresponsive on 19 March, staff did not enter the cell to check on his welfare or provide assistance and did not call a medical emergency code. Although these failures did not affect the outcome for Mr Billingham, they could make the difference between life and death in other medical emergencies.

11. We are also concerned that when Mr Billingham was found unresponsive, none of the staff who responded switched on their Body-Worn Video Camera.

## Recommendations

- The Head of Healthcare should ensure that healthcare staff have a clear process for escalating requests for hospital appointments where a prisoner's medical condition is deteriorating and/or where it is felt that access needs to be prioritised.
- The Head of Healthcare should ensure that where healthcare staff have difficulties booking or changing a hospital appointment, they record all communication with hospital staff in the prisoner's medical record, including the outcome of their request.
- The Head of Healthcare should ensure that:
    - healthcare staff share key information with prison staff so that prison staff can consider appropriate levels of monitoring; and
    - this is recorded in the prisoner's medical records.
- The Governor and the 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 the policy set out in PSI 33/2015.
- The Governor should ensure that staff understand that when there is a potential risk to life, they should enter a cell at night, subject to a personal risk assessment.
- The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies in line with Prison Service Instruction (PSI) 03/2013. In particular, where there are serious concerns about the health of a prisoner, staff should use a medical emergency code immediately to alert control room staff to call an ambulance automatically.
- The Governor should ensure that:
    - staff responding to reportable incidents, including medical emergencies, activate their BWVCs at the earliest opportunity; and
    - staff are familiar with the policy on the recording of medical emergencies set out in paragraph 5.16 of PSI 04/2017.
- The Governor should share this report with the OSG who carried out the roll check on 19 March 2021 and the officer who responded to the OSG's call for assistance so they are aware of the Ombudsman's findings.

## The Investigation Process

12. 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.

13. The investigator obtained copies of relevant extracts from Mr Billingham's prison and medical records, and CCTV footage. He interviewed one member of staff by telephone, in line with COVID-19 restrictions, on 2 July 2021.

14. NHS England commissioned a clinical reviewer to review Mr Billingham's clinical care at the prison. There were significant delays in the completion of the clinical review, which was not available to the PPO until 29 November 2021.

15. We informed HM Coroner for Birmingham & 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.

16. The Ombudsman's family liaison officer contacted Mr Billingham's next of kin to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They did not respond to our letter.

17. In September, the coroner's office sent the PPO a set of questions they had received from Mr Billingham's next of kin. These included questions about Mr Billingham's treatment in the days prior to his death and what medication he was prescribed. The clinical reviewer has answered these questions in her report.

18. Mr Billingham's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

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

# Background Information

## HMP Birmingham

20. HMP Birmingham is a medium security prison with capacity to hold up to 1,099 men. It serves the courts of Birmingham and other courts across the West Midlands.

21. Physical healthcare is provided by Birmingham Community Hospitals. Mental healthcare is provided by Birmingham and Solihull Mental Health NHS Foundation Trust. The prison has an inpatient healthcare unit and 24-hour nursing provision.

## HM Inspectorate of Prisons

22. 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.

23. 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.

24. 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.

25. The most recent inspection of HMP Birmingham was a scrutiny visit (a shortened inspection due to COVID-19) 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. Inspectors also reported that prisoners waited too long for GP and dentist appointments.

## Independent Monitoring Board

26. 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 31 June 2021, the IMB reported that staff were not routinely using or wearing their Body-Worn Video Cameras (BWVC). The IMB had also raised this issue in their previous annual report.

## Previous deaths at HMP Birmingham

27. Mr Billingham was the eighth prisoner to die at HMP Birmingham since March 2019. Of the previous deaths, six were from natural causes, and one was self-inflicted.

28. In our investigation into a death at Birmingham in 2020, we made a recommendation about the need for staff to use emergency codes during a medical emergency. The prison accepted our recommendation, and the Governor issued a Notice to Staff which required the staff to confirm they knew how to call a correct medical code. In an investigation into a death in September 2018 we made a recommendation to the PGD for the West Midlands about continuing issues with staff not entering cells where there is a potential risk to life. The PGD said in response that the regional audit team would review progress and the Governor tasked a prison manager to review and update training for night staff.

29. In two other investigations into deaths at Birmingham in 2019, we were concerned about the appropriateness of the use of restraints. We recommended the Governor revise the risk assessment form for hospital escorts to make it clear that healthcare staff must provide information on the prisoner's current state of health and mobility; and that prison managers must confirm that they have read and taken into account the healthcare information about the prisoner's current state of health and mobility in determining the level of security needed. We also recommended that the Prison Group Director (PGD), for West Midlands assure herself that meaningful action is taken to ensure that this happens. The prison accepted our recommendation, and the Governor issued a briefing to all operational staff. In addition, a meeting between prison healthcare, security and safer custody staff was held chaired by a prison manager. Security staff revised the escort risk assessment form in July 2019.

## COVID-19 (coronavirus)

30. COVID-19 is an infectious disease that affects the lungs and airways. It is mainly spread through droplets when an infected person coughs, sneezes, speaks or breathes heavily. On 11 March 2020, the World Health Organisation (WHO) declared COVID-19 a worldwide pandemic.

31. COVID-19 can make anyone seriously ill, but some people are at higher risk of severe illness and developing complications from the infection. People at high risk (clinically extremely vulnerable) include those who have had an organ transplant; have severe lung or kidney disease; or are having certain types of cancer or other treatment which significantly increases the risk of infection. Examples of those at moderate risk (clinically vulnerable) are people over 70; people under 70 with an underlying health condition, such as diabetes, or chronic respiratory, heart, liver or kidney disease; those with a weakened immune system; or who are very overweight. (These lists are not exhaustive.)

32. In response to the initial pandemic outbreak, HM Prison and Probation Service (HMPPS) introduced several measures to try and contain the outbreak - to be implemented at local level, depending on the needs of individual prisons. (An outbreak is defined as two or more prisoners or staff in the prison who meet the case definition for COVID-19 or have a positive test result and among whom

transmission was likely to have occurred within a 14-day period.) A key strategy is ‘compartmentalisation’ to cohort and protect prisoners at high and moderate risk; isolate those who are symptomatic; and separate newly-arrived prisoners from the main population. Other measures include social distancing and the use of personal protective equipment (PPE).

# Key Events

33. On 13 February 2018, Mr William Billingham was remanded into HMP Birmingham charged with murder. On 2 October, Mr Billingham was sentenced to life imprisonment for murder, with a tariff of 27 years.

34. In 2015, prior to his arrival in prison, Mr Billingham had been diagnosed with chronic obstructive pulmonary disease (COPD – a chronic lung disease). He also had asthma. Prison healthcare staff prescribed medication to manage his COPD.

## 2019

35. A prison GP saw Mr Billingham for COPD reviews in February and September 2019. In September, the GP noted that Mr Billingham's COPD was worsening, and he prescribed a steroid medication for Mr Billingham to keep in his cell and use when needed. In October, Mr Billingham had a chest x-ray. The results showed no deterioration of his lungs since his last x-ray in May 2018.

## 2020

36. In March 2020, COVID-19 restrictions began to come into force. Prison regimes were severely curtailed, a COVID-19 management strategy was implemented, and a range of services including drug and health services were reduced in scope. Face-to-face appointments were reduced, and some non-urgent appointments were cancelled.

37. On 28 March, Mr Billingham was advised that he met the Public Health England criteria of clinically extremely vulnerable to complications from COVID-19. He was offered 12 weeks of in-cell shielding. Mr Billingham said that he did not want to fully isolate and signed a disclaimer.

38. On 7 April, he was offered a cell on J Wing, which had been set up as a COVID-19 isolation unit. Mr Billingham accepted and moved onto J Wing.

39. On 18 August, Mr Billingham was supposed to have his annual COPD review. This did not happen due to COVID-19 restrictions. Spirometry (lung capacity and breathing) tests were not available for the same reason.

40. On 23 September, the prison reviewed Mr Billingham's security categorisation level and he was downgraded from category B to category C.

41. On 7 October, Mr Billingham saw a specialist nurse for an informal review of his COPD.

42. On 22 October, as COVID-19 cases began to rise significantly, Mr Billingham was offered a further 12 weeks of in-cell shielding. Mr Billingham said that he did not want to fully isolate and signed a disclaimer.

43. On 9 November, Mr Billingham told a nurse that he felt bloated and that it was, at times, causing him breathing problems. He had a distended (abnormally swollen)

abdomen. The nurse arranged blood tests and a GP review. The results of the blood tests were normal.

44. On 22 December, Mr Billingham saw a nurse. The nurse reviewed his distended abdomen and referred him to a prison GP. On 23 December, a prison GP assessed Mr Billingham but was unable to feel any masses his abdomen. He referred Mr Billingham for an abdominal ultrasound and blood tests.

## 2021

45. On 10 January 2021, a prison GP reviewed the results of the blood tests. The results indicated that Mr Billingham could have cancer. The GP noted that Mr Billingham was already booked to have an abdominal ultrasound.

46. The following day, Mr Billingham saw a nurse as he was short of breath. She assessed him and referred him to the GP. A GP prescribed him a one-off dose of prednisolone (a steroid).

47. Later that day, the nurse went to Mr Billingham's cell to give him his medication. She completed a NEWS-2 assessment (NEWS-2 is a tool to measure clinical deterioration in adult patients) and he scored 4, indicating he needed to be reviewed regularly. She contacted the GP for advice.

48. The GP advised the nurse that Mr Billingham's condition was not improving, and that he needed to move into the prison healthcare unit or be referred to a hospital. Mr Billingham declined both options and remained on J Wing. His NEWS-2 score was now 5 which meant he needed to reviewed hourly.

49. A nurse assessed Mr Billingham again later that evening. There had been an improvement in his health (a NEWS-2 score was not recorded) and she told Mr Billingham that if his condition worsened, he should alert prison officers and she would send him out to hospital. She set a review of his health for the following day. On 12 January, a nurse reviewed Mr Billingham. His health had improved (a NEWS-2 score was not recorded).

50. On 3 February, Mr Billingham had a scheduled hospital appointment for an ultrasound of his abdomen. An escort risk assessment was completed, and the Head of Security assessed that Mr Billingham should go out to hospital 'double-cuffed' (where a prisoner's wrists are handcuffed together and then attached to a prison officer by a handcuff or an escort chain).

51. When Mr Billingham reached reception, ready to depart for the hospital, the Reception Manager queried the cuffing arrangements on the grounds that they were not in line with policy and were excessive, given Mr Billingham's security category and the lack of identified heightened risk factors. Following a discussion, the Head of Security amended the risk assessment and Mr Billingham was escorted to hospital 'single-cuffed' (where a prisoner is attached to an officer by a handcuff or an escort chain). (During the COVID-19 pandemic, prisoners have been attached to staff by an escort chain – a long chain with a handcuff at each end, rather than by handcuffs to maintain a distance between them.)

52. Resolving the handcuffing issue delayed the departure of the escort. When Mr Billingham and the prison officers arrived at the hospital, they were ten minutes late for the appointment. As the clinic was full, Mr Billingham was not admitted or seen by hospital staff and he returned to Birmingham. Healthcare staff re-referred Mr Billingham for an ultrasound, which was rebooked for April.

53. On 16 March, Mr Billingham was unable to have spirometry tests as part of his COPD and asthma reviews as they had been suspended as part of COVID-19 restrictions.

54. On 17 March, a nurse saw Mr Billingham. He told her he was experiencing shortness of breath and it was getting worse. She assessed him and took observations (a NEWS-2 score was not recorded). She referred him to the prison GP.

55. On 18 March, a nurse saw Mr Billingham. Mr Billingham was sitting in his chair in his cell and was experiencing shortness of breath. He told her he was feeling worse and that his COPD medications were not working. She assessed him and took observations (a NEWS-2 score was not recorded). That morning, a prison GP prescribed Mr Billingham his salbutamol inhaler and another GP prescribed prednisolone.

56. Later that day, a prison GP assessed Mr Billingham in person and advised that Mr Billingham should be admitted to the prison healthcare unit for observation as his health was deteriorating. Mr Billingham declined to move to the healthcare unit.

57. Mr Billingham remained on J Wing. At around 7.30pm, he was seen in his cell by an Operational Support Grade (OSG), who had just started his shift. The OSG said Mr Billingham was sitting in his chair and that he saw him moving.

## Events of 19 March 2021

58. At around 6.00am, the OSG carried out a routine roll check (count of prisoners) on J Wing. At 6.02am, he reached Mr Billingham's cell and looked through the observation panel of the cell door. He saw Mr Billingham in his chair in his cell. The OSG called out to Mr Billingham, but Mr Billingham did not respond. He thought Mr Billingham "did not look right" because of his colour and he called for support over the radio. He then went to complete the roll count.

59. At 6.06am, an officer reached Mr Billingham's cell in response to the OSG's call for assistance. In her statement she said that, from what she could see through the observation flap, she thought Mr Billingham may have died as she could not see any signs of breathing or chest movement and his skin was pale. CCTV footage shows that at 6.07am, the officer and OSG walked away from Mr Billingham's cell.

60. CCTV footage shows that at 06.10am, they returned to the cell with a Custodial Manager (CM), who was the Night Orderly Officer (the officer in charge of the prison overnight), and nursing staff. At 6.12am, the CM called a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties) and the prison control room called an ambulance immediately.

61. The CM opened the cell and a nurse assessed Mr Billingham. She noted he was cold to the touch and there was rigor mortis in his arms. Healthcare staff assessed that CPR was therefore inappropriate and it was not attempted.

62. Ambulance paramedics arrived at the prison at 6.26am. They assessed Mr Billingham and at 6.43am they confirmed that Mr Billingham had died.

## Contact with Mr Billingham's family

63. Following Mr Billingham's death, the prison appointed a family liaison officer (FLO). At 10.30am, the FLO rang Mr Billingham's next of kin to break the news of Mr Billingham's death and to offer condolences. Mr Billingham's next of kin was due to the leave the country the following day for work, so the FLO corresponded with them via email, offering information and support.

64. Mr Billingham's funeral was held on 4 June 2021. In line with Prison Service policy, the prison contributed to the cost of the funeral.

## Support for prisoners and staff

65. After Mr Billingham's death, a prison manager 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.

66. The prison posted notices informing other prisoners of Mr Billingham'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 Billingham's death.

## Post-mortem report

67. The pathologist concluded that Mr Billingham died of severe chronic obstructive pulmonary disease (COPD – a chronic lung disease).

68. The toxicology report found therapeutic levels of amitriptyline in Mr Billingham's system and excluded drug use as a cause of death.

# Findings

## Clinical findings

69. The clinical reviewer found that the care Mr Billingham received at HMP Birmingham was equivalent to that which he could have expected to receive in the community.

70. She did, however, identify a number of concerns about Mr Billingham's care.

### Escalating diagnostic test appointments

71. In December 2020, a prison GP requested that Mr Billingham have an ultrasound of his abdomen. However, Mr Billingham was refused his ultrasound on 3 February 2021 because he was late for the appointment. The appointment was rebooked for the first week in April, but Mr Billingham died before it could take place.

72. Mr Billingham's condition had been worsening over the previous three months, the abdominal distention was contributing to his shortness of breath, and blood tests had suggested he could have cancer. In these circumstances the clinical reviewer considered that she would have expected healthcare staff to have requested an earlier ultrasound appointment when it needed to be re-booked. If the hospital were unable to accommodate this request, it should have been documented in the healthcare records. We recommend:

**The Head of Healthcare should ensure that healthcare staff have a clear process for escalating requests for hospital appointments where a prisoner's medical condition is deteriorating and/or where it is felt that access needs to be prioritised.**

**The Head of Healthcare should ensure that where healthcare staff have difficulties booking or changing a hospital appointment, they record all communication with hospital staff in the prisoner's medical record, including the outcome of their request.**

## Information sharing

73. On the afternoon of 18 March (the day before Mr Billingham was found dead), a prison GP had advised Mr Billingham that he should move onto the healthcare unit for closer observation. Mr Billingham declined this move.

74. It was Mr Billingham's right to decline the move. However, we consider that healthcare staff should have shared the information with prison staff that Mr Billingham's health had deteriorated and that increased clinical monitoring was recommended. Sharing the information would have enabled prison staff to consider whether they needed to increase their observations of Mr Billingham.

75. We could find no evidence that the information on Mr Billingham's health was shared with prison staff. In interview, the OSG said that there was no mention of Mr

Billingham or his health in the verbal handover he received when he started his shift. We make the following recommendation:

**The Head of Healthcare should ensure that:**

- **healthcare staff share key information with prison staff so that prison staff can consider appropriate levels of monitoring; and**
- **this is recorded in the prisoner's medical records.**

## Restraints, security and escorts

76. 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 takes into account a prisoner's health and mobility.

77. Prison Service Instruction (PSI) 33/2015, External Escorts, says that normal practice is for male Category B and Escape-List prisoners to be double cuffed while on escort and that "all other prisoners will be single cuffed unless the individual risk assessment indicates that double cuffing is required and is proportionate".

78. When the escort risk assessment was completed for Mr Billingham's ultrasound appointment on 3 February, Mr Billingham's security category was correct and recorded as C and his risk of escape and hostage taking and risk to prison and hospital staff and the public was assessed as low. The section on additional risks noted that there was "no info to indicate increased or high-risk escort". Despite this, the Head of Security decided that Mr Billingham should be 'double cuffed' contrary to the policy set out in PSI 33/2015.

79. The Reception Manager is to be commended for correctly identifying that double cuffing was excessive, given Mr Billingham's security category and lack of additional risk factors. When this was raised, the Head of Security agreed to reduce the level of restraints to single cuffs. However, this discussion delayed the departure of the escort and as a result Mr Billingham missed his ultrasound appointment.

80. We cannot know if the ultrasound would have changed Mr Billingham's treatment or identified new treatment needs, and we cannot say whether the fact that it did not take place contributed to his death. However, it was clearly an important appointment and the prison should ensure that these types of preventable delays are avoided. We make the following recommendation:

**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 the policy set out in PSI 33/2015.**

## Entering cells where there is risk to life

81. PSI 24/2011 on management and security at nights requires that all prisoners are locked in their cells during night state. Under normal circumstances, the night orderly officer must give authority to unlock a cell during night state, and no cell should be opened unless at least two or three members of staff are present, one of whom should be the night orderly officer. However, the PSI states that the preservation of life must take precedence. It says that where there is, or appears to be, immediate danger to life, cells may be unlocked without the authority of the night orderly officer and an individual member of staff may go into the cell on their own. However, night staff should not take action that they feel would put themselves or others in unnecessary danger.

82. The PSI says that 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.

83. In interview, the OSG said that although he had a key pouch, he did not see any point in entering the cell as he assessed that Mr Billingham was showing no signs of life. He said that he and the officer did not discuss entering the cell when she arrived. In her statement, the officer said that "it was apparent that [Mr Billingham] may have passed (sic)" as she could not see any signs of breathing or chest movement and his skin was pale.

84. Once a nurse arrived and assessed him, it was clear that Mr Billingham was dead. However, we do not consider that prison staff were able to make that assessment from outside the door. We consider that, in the eight minutes between the OSG failing get a response from Mr Billingham and healthcare staff arriving, the OSG and officer should have made a personal risk assessment and considered entering the cell. Where a prisoner is not breathing and is pale, it does not necessarily follow that they are dead. They may need urgent medical treatment.

85. While it made no difference to the outcome for Mr Billingham, in another case an eight-minute delay in entering a cell to assess an unresponsive prisoner could make a significant difference. We make the following recommendation:

    **The Governor should ensure that staff understand that when there is a potential risk to life, they should enter a cell at night, subject to a personal risk assessment.**

## Use of Emergency Codes

86. PSI 03/2013, Medical Emergency Response Codes, requires prisons to have a medical emergency response code protocol which should trigger healthcare staff to attend immediately (if they are on duty) and control room staff to call an ambulance immediately. It says that all prison staff must be made aware of and understand the protocol and their responsibilities during medical emergencies. It makes it clear that there should be no delay in calling an ambulance (for example, it must not be a requirement for a member of the prison healthcare team or a Duty Manager to

attend the scene before emergency services are called). The PSI also says, "It is better to act with caution and request an ambulance that can be cancelled if it is later assessed as not required".

87. In interview, the OSG said that he did not call an emergency code because he wanted the nurse to assess whether it was an emergency. He said Mr Billingham could have been in a deep sleep.

88. The officer said in her statement that she looked through the observation panel and assessed Mr Billingham "may have passed". She did not call an emergency code.

89. When the CM arrived on scene, he called a code blue. There had been a 10-minute gap between the OSG failing to get a response from Mr Billingham and an ambulance being called.

90. While it made no difference in this case, in another case a 10-minute delay in calling an ambulance could make a significant difference. We make the following recommendation:

**The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies in line with Prison Service Instruction (PSI) 03/2013. In particular, where there are serious concerns about the health of a prisoner, staff should use an emergency code immediately to alert control room staff to call an ambulance automatically.**

## Use of Body-Worn Video Cameras

91. PSI 04/2017, National Security Framework – Security Management – Body Worn Video Cameras, requires prisons to have a local policy on staff using and wearing body-worn video cameras (BWVC) and that they should be trained in their use. The policy mandates BWVC use for incident response, which includes medical emergencies. The policy also sets out the need for BWVC to be used during night state. The mandatory action section states:

> "*BWVC must be deployed and set to record during a response to any reportable Incident.*
>
> *BWVC must be issued to appropriately trained staff for use both during "patrol state" and "night state" of the establishment.*
>
> *Where BWVC is deployed within a prison it must be used…when a user is responding to an alarm bell or Incident"*

92. We note that in their last two annual reports the IMB at HMP Birmingham expressed concerns about staff not wearing and turning on their BWVCs and made recommendations. We asked Birmingham for the BWVC footage of this incident response and were told there was none. This means that none of the uniformed staff, including the 'response officers' and the Night Orderly Officer, turned on their BWVCs when they responded to the incident. We make the following recommendation:

**The Governor should ensure that:**

- **staff responding to reportable incidents, including medical emergencies, activate their BWVCs at the earliest opportunity; and**
- **staff are familiar with the policy on the recording of medical emergencies set out in paragraph 5.16 of PSI 04/2017.**

## Learning lessons

93. It is important that staff learn the lessons identified in our reports. We, therefore, recommend:

**The Governor should share this report with the OSG who carried out the roll check on 19 March 2021 and the officer who responded to the OSG's request for assistance so they are aware of the Ombudsman's findings.**

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