

**Investigation into the circumstances surrounding the
death of a prisoner at
HMP Birmingham, in June 2006**

**Report by the Prisons and Probation Ombudsman for
England and Wales**

November 2006

This is the report of an investigation into the circumstances of the death of a prisoner in June 2006. The post mortem report indicates that the man suffered a heart attack. At the time of his death, he was a prisoner at HMP Birmingham, having been remanded there on 10 May following a failure to surrender to bail. He was aged 60.

The man who died collapsed during a meeting with his legal representative late in May, and was taken to hospital by emergency ambulance. He had a family history of heart disease, and had suffered a heart attack three years earlier. I would like to extend my condolences to his family and friends for their unexpected and sad loss.

The investigation was carried out on my behalf by my colleague. A family liaison officer provided liaison with the man's family. In addition, an independent review into his medical care and treatment was undertaken by a doctor on behalf of the Heart of Birmingham Primary Care Trust (PCT). I am most grateful for his assistance. I am also grateful to the Governor and staff of Birmingham for their ready co-operation with this investigation.

This report makes two recommendations, both concerned with clinical matters. The first relates to the way in which new prisoners with long term ill health should be managed. The second refers to contacting prisoners' GPs if they present with a history of chronic illness.

Stephen Shaw CBE
Prisons and Probation Ombudsman

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SUMMARY

The man who died was remanded to HMP Birmingham on 10 May 2006, having failed to answer to bail. He had not been in prison before, but went through the usual first night in custody procedures without reporting any concerns to staff. He was not receiving any medication or other treatment, but did tell healthcare staff that he had had a heart attack three years previously.

Once settled on the wing, the man did not make any close friends and was described by staff as someone who kept himself to himself. He spoke briefly to his cell mate, telling him he had lost his family and his home and felt he had nothing to live for. The man was seen by healthcare staff on 15 May, when it was discovered he had not been eating his meals. He explained to the doctor that he had nothing to live for and was intent on starving himself to death. For this reason, he was then placed on self harm monitoring procedures. On 24 May, following a period when staff reported an improvement in his mood and condition, he was removed from this enhanced monitoring.

A few days later, the man had a meeting with his solicitor. During the meeting, he complained of pains in his chest. The solicitor put the man in the recovery position and called for staff help. A nurse from healthcare soon arrived and an ambulance was requested which took him to the hospital. The man died there early the next morning.

The clinical review shows that the man's history of coronary heart disease was identified on his arrival at HMP Birmingham and during his subsequent General Health Assessment in the Well Man Clinic. However, he was not receiving any continuing care for his condition and he had said that he did not want any member of the healthcare team to contact his GP regarding his health.

The post mortem shows that the man died from a heart attack.

THE INVESTIGATION PROCESS

1. This investigation was formally opened on 6 June 2006 when one of my investigators issued notices to staff and prisoners at HMP Birmingham. The notices invited anyone who might have information relating to the man who died to make themselves known. As a result, the man's cell mate contacted the investigator, and we were subsequently able to speak to him as part of our enquiries.
2. My investigator visited Birmingham prison on 27 June 2006. She met the Head of Safer Custody. She also met with a representative from the Prison Officers' Association (POA) and the Independent Monitoring Board (IMB) to explain how the investigation would be carried out. During this visit, she collected copies of the man's prison files, including his main prison record, his medical records and statements from prison staff, and was briefed about the circumstances surrounding his death.
3. The Heart of Birmingham Primary Care Trust identified a doctor to lead a review of the man's clinical care. I am grateful to him for producing his report in a timely manner.
4. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. Upon completion, this report will be sent to the Coroner to assist him in his enquiries into the man's death. My investigator has also spoken to the man's solicitor and to a Detective Constable at the West Midlands Police.
5. One of my Family Liaison Officers contacted the man's family to inform them of this investigation and to provide an opportunity to contribute. They did not wish to be involved and raised no concerns about the care he had received.

THE MAN

6. The man who died was born in January 1946 in Stafford. On reception at HMP Birmingham, he reported that he had been married for 30 years and had two children. However, he explained that he had separated from his wife and, as a consequence, he had been homeless for a time.
7. The man reported a history of heart problems in his family, and indeed that he had suffered a heart attack some three years earlier. However, he said he was not currently receiving any treatment.
8. He had not previously been involved with the criminal justice system until his arrest on 10 May 2006, following a failure to attend court while on bail.
9. In prison, the man who died kept himself to himself. He did not come out of his cell to work, attend education or association. At first, he had been withdrawn and did not eat his meals, telling a doctor in healthcare that he had nothing to live for, having lost his family and his home. However, he later reported that he would 'give things time to settle down', and then try to contact his wife through his solicitor.

HMP BIRMINGHAM

10. Birmingham is a local prison for adult male prisoners. It serves the Crown and Magistrates' Courts of Birmingham, Stafford and Wolverhampton and several Magistrates' Courts in the surrounding areas. The prison has recently undergone a period of considerable change as a result of a multi-million pound investment programme. Some 450 additional prisoner places have been provided, together with new workshops, educational facilities, a new healthcare centre and gymnasium, as well as extensions and improvements to existing facilities.
11. The provision of healthcare within the prison is the commissioning responsibility of the Heart of Birmingham Primary Care Trust. Primary care clinics are delivered by GPs and visiting consultants. The healthcare centre has the opportunity to draw upon the broader expertise and range of healthcare services at the local City Hospital. The primary healthcare team comprises doctors, nurses and healthcare assistants. There is an in-patient facility, which is staffed by registered mental health nurses and a healthcare assistant during the day, and a trained nurse and a healthcare assistant at night. They provide care for patients with primary mental health needs and those with primary physical health needs, requiring 24 hour nursing care.
12. The prison was last inspected by HM Chief Inspector of Prisons in May 2004. Her unannounced inspection found that Birmingham had improved in all four key areas that the Inspectorate assesses: safety, respect, purposeful activity and resettlement. However, some areas for development were identified, particularly the relationships between staff working in different parts of the prison. For example, work between healthcare and wing staff needed to become more joined up.
13. The man's death is the tenth death (the seventh from apparently natural causes) to have occurred at Birmingham since April 2004 when my office became responsible for the investigations. I have identified no common themes between this investigation and the other nine.

KEY FINDINGS

14. The man who died was remanded to Birmingham prison on 10 May 2006, having failed to surrender to bail. He arrived at the prison at 5.12 pm. On his Personal Escort Record (PER), the medical box is highlighted - indicating that this was an area of concern. Staff noted that he had had a heart attack three years previously. It is also recorded on this form that the man had refused his lunch. A Cell Sharing Risk Assessment was carried out on reception. This concluded that he was not a risk to himself or to others and was suitable for shared accommodation.
15. His First Reception Health Screen remarks that the man had been registered with a doctor in the community, but had not visited him in the months before he came into Birmingham prison. He told staff that he had been homeless for a few months, and confirmed that he did not have any outstanding hospital or GP appointments, was not receiving any prescription medication, and had no history of recent physical injury. The man said that he had not been in prison before. As there were no health problems, he was admitted directly to D wing.
16. On 11 May, he was seen by a nurse who carried out a more general health assessment. At this point, the man said he did not want his medical information to be shared with anyone, and declined consent to contact with his own GP for his past medical history. However, he again reported that he had a heart attack about three years earlier. When asked about his current situation, he said he did not have any concerns about his health at present.
17. The man was seen by a doctor on 15 May, following the discovery that he had not been eating his meals. The doctor recorded that there was no history of psychiatric ill health, and the man appeared neat, engaged well and was pleasant. At this consultation, he told the doctor that he had no reason to live any more. He said he had lost his wife, family and home, and was committed to starving himself to death. The doctor recorded that he discussed this with the man, who was fully aware of the implications of his actions and who said he was not happy with the idea of medical intervention if he became physically unwell. The doctor recommended that the man be placed on the self harm monitoring procedures (Assessment, Care in Custody & Teamwork – ACCT), on a constant watch.
18. The ACCT observations started immediately. A senior officer met with the man and conducted a thorough interview with him. At the end of the interview, the senior officer and the man agreed a plan of his care.
19. Several further reviews of the man's position were conducted. These were well documented and show that he was able to speak to staff about his concerns and to obtain practical help with some of the issues that were troubling him. The ACCT observation entries were also thorough and indicate a high level of staff interaction.
20. The next day (16 May), the man was again seen by the same doctor. He said that he had changed his mind about starving himself to death, and said he

would not contemplate suicide as he was not a violent man and believed suicide to be a violent act. He also reported that he intended to let things settle down, and perhaps approach his wife, through his solicitor, in a few months' time. Although this seemed positive, the doctor noted that staff needed to be cautious of the reasons for such a sudden change in the man's resolve and the constant observations were to continue. He also suggested some psychiatric input if the man was willing to consider this. On 24 May, following a period of observation during which time the man's mood and condition seemed improved, the ACCT document was closed.

21. Another prisoner shared a cell with the man for a few weeks. He told my investigator that the man did not leave his cell for anything except to collect his meals. He said he did not seem to bother with anything - he did not go to work or education and he did not seem to be interested in life. The man who died had told him that he had nothing to live for now; his cell mate said that he seemed totally "shut down". He said that he knew that the man had previously not eaten for five days. However, he said that he was eating when they shared a cell - albeit very little. On the morning of his legal visit, the man's cell mate said that the man seemed his normal self, but felt he would have been worried. When he spoke to the investigator, the cell mate said he was in the same position as the man who died. He had spoken to him about that and urged him to think positively about things. However, he was not sure whether the man was able to do this.
22. The man's solicitor, visited him as previously arranged. She said when she went into the visits area she was told by one of the officers that the man was not feeling very well. As she approached him, she asked him what was the matter and he told her he had pain in his chest, and pins and needles in his arm. She said she was concerned and told the officer she thought the man might be having a heart attack, and asked that a doctor should be called. Staff told her that the doctor would not be in the prison until 9.00 am, but a member of healthcare had been contacted and was on the way. She then returned to the man, who was seated in a chair holding his chest. She suggested he might be more comfortable lying down, and she helped him get into the recovery position.
23. A senior officer was in charge of visits that morning. He said that at about 8:00 am he was told by an officer that the man was having chest pains, and that his solicitor was with him and had put him into the recovery position. The senior officer said he called for medical assistance and informed the duty governor over the radio about what was happening. The control room log times the call at 8.20 am. The senior officer said he then helped to get the man comfortable and, sensing the urgency of the situation, contacted the duty governor again to say that he was calling an ambulance. He said the response nurse soon arrived, as did the duty governor, and they took over the situation.
24. The nurse who was the emergency response nurse that morning had been called to attend 'Legal Visits' immediately. When she arrived, she found the man who died lying on his right side. He told her he had a left sided chest

pain and a numb left arm. She also noted he was of a poor colour. She gave him oxygen and sprayed glyceryl trinitrate (GTN), a treatment that relieves the symptoms of angina, under his tongue. After checking he was not allergic, she also gave him 300mg of aspirin. The nurse explained that the man said he had suffered a heart attack five years previously. She said that, whilst he was still experiencing pain, he told her that it was not getting any worse. She also requested a blue light ambulance. Records show that the ambulance was called at 8:25am, arrived at 8:35am, and departed the prison at 8:58am.

25. At about 11.30 am, the nurse spoke to the staff nurse at the local hospital and was advised that the man was being assessed by medical staff.
26. Staff who accompanied the man to the hospital contacted the control room at 9:45pm that evening. They reported that there was no improvement in his condition and he remained on life support. At 12:50am, they contacted the control room again, informing them that the man's kidneys had failed. At 4:00am, a senior officer contacted control again to say that the man had died.
27. At 4:01am, the control room log shows that the contingency plans for a death in custody were activated and followed appropriately. The relevant people were contacted and informed and the staff involved were debriefed and supported.
28. Following the man's death, the police informed his family. The Governor visited the family on the same day. He provided contact numbers for himself, other governors at the prison, and the chaplain. He also explained the procedures that would now take place, including this investigation. On 14 June, the Governor visited the family again to return his belongings and personal effects.

ISSUES

The man's medical care

29. The clinical reviewer makes detailed observations on the man's medical care and I endorse the recommendations arising from his report.
30. It is evident that in the short time the man was at Birmingham he was, in the main, appropriately cared for. However, his history of a previous heart attack and strong history of family heart problems should have triggered a routine referral to a doctor after his initial General Health Assessment.

Where new receptions are identified as having any long-term ill health at their initial health screen or general health assessment, arrangements should be made for the prisoner to be seen by a member of the GP team at the next available appointment. A policy for the clinical management of such prisoners should be developed in agreement with the Prison Clinical Governance Committee.

31. I note that the man did not give consent for his GP in the community to be contacted. Nonetheless, I agree with the clinical reviewer and believe there should be consideration for some system whereby a prisoner's previous medical history can be made available to prison medical staff. As the man who died was not apparently receiving any treatment for heart disease, and said he was not on prescribed medication, it seems that healthcare staff felt there was no need for any further action.

Where a prisoner is identified on reception or in the Well Man Clinic as having a long-term illness, but is not receiving any care or treatment for that illness, the prisoner's registered GP should be contacted and care needs discussed, subject to prisoner consent. The consent procedure should be reviewed and amended as appropriate to ensure that this functions effectively.

32. The man had a condition that could have become acute at any time. I am satisfied that, when he experienced pain just before he died, staff were alerted, a member of healthcare was quickly summoned, and an ambulance was called soon afterwards. It is unlikely that assistance could have come any quicker had the man not been in prison. Indeed, it could well have taken longer.

RECOMMENDATIONS

1. Where new receptions are identified as having any long-term ill health at their initial health screen or general health assessment, arrangements should be made for the prisoner to be seen by a member of the GP team at the next available appointment. A policy for the clinical management of such prisoners should be developed in agreement with the Prison Clinical Governance Committee.
2. Where a prisoner is identified on reception or in the Well Man Clinic as having a long-term illness, but is not receiving any care or treatment for that illness, the prisoner's registered GP should be contacted and care needs discussed, subject to prisoner consent. The consent procedure should be reviewed and amended as appropriate to ensure that this functions effectively.

