

**Prisons &
Probation**

Ombudsman
Independent Investigations

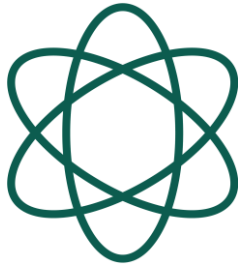
Independent investigation into the death of Mr Floyd Carruthers, a prisoner at HMP Birmingham, on 14 June 2021

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.

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 Floyd Carruthers died in hospital as a result of a heart infection at the site of his pacemaker on 14 June 2021, while a prisoner at HMP Birmingham. He was 58 years old. I offer my condolences to Mr Carruthers' family and friends.

Mr Carruthers arrived at Birmingham on 12 April 2021. Although healthcare staff noted that Mr Carruthers had a pacemaker fitted and that they needed more information about it, they never followed it up or put a care plan in place. The clinical reviewer found that this aspect of Mr Carruthers' care was not equivalent to that he could have expected to receive in the community.

Mr Carruthers did not leave his cell at all in the three days before he was taken to hospital on 29 May. Given that he was not collecting his evening meal or showering during that period, we consider that staff should have been more alert to the possibility that his self-neglect might indicate a decline in his physical or mental health.

I am concerned that a prison manager authorised the use of double cuffs on Mr Carruthers when he was taken to hospital, without any input from healthcare staff. I am also concerned that there was an excessive delay in enabling the ambulance to leave the prison.

My investigation found that Mr Carruthers should have been released from prison a week before he died. He was already in hospital by that time, but had he been released when he should have been, his family would have been able to visit him without the presence of prison officers.

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

August 2022

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Summary

Events

1. On 12 April 2021, Mr Floyd Carruthers was remanded in prison custody, due to breaching two court orders, and was sent to HMP Birmingham. He was sentenced to 66 days imprisonment on 6 May.
2. When Mr Carruthers arrived at Birmingham, a prison GP noted that he had a pacemaker fitted and that more information about it was needed. This was never followed up.
3. Mr Carruthers did not engage much with staff or other prisoners and was described as someone who kept himself to himself. On 25 May, he left his cell to collect his evening meal but, after that, he did not leave his cell again until he was taken to hospital four days later.
4. On 29 May, when staff unlocked Mr Carruthers' cell for the midday meal, they found him slumped in a chair. They called for a nurse, who found that Mr Carruthers had a very high heart rate and a low blood oxygen level. Staff called for an ambulance which took Mr Carruthers to hospital.
5. Mr Carruthers was admitted to hospital and diagnosed with an infection at the site of his pacemaker.
6. Mr Carruthers' condition continued to deteriorate, and he died in hospital on 14 June. A post-mortem established that he died as a result of his heart infection.

Findings

7. Although a prison GP identified that more information should be obtained about Mr Carruthers' pacemaker, this was never done, and no care plan was put in place. The clinical reviewer found that this aspect of Mr Carruthers' care was not equivalent to that he could have expected to receive in the community.
8. The clinical reviewer was also concerned that blood test results were not recorded in Mr Carruthers' medical record.
9. We are concerned that staff did not seem to realise that Mr Carruthers had not left his cell for four days. During that period, he did not have a shower and had only one evening meal, which was collected for him by a member of staff. We consider that staff should have been more alert to the possibility that Mr Carruthers' self-neglect indicated a decline in his physical or mental health.
10. The ambulance was held at the gate for 25 minutes when it was ready to leave the prison with Mr Carruthers, which was unacceptable.
11. When Mr Carruthers was taken to hospital, he was double cuffed (his wrists were cuffed together, and he was attached to an officer using an escort chain). We are concerned that the escort risk assessment contained no contribution from healthcare staff and that the authorising manager made the decision to use double cuffs without any information about Mr Carruthers' state of health.

12. Mr Carruthers should not have been in prison custody when he died as he had completed the custodial part of his sentence on 7 June. We note that he was in hospital by this time, but his family would have been able to visit him without the presence of prison officers if he had been released when he should have been.
13. There were long delays in the prison providing information requested by the PPO investigator which caused significant delays to our investigation.

Recommendations

- The Head of Healthcare should ensure that prisoners with a pacemaker fitted have a care plan and ongoing monitoring/reviews with links to external cardiology departments.
- The Head of Healthcare should undertake an audit of blood test requests and results to understand why the blood test results were not recorded in this case and take the required action to avoid recurrence.
- The Governor should ensure that all staff are alert to signs of self-neglect and aware of their safeguarding responsibilities under PSI 16/2015.
- The Governor should ensure that there are no unnecessary delays in discharging ambulances.
- 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, in all cases:
 - healthcare staff complete the medical information section of the escort risk assessment to say whether the prisoner's current medical condition affects their mobility and risk of escape; and
 - authorising managers show that they have taken this information into account when assessing a prisoner's current level of risk.
- The Governor should ensure that a prisoner's custodial status is accurately updated in a timely way, and that there are safeguards in place to prevent a prisoner being held in custody beyond the end of their sentence.
- The Governor should ensure that prison documentation is stored securely and provided promptly when requested during a PPO investigation, in line with PSI 58/2010.

The Investigation Process

14. 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.
15. The investigator obtained copies of relevant extracts from Mr Carruthers' prison and medical records.
16. NHS England commissioned a clinical reviewer to review Mr Carruthers' clinical care at the prison.
17. We informed HM Coroner for Birmingham and Solihull of the investigation. She gave us the cause of death. We have sent the Coroner a copy of this report.
18. The Ombudsman's family liaison officer wrote to Mr Carruthers' sister and mother to explain our investigation. They had no questions but asked for a copy of the report.
19. The initial report was shared with Mr Carruthers' sister and mother. They commented via their solicitor, on the lateness of the payment of funeral expenses by the prison. Paragraph 45 has been amended to reflect this.
20. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS found no factual inaccuracies.

Background Information

HMP Birmingham

21. HMP Birmingham is a local prison which holds up to 1,054 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

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. In August 2018, the running of the prison was transferred from G4S to HM Prison and Probation Service (HMPPS).
23. 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.
24. 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

25. 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 2021, the IMB reported that the prison was safer than previously, and that prisoners were treated fairly and with respect. They were concerned that the COVID-19 pandemic had resulted in a regime that left prisoners too long in their cells.
26. The IMB said that healthcare at the prison was good and that it had coped well with the challenges of COVID-19.

Previous deaths at HMP Birmingham

27. Mr Carruthers was the ninth prisoner at Birmingham to die since June 2019. Of the previous deaths, seven were from natural causes and one was self-inflicted.
28. We have previously recommended that staff should complete and review blood test results promptly and we were told that the process had been reviewed in

September 2020. We have also previously made a recommendation about the need for healthcare staff to contribute to escort risk assessments and for authorising managers to show that they have taken the healthcare information into account. We were told that the form had been revised in July 2019 and that in November 2019, staff had been reminded about the legal position on restraints and their responsibilities. We are disappointed to be making the same recommendation again in this case.

Key Events

29. On 12 April 2021, Mr Floyd Carruthers was remanded in prison custody as a result of breaching two civil court orders (taken out by his housing association following disputes between him and a neighbour). He was sent to HMP Birmingham.
30. At his reception health screening, Mr Carruthers said he had no current physical or mental health conditions. Healthcare staff obtained his medical records, which showed that Mr Carruthers was not taking any medication. A prison GP noted that Mr Carruthers had a pacemaker and that information about it would be needed. This was never followed up.
31. On 6 May, Mr Carruthers was sentenced to 66 days imprisonment for breaching the court orders.
32. Mr Carruthers had a history of schizophrenia but was not taking any medication for it and there were no concerns about his mental health when he arrived at Birmingham. However, the day after he was sentenced, a mental health nurse visited him to make sure that he was alright. Mr Carruthers told her that he had no concerns, and she was satisfied that no further action was required.
33. On 15 May, a healthcare assistant took a blood sample from Mr Carruthers for testing. (This appears to have been routine rather than in response to any specific concern.) The blood test results were not recorded.
34. Mr Carruthers was sharing a cell for a short period in the middle of May, but on 18 May his cellmate moved out and he remained the lone occupant of that cell for the remainder of his time at Birmingham. Staff described him as a very quiet person who kept himself to himself.

25 - 29 May

35. CCTV shows that Mr Carruthers left his cell shortly before 5.00pm on 25 May. He was out of his cell for about four minutes, during which time he shuffled slowly to the end of the wing and returned with a plate of food. Although staff, and on one occasion a prisoner, spoke to him through his cell door on the following days, that was the last time he is seen on CCTV or leaving his cell before 29 May when he went to hospital.
36. At around 11.30am on 26 and 27 May, CCTV shows an officer and prisoner delivering food packs to cells, including Mr Carruthers'. On both days Mr Carruthers does not leave his cell to collect an evening meal.
37. On 28 May, when staff unlocked Mr Carruthers at the time of the evening meal, he told a Custodial Manager (CM) that he did not want to collect his food and did not feel like eating. She said that Mr Carruthers told her that he had been eating and when she asked if he would eat his food if she collected it, he said he would. She went and collected his evening meal for him. She said that he was grateful for this and did not seem any different from normal.
38. An Operational Support Grade (OSG) conducted the roll checks (counts to confirm that all prisoners are in their cells) for the night of 28/29 May and the welfare check

early in the morning of 29 May. She could not recall anything unusual, or where Mr Carruthers was in his cell.

39. At around 11.22am on 29 May, an officer unlocked Mr Carruthers' cell for the midday meal. He found him bent over in a chair with his television on. He asked Mr Carruthers if he would like him to collect his meal for him and he grunted in response. He asked him again and Mr Carruthers replied 'yes'. After returning with his food, the officer asked a CM to have a look at Mr Carruthers because he was concerned about him.
40. At around 11.31am, the CM went to Mr Carruthers' cell. She asked for healthcare staff to attend as he seemed unwell, and they arrived a few minutes later. A nurse recorded in Mr Carruthers' clinical notes that he told him he had not moved out of his chair since the previous day and was unable to move his neck. The nurse noted that all of his food since the previous morning was left uneaten in his cell. (The CM told us that this was not the case as the only food in the cell was the cold pack delivered the evening before, which contained milk, coffee, teabags and cereal.) When first checked by the nurse, Mr Carruthers had an extremely high heart rate of 220 bpm (beats per minute), although this settled down a little to 180 bpm. His blood oxygen level was very low at 78% and his breathing rate was slightly raised. The nurse asked for an ambulance to be called, and this was done at 12.02pm.
41. The ambulance arrived at the prison at 12.22pm and the paramedics were with Mr Carruthers at 12.31pm. In their notes, they say that Mr Carruthers said that he had not eaten for two days and had been on his chair for a long time. Their initial findings were that he was confused and unable to stand up, and that he was breathing very rapidly at 40 breaths a minute (over 20 breaths a minute is considered high). Although his heart rate had settled down to within normal range, they found it difficult to detect a pulse at his wrists. The ambulance was ready to leave the prison at 1.23pm but was held at the gate for 25 minutes. The ambulance staff said that the delay was caused by the time it took to arrange prison escorts and paperwork, and that they frequently told prison officers that Mr Carruthers was potentially very unwell and needed to get to hospital. When he left the prison, Mr Carruthers was accompanied by two prison officers and he was double cuffed (his wrists were cuffed together, and he was attached to an officer using an escort chain - a long chain with a cuff at each end). (The restraints were later reduced to an escort chain only, which was later removed altogether.)
42. In hospital Mr Carruthers was diagnosed with sepsis (a potentially life-threatening condition that occurs when the body's response to an infection damages its own tissues) from an infection at the site of his pacemaker, and his kidneys were failing. He underwent dialysis (a procedure involving a machine that filters the blood removing harmful waste product when kidneys are unable to perform this function). Heart surgery was considered to remove and replace the pacemaker, but Mr Carruthers was not well enough for this to take place.
43. At 11.00am on 14 June, Mr Carruthers died in hospital.

Contact with Mr Carruthers' family

44. On the afternoon of 29 May, shortly after Mr Carruthers was taken to hospital, the prison informed Mr Carruthers' mother that he was there. Members of Mr Carruthers' family visited him while he was in hospital.
45. An officer was appointed as the prison's family liaison officer, and he coordinated prison contact with the family, both when Mr Carruthers was in hospital and after he died. His funeral took place on 6 August. The prison contributed to the costs in line with national policy. However, the family reported that the payment from the prison was very late and was not made until March 2022.

Support for prisoners and staff

46. After Mr Carruthers' death, a CM debriefed the staff who were at the hospital when Mr Carruthers died to ensure that they had the opportunity to discuss any issues arising, and to offer support. He followed this up the next day to ensure that the staff were alright, and the staff care team also offered support.
47. The prison posted notices informing staff and prisoners of Mr Carruthers' death, and offering them support.

Post-mortem report

48. The post-mortem report concluded that the cause of Mr Carruthers' death was cardiac tamponade (a build-up of fluid around the heart resulting in pressure that prevents the heart from working properly) and hypostatic pneumonia (pneumonia usually resulting from a collection of fluid in an area of the lungs). This was caused by haemorrhagic pericarditis (inflammation and build-up of blood inside the fibrous sac surrounding the heart). The haemorrhagic pericarditis was caused by infective endocarditis (an infection of the inner lining of the heart) associated with the pacemaker, which had been implanted to regulate 2nd degree atrio-ventricular block (abnormal heart rhythms).

Findings

Clinical care

Pacemaker monitoring

49. On the day Mr Carruthers arrived at Birmingham, a prison GP noted that he had been fitted with a pacemaker and that further information about it was needed. However, this was not followed up.
50. The clinical reviewer noted that NHS guidance says that patients with pacemakers should be checked every three to 12 months. She considered that efforts should have been made to obtain more information about the type of pacemaker Mr Carruthers had, when it was last checked, and a care plan created around his needs. She found that this aspect of Mr Carruthers' care was not equivalent to that he could have expected to receive in the community. We recommend:

The Head of Healthcare should ensure that prisoners with a pacemaker fitted have a care plan and ongoing monitoring/reviews with links to external cardiology departments.

Blood tests

51. Mr Carruthers' blood test results (from the sample taken on 15 May) were not entered in his medical record. Despite liaising with the prison healthcare team, the clinical reviewer was unable to establish why the blood test results were not available and uploaded. We recommend:

The Head of Healthcare should undertake an audit of blood test requests and results to understand why the blood test results were not recorded in this case and take the required action to avoid recurrence.

Safeguarding

52. CCTV shows that Mr Carruthers did not leave his cell between collecting his evening meal at around 5.00pm on 25 May and when he was taken to hospital on 29 May. Staff delivered food packs to his cell on the mornings of 26 and 27 May but he did not collect an evening meal on either day. On 28 May, a CM collected his evening meal for him after he said he did not want to collect it, but she did not think anything was wrong. When healthcare staff were called on 29 May, Mr Carruthers told a nurse that he had not got out of his chair since the previous day, and she noted that all his food since the previous morning remained untouched. Paramedics noted that he was very weak, unable to stand and was confused and disoriented.
53. We are concerned that staff did not seem to realise that Mr Carruthers had not been out of his cell for four days. He was not collecting his evening meal or showering for this period and yet there was nothing in his prison record that expressed any concern for his welfare. PSI 16/2015, *Adult Safeguarding in Prison*, identifies people who do not leave their cells as a trigger point for concern and consideration of intervention. We consider that staff need to be alert to signs of self-neglect, which could indicate a decline in physical or mental health and refer to healthcare staff if necessary. We recommend:

The Governor should ensure that all staff are alert to signs of self-neglect and aware of their safeguarding responsibilities under PSI 16/2015.

Delay in the ambulance leaving the prison

54. The ambulance crew reported that they experienced delays on both entry to the prison and on leaving. They arrived at the prison gates at 12.22pm and were on the wing with Mr Carruthers at 12.31pm. Although not ideal, nine minutes is not particularly unusual given the operating procedures in prisons. However, the time it took for the ambulance to leave the prison was excessive. It was ready to leave at 1.23pm but was held at the gate for a further 25 minutes while paperwork and escorts were being arranged. We recommend:

The Governor should ensure that there are no unnecessary delays in discharging ambulances.

Escort risk assessment

55. 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 the prisoner's health and mobility.
56. 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 he has 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.
57. The medical section of the escort risk assessment form for Mr Carruthers' transfer to hospital on 29 May was left blank. The authorising manager therefore made his decision to restrain Mr Carruthers without any input from healthcare staff on Mr Carruthers' current state of health and mobility. We are concerned therefore, that this decision was not made in line with the High Court judgment. We recommend:

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, in all cases:

- **healthcare staff complete the medical information section of the escort risk assessment to say whether the prisoner's current medical condition affects their mobility and risk of escape; and**
- **authorising managers show that they have taken this information into account when assessing a prisoner's current level of risk.**

Failure to release Mr Carruthers from custody

58. On 6 May, Mr Carruthers was sentenced to 66 days imprisonment and should have been released at the half-way point in his sentence, which the prison has retrospectively calculated as 7 June. However, when he died, the prison still had Mr Carruthers categorised as a remand prisoner.

59. When Mr Carruthers returned from Birmingham County Court on 6 May, no one checked to see what the outcome of his case had been. The Head of Offender Management Services at Birmingham said that although the staff who had escorted Mr Carruthers had made a note on the escorting paperwork to say that he had been sentenced, the normal process was that the court would email the paperwork to the prison, which did not happen.
60. Mr Carruthers had an outstanding court matter and was due to attend Birmingham County Court on 24 May. However, he did not attend, and the prison said this was because they were not notified by the court to produce him. The appearance was rescheduled for 2 June, by which time Mr Carruthers was in hospital.
61. Because of the outstanding court appearance, staff at Birmingham may have assumed that Mr Carruthers was still a remand prisoner. However, the outstanding matter was an application from Mr Carruthers' housing association, Midland Heart, for a variation to Mr Carruthers' restraining order when he was released from prison.
62. The prison relied on the court to notify them electronically about the outcome of cases, and when this did not happen in Mr Carruthers' case, there was nothing in place to follow this up. We are concerned that Mr Carruthers should not have been in prison custody when he died. We note that he was already in hospital by the time he should have been released, but it would have enabled his family to be with him in the hospital without the presence of prison officers if he had been released when he should have been. We recommend:

The Governor should ensure that a prisoner's custodial status is accurately updated in a timely way, and that there are safeguards in place to prevent a prisoner being held in custody beyond the end of their sentence.

Delays in providing evidence to the PPO

63. Prison Service Instruction (PSI) 58/2010, *The Prisons and Probation Ombudsman*, says that Governors must ensure that when the PPO is carrying out investigations or enquiries, staff comply with requests for information and assistance. At the start of the investigation, the PPO investigator requested information, some of which took several months for Birmingham to provide. This included CCTV, and staff statements which were made a long time after Mr Carruthers' death, which not surprisingly affected the ability of the staff to recall the events in meaningful detail. We recommend:

The Governor should ensure that prison documentation is stored securely and provided promptly when requested during a PPO investigation, in line with PSI 58/2010.

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