Investigation into the circumstances surrounding the death of a man, at hospital in June 2010, whilst in the custody of HMP Birmingham

Report by the Prisons and Probation Ombudsman for England and Wales

February 2011

This is the report of the investigation into the circumstances surrounding the death of a man who died on 17 June 2010, at hospital. He was in the custody of HMP Birmingham when he passed away. He was 58 years old.

The loss of any family member can be distressing, but especially when they are in custody. I offer my sincere condolences to the man's family and friends. I apologise for the delay issuing my report and any additional distress this may have caused.

The man arrived at Birmingham on 27 May after being sentenced to serve eight weeks in prison. He had a history of ischaemic heart disease with four previous heart attacks. Shortly after 11.00am on 17 June, he was found unconscious in his cell by his cellmate. He received immediate resuscitation by the duty nurse, and a defibrillator was used, with staff giving him four shocks. The paramedics arrived promptly and took him to hospital where the resuscitation attempts continued. However, a doctor pronounced him dead shortly after arrival, at 12.30pm. The post mortem later confirmed that the primary cause of death was an acute left heart failure and coronary artery atheroma (blocked arteries).

The investigation was conducted by one of my investigators. I would like to thank the Governor of Birmingham and the Safer Custody Manager who acted as liaison for their assistance during the investigation. I commissioned a clinical review of the man's healthcare. I would like to thank the clinical reviewer, who was appointed by the local Primary Care Trust to undertake the review. He has concluded that, overall, the treatment provided to the man was appropriate.

I make four recommendations in this report. They concern reception procedures, accurate information recording, prescription and administration policy and monitoring, and staff responsibilities.

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

Jane Webb
Acting Prisons and Probation Ombudsman **February 2011**

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SUMMARY

The man was a 58 year old man who suffered from ischaemic heart disease, essential hypertension (high blood pressure), alcoholism and depression. He had survived four heart attacks but continued to smoke. He also had mobility problems, having recently undergone hip surgery, and he walked with the aid of sticks. He was awaiting surgery for a hernia and took several different medications.

On arrival at Birmingham on 27 May 2010, after receiving an eight week custodial sentence, the man was given a health assessment. His medical history and physical disability was noted and he was prescribed appropriate medication. As he was on warfarin treatment, he had regular tests and the doses were adjusted in order to stop blood clotting. The subsequent test results were not consistently stable.

One morning, on 17 June, the man was found unconscious in his cell by his cellmate. He received immediate resuscitation by the duty nurse, including the use of a defibrillator. Paramedics arrived promptly and took him to the nearby hospital where resuscitation continued. However, he was pronounced dead shortly after arrival.

I make four recommendations as a result of this investigation. These concern reception procedure, accurate information recording, prescription and administration policy and monitoring.

THE INVESTIGATION PROCESS

1. My office was notified of the man's death in June 2010. Notices announcing the investigation were supplied by my investigator and displayed by the prison to staff and prisoners, who were invited to contribute any relevant information. No prisoners or staff made contact.

2. All the relevant prison records relating to the man were studied by my investigator. They included his main prison record, medical records and statements made by staff. One of my family liaison officers contacted the man's sister. The family wanted to know whether he received the correct medication while he was in prison. I hope that my report addresses this issue. His sister also provided some further information about her brother, and gave positive feedback about the contact between her and the prison liaison officer after her brother's death. I am grateful for her contribution to the investigation.

3. A clinical review of the man's healthcare was undertaken by a clinical reviewer, on behalf of the local Primary Care Trust. He made himself readily available to answer any queries during the investigation, and his assistance was much appreciated.

4. Her Majesty's Coroner was contacted by my investigator to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. Upon completion, a copy of this report will be sent to the Coroner to assist his enquiries into the man's death.

5. My investigator visited Birmingham on 22 July, to familiarise himself with the general environment where the man suffered heart failure. He also visited the wing and cell where he was found collapsed and spoke with members of staff, including the liaison officer.

6. On 29 September, my investigator returned to Birmingham where, together with the clinical reviewer, he interviewed a doctor. The interview was recorded and a transcript was made, which is attached as an annex to this report.

7. After the publication of the draft report, I received comments from both the man's family and NOMS. His sister asked why he was taken from court to prison when he was so unwell. My investigator and family liaison officer have provided some more information about his previous convictions which have helped to explain why he was sent to prison on this occasion. His sister also said she was concerned that his prison records had not moved with him, that the reception process was poor and that there had been problems surrounding the administration of warfarin. However, she believed that staff had done all they could following his heart attack and she was pleased that he had a supportive cellmate.

8. NOMS pointed out that there were some inconsistencies surrounding the number of recommendations in the draft report. I thank them for pointing this out, and have clarified both the forward and summary as a result. I have also received a

response to the recommendations and have attached this in the relevant section at the end of this report.

HMP BIRMINGHAM

9. HMP Birmingham is a large Victorian prison built in 1849, which serves the Birmingham court circuit. It holds adult male offenders and includes both remand and convicted prisoners. In 2002 it was extended to provide 450 additional prisoner places, with a new healthcare centre, workshops, education facilities and gym. It has an operational capacity of 1,450.

10. Healthcare at Birmingham is provided by the local Primary Care Trust. Key services include general health assessment, dental, GP and therapy services, chronic disease management, general and specialist nursing service. Each wing has a dedicated healthcare room and a treatment hatch where supervised medication is distributed twice a day. All healthcare staff have annual resuscitation and defibrillation training.

11. There are portable automated defibrillators located throughout the prison, ready for emergency use on each wing. The machines analyse the heart rhythm and diagnose the shockable rhythms. Defibrillation consists of delivering a dose of electrical energy to the affected heart with the defibrillator. This halts abnormal electrical activity in the heart and can allow a normal rhythm to be re-established.

Previous deaths at Birmingham

12. There have been 34 deaths at the prison since April 2004, when the Ombudsman became responsible for their investigation. Nineteen deaths have occurred through natural causes, three of which have also been as a result of heart attacks. However, the circumstances of the previous investigations are not similar to those in this case. I have previously made a recommendation about issuing medication, and I make a similar recommendation in this report.

Her Majesty's Inspectorate of Prisons

13. The then Chief Inspector of Prisons conducted a full, unannounced inspection of Birmingham between 2 and 11 December 2009. The report of the inspection includes the following comments:

    > "Health services were generally well managed, with a recent new contract. … Health facilities and the screening process in reception were good …. Prisoners had reasonable access to the GP and waiting lists were satisfactory. Facilities for administering medicines were adequate."

Independent Monitoring Board (IMB)

14. Each prison is monitored by an Independent Monitoring Board, members of which are drawn from the local community. They have full access to prisoners and every aspect of the establishment. Each IMB produces an annual report which is sent to the Secretary of State for Justice, in which they highlight areas of concern and strength within the prison. In their latest published report, covering the period from 1 July 2007 to 30 June 2008, the IMB made a number of

comments about provision for disabled prisoners. They also made the following comment about staff-prisoner relationships:

> “The Board remains impressed with the team responsible for Safer Custody, and indeed with the caring approach of most of the staff in the prison.”

KEY EVENTS

15. The man was born in Staffordshire in 1952. He was 58 year old and had multiple illnesses. A heavy drinker for most of his life, his drinking increased after several bereavements and the breakdown of his relationship. He suffered from ischaemic heart disease, essential hypertension (high blood pressure), alcoholism and depression. He had also survived four previous heart attacks.

16. On 27 May 2010, the man was sentenced to eight weeks imprisonment at a magistrates' court and sent to Birmingham. He had served several previous prison sentences. After recently suffering a fractured left hip, he walked with the aid of walking sticks. During his induction he told staff that he was an alcoholic, was suffering from withdrawal and thought he would benefit from a detoxification programme. He said that he was expecting to receive medical treatment and had never harmed himself. He was a smoker and was issued with a smoker's pack (given to prisoners who smoke until they are able to obtain their own supply of cigarettes or tobacco). He was described as cheerful, polite and co-operative.

17. Later the same day, the man was seen by Nurse A in reception. He told her about his medical history of heart failure, hypertension and heart disease. He stated that he had blacked out a few days earlier and had suffered a cut over his right eye. He was not concerned about his physical health. She noted that he was under the care of a surgeon at hospital for a hernia, that he was a very heavy drinker and smoked five ounces of tobacco a week. The nurse recommended that he must be accommodated on the ground floor and have a bottom bunk due to his mobility problems. A medical psychiatric report was not required as he had not received treatment from a psychiatrist, had never stayed in a psychiatric hospital and did not have a psychiatric nurse in the community. As he was taking different forms of medication each day for his heart, stroke prevention and other ailments, the nurse referred him to a doctor to prescribe medication.

18. Nurse A also booked the man in for an International Normalised Ratio test (INR) as he was taking warfarin (to prevent clotting in the blood). The INR test result is given as a number, and describes how quickly the blood clots. A result of 1.0, up to 1.5, is normal. An INR which is lower than 1.0 means that the blood is "not thin enough" or clots too easily. An INR which is higher than the desired range means the blood is "too thin" and does not clot easily. People having warfarin treatment will have different target INR ranges to aim for, depending on the reason for their treatment. His target was a range of 2.0 to 3.0. Warfarin doses are adjusted, initially every few days, aiming for the desired target range of INR. Changes in the warfarin dose take several days to affect the INR result.

19. That evening, the Prison Doctor A prescribed the following medication:

    - warfarin sodium tablets 3x3milligrams (mg) and 3x5mg, one a day of each (8mg)

- paracetamol tablets (a painkiller), 16x500mg, two to be taken four times daily
- furosemide tablets (to ease fluid retention), 28x40mg, once a day
- spironolactone tablets (which, when combined with furosemide, makes a more effective diuretic), 28x25mg, once a day
- simvastatin tablets (to treat high cholesterol in blood), 28x40mg, one every night
- citalopram hydrobromide tablets (an anti-depressant), 28x20mg, once a day
- digoxin tablets (to slow down a rapid and irregular heartbeat), 28x125micrograms, once a day
- bisoprolol fumarate tablets (to slow the heartbeat and protect the heart following heart attack), 28x1.25mg, once a day
- ramipril capsules (for high blood pressure), 28x2.5mg, one every morning and two every night
- vitamin B Compound Strong tablets (for addiction to alcohol, helps to absorb and replace vitamins) x28, once a day
- thiamine hydrochloride tablets (to help against alcohol dependency), 28x100mg, once a day
- diazepam syrup (for immediate detoxification and to prevent a withdrawal seizure), 2mg/5ml, 10mg twice a day.

20. The next morning, 28 May, Prison Doctor B saw the man about his alcoholism. He told the doctor that he drank up to one litre of whisky each day, and last had alcohol two days ago. The doctor noted his history of heart problems, and that he had undergone an operation to pin a fractured hip six weeks previously. He also noted that the man was suffering a large right inguinal hernia (a weakness, tear, gap or opening in the muscle wall of the lower abdomen or groin), which was reducible and not tender. He had psoriatic plaques (psoriasis is a skin disorder) on his elbow. On examination, the doctor noted that the man was tired, looked older than his age, was calm, his speech was normal and coherent and he was alert. There was no sweating or facial flush and he was not pale or jaundiced. His blood pressure was 118/77 (which is within the normal range) and his pulse 95 (again within the normal range for an adult). The doctor then asked for the hospital appointment (to address the hernia) to be checked and commented that the man should continue on alcohol detoxification. He also prescribed 400 micrograms of glyceryl trinitrate spray (to give rapid relief from the pain of an angina attack), to be used when required.

21. The man was then seen by Nurse B. She noted that he had previously suffered four heart attacks and a broken left hip, and had not received a total hip replacement as his heart could not have coped with the operation. He was awaiting the results of a bone scan from a few weeks previously. He told her that he had lost five stones in weight in the last six months, had night sweats, had a cough for more than three weeks and was regularly coughing up sputum. There was a family history of heart disease. His sister had suffered a heart attack, his father died from a heart attack and his brother had coronary artery bypass grafting (surgery that improves blood flow to the heart). The nurse noted he had no history of mental health problems, and she told him about access to services

and referred him to the Disability Officer. After taking his clinical observations and finding that he had low blood pressure (82/57), she referred him to a doctor.

22. The same morning, Prison Doctor C, noted the man's INR test was 1.5 (below the desired range). He then prescribed warfarin sodium tablets, 10x5mg,10mg, to be taken once a day under supervision. (Some medications can be kept in possession by prisoners whilst other medication, such as warfarin, is given under the supervision of a nurse.)

23. The following afternoon, on 29 May, Nurse C was checking the previous days' medication when it became apparent that the man had been given two doses of warfarin on 28 May, totalling 18mg in 12 hours. He had been given 8mg at 10.00am and 10mg at 10.00pm, as two different drug charts had been opened. She informed Prison Doctor C, who requested that another INR test should be done. The INR was 3.9 (above range), so he decided to stop giving the man warfarin for two days and then repeat the INR test.

24. Nurse C told the man, who said he was not aware he had received two doses of warfarin. The nurse completed an incident form regarding the drug error. She also asked Nurse D to check his clinical observations. Nurse D found his blood pressure to be normal (118/64), and his pulse was 89. He complained of feeling light-headed but he appeared well, was able to communicate and was laughing and making jokes. She referred him to the night nurse to review.

25. Two days later, on 31 May, Prison Doctor D found that the man's INR was now 2.3 (within range). The doctor decided to continue treatment with a low dose of warfarin (5mg a day) for the next two days and then review his INR again.

26. On 2 June, the man's INR had fallen to 1.9 (below range) so Prison Doctor C increased the dose of warfarin to 7mg, once a day for one week. The hospital was contacted regarding his hernia appointment but, as the appointment could not be changed, it was decided that it should wait until after his release on 23 June.

27. The man was moved to L wing on 7 June, and shared a cell with another prisoner. When offered a cell move, the prisoner refused saying that they got on okay together. He helped him to manage his daily routine.

28. Prison Doctor E saw the man on 9 June. He complained of muscular pain so the doctor advised him to use Algesal cream (an anti-inflammatory rub for muscular pain), 50g, to be applied three times a day, and promethazine hydrochloride tablets (a sedative to aid sleep), 14x25mg, one at night. His INR test was 2.3 (within range) and therefore he continued taking 7mg of warfarin daily. The doctor asked for his INR to be checked again in a weeks' time.

29. A week later, on 16 June, the man's INR was down to 1.4 (below range). Prison Doctor C noted that he had not been given any warfarin for the past two days and decided that he needed to go back to taking 7mg a day.

30. On Thursday 17 June, the man and his cellmate did not go on exercise at 9.00am, when the rest of the wing did. Officer A was asked by the man if he could leave their door unlocked and open as he had diarrhoea and was concerned about the smell in the cell. Prisoners on exercise returned to the wing at around 10.15am and the Officer then locked the cell door. He thanked the Officer for leaving the cell door open.

31. A short while later (it is not clear at exactly what time), the cellmate asked Officer B if he could change his kit (meaning his prison issue clothes). The Officer unlocked the cell and the cellmate suggested to the man that he also change his kit. They then left the cell together. The cellmate changed his kit and then went to wait to use the telephone on the landing. Whilst waiting he saw the man go across the landing to their cell carrying two pairs of jeans. The Officer then walked past the cellmate to go upstairs and said to him, “Don’t go back to your cell yet, the man is on the toilet.”

32. The cellmate was talking to Officer A when he decided that he wanted a cigarette (prisoners are not allowed to smoke on landings). He went back to the cell but, before going in, he looked through the cell door flap in case the man was still using the toilet. He could not see him but could see the waste bin and a toilet roll on the floor. He looked to the side and saw him with his bare legs crooked to one side, and his head over the sink as though he was about to be sick. He went into the cell to ask him if he was okay. He saw that he was slumped on the toilet, but there was no noise. He lifted his head and shook him several times to try and wake him up. He then shouted to Officer A.

33. Officer A responded quickly and told the cellmate to leave the cell. The officer saw the man sat slumped forward on the toilet. He shouted to him who mumbled incoherently to him. The Officer then used his radio to contact the Control room and ask for healthcare staff to attend. The officer was joined in the cell by two prisoners and they helped to prop him up. (These two prisoners were out of their cells as they were working on the wing.)

34. Nurse E arrived and she noted that the man had a faint pulse and shallow, slow breathing. The nurse asked the officer and the two prisoners to move him onto a mattress on the floor and then she rechecked his breathing and pulse. She could not feel or hear air going in or out, and now could not find a pulse. She asked the officer to bring the defibrillator from M wing office and started cardiopulmonary resuscitation (CPR), by giving chest compressions while one of the prisoners gave breaths via an ambu bag (a mechanical device to aid respiration) as instructed by the nurse. She asked for an emergency ambulance and for other healthcare staff to attend.

35. An emergency ambulance was requested at 11.18am, at the same time as other nurses arrived on the scene. Officer A returned with the defibrillator which was attached to the man and, on the advice of the machine, the first electric shock was given. CPR was continued by Nurse E, a Sister and Nurse F. After the second check by the defibrillator, no shock was advised and so CPR was continued. He was shocked four times in total.

36. The paramedics arrived at 11.22am and they attached their defibrillator to the man and continued CPR. No further shocks were advised by the machine. They tried unsuccessfully to intubate him (intubation means placing a flexible tube into a windpipe to maintain an open airway). He was transferred to a stretcher by the nurses and paramedics and taken to the ambulance.

37. At 11.54am, the ambulance left the prison. The man did not have a pulse when they left. Two officers escorted him in the ambulance to hospital. No restraints were used as attempts to resuscitate him were still taking place. On the way, one of the paramedics told Officer C that the man had a pulse again. The ambulance arrived at the hospital at 11.56am. He was taken to the resuscitation room where CPR continued until 12.20pm. The hospital doctor pronounced death at 12.30pm.

38. Shortly after the man's death, the prison activated its death in custody contingency plan. The West Midlands Police, the Governor, the Independent Monitoring Board and the Ombudsman were informed. A prison family liaison officer was appointed. The police visited the prison at 2.15pm, interviewed staff and prisoners and took several statements. The police found that there were no suspicious circumstances.

39. At 2.20pm, a debriefing about the man's death took place at the prison. Support and counselling were offered by the prison to the healthcare staff, prison officers and prisoners who had either been directly involved in this incident or who had been affected in any way. A governor visited the man's cellmate to offer support. Notices to inform prisoners and staff of the man's passing were issued throughout the prison.

40. Another governor went to the man's home address that afternoon to try and trace his family. As there was no reply she spoke to a neighbour and left her mobile telephone number. At 8.30pm, the man's sister spoke to the governor, who confirmed that her brother had died. She offered to visit her that night, but the sister said she would wait until the next day.

41. Accompanied by a prison principal officer and the chaplain, the governor visited the man's sister and her partner at her home at 10.00am. They spoke to her about how her brother had died and explained the procedures regarding a death in custody. The funeral arrangements were also explained and the prison offered to organise the funeral on their behalf.

42. At 9.50am on 18 June, a post mortem examination was carried out at a mortuary by a Forensic Pathologist. No recent injuries or marks were found that could have contributed to his death. He found that the man had severe and widespread narrowing of the branches of his left coronary artery and that the extent of the disease was such that it could have caused his death at any time. There was evidence of previous heart attacks and, in addition to the heart disease, evidence of chronic bronchitis and emphysema, most likely caused by smoking. He concluded that the cause of death was acute left heart failure and coronary artery atheroma.

ISSUES

Clinical care

43. On his arrival at Birmingham, it was noted that the man had a history of ischaemic heart disease, having also had four previous heart attacks. He had recently undergone surgery for a broken hip and used two walking sticks for mobility. He was also under the care of a surgeon for a hernia.

44. When interviewed by my investigator, Prison Doctor C was asked if he was the man's registered and usual doctor whilst he was in prison. He replied that prisoners registered with him because he was the only doctor who was employed at Birmingham at that time. When asked if he knew the man very well, the doctor replied that he did not know him at all, and had not met him while he was in prison. Asked whether the man would have been dealt with differently to a long-term prisoner, the doctor said, "No, from healthcare's point of view, no, everybody gets treated the same way."

45. The clinical reviewer found that the man did not receive any formal cardiovascular medical assessments or blood tests, other than the INR tests. Upon admission, it is usual practice for prisoners with chronic diseases to be booked into a routine prison doctor's surgery. This procedure was not followed, and, although he was given medication for his ailments, it is important that plans are made to address chronic diseases as soon as possible.

    The Head of Healthcare should review reception procedures to ensure that prisoners with chronic diseases are identified and a doctor's appointment is booked.

46. During his first reception screening the nurse also noted that the man was a very heavy drinker and documented that he drank nine units of alcohol a day and smoked five ounces of tobacco each week. The following day, when he was seen by Prison Doctor B regarding his alcoholism, the doctor used free text to note that he drank up to one litre of whisky each day, or 40 units.

47. My investigator was told that the current computer electronic medical records system, which is known as EMIS, does not allow an exact alcohol entry beyond nine units a day. This did not necessarily impact on the care delivered as the man was medically assessed the next day, but there is a discrepancy in his documented daily alcohol intake. As Prison Doctor B's entry showed, this could have been added by using a free text entry.

    The Head of Healthcare should ensure that alcohol intake levels are recorded accurately on EMIS.

48. Following his reception screening on 27 May, in addition to other medication, Prison Doctor A prescribed 8mg warfarin to be taken each day. On 28 May, the man was further prescribed 10mg of warfarin a day by Prison Doctor C. At about 2.00pm on 29 May, Nurse C discovered that he had been given two doses of warfarin on 28 May, totalling 18mg. She informed the prison doctor of the

medication error and completed an incident form. He had been issued the duplicate dose as two drug charts had been compiled following his movement from one prison wing to another.

49. During the interview with Prison Doctor C, my investigator asked whether the initial drug chart should follow the prisoner when they move locations. The doctor agreed that this is what should happen, but had not done so on this occasion. He confirmed that the procedure should be changed, and also that the matter had been discussed at a clinical governance meeting and a medicines management meeting. He said:

    "… frequently we bring it up and talk about it and we try to keep on top of it by saying that always the prisoner … should have a medicine chart following them if they're on prescribed medication."

50. My investigator asked if the error with the two warfarin prescriptions had any effect on the man. He said, "I don't think it had an effect, an immediate effect, but it potentially could have had a serious effect, yes."

51. The clinical reviewer found that although the man's subsequent INR levels were not consistently stable, this may not necessarily have been a factor in his death. The issue of duplication of drug charts has been discussed at previous meetings and mistakes have reduced, but the problem persists of drug charts not following prisoners when they move wings.

    The Head of Healthcare should review the drug prescription and administration policy to ensure there is no duplicate administering of supervised medications.

52. When Prison Doctor C reviewed the man's INR level on 16 June, he found it to be 1.5 and noted that he had not had warfarin for two days. The doctor then put him back to 7mg of warfarin per day, which was the dosage prescribed on 9 June when his INR level was in normal range at 2.3.

53. In interview, the clinical reviewer asked the doctor what the procedure would be in the case of the man missing two doses of warfarin. He said that the nurse should have gone to the cell and enquired why he had not asked for it, and for what reasons. The clinical reviewer asked whether this should have been documented and the doctor said that this should have been recorded on EMIS but, on this occasion, was not.

    The Head of Healthcare should review the drug prescription policy to ensure that, when doses of medication are missed, they are followed up and that staff record why the medication was not issued.

54. Shortly after the man was found collapsed by his cellmate, a governor interviewed the cellmate. The cellmate told him that the man had been suffering with diarrhoea for the past couple of days and had not had his medication (including his warfarin) for the past two days. He said that the man had told a

member of staff at around 7.00pm on Monday 14 and Tuesday 15 June, but no medications had been received.

55. Whenever a prisoner does not receive his supervised medication the reason should be investigated and appropriate action taken. Both the prescription charts and a note on EMIS from Prison Doctor C suggest that he did not receive his warfarin. It is important that officers inform healthcare staff when prisoners have not received medication. I have been unable to establish whether the man did inform officers that he needed medication. While I do not make a recommendation, I hope that the Governor reminds discipline staff that they should tell healthcare staff when a prisoner requests medication.

56. In his clinical review, the reviewer has noted that the man received prompt attention after being discovered in his cell. The nurse responded quickly, and a defibrillator was brought to the cell and used appropriately. While on this occasion, the use of the defibrillator was in vain, I am pleased to note that one was available because they are located around the prison. He has also noted that an ambulance was called quickly, and that paramedics arrived at his cell within eight minutes.

57. During the attempt to resuscitate him, he was placed onto a mattress. CPR is, however, much more effective when performed on a hard surface. While I do not make a recommendation, the Head of Healthcare may wish to remind staff of this.

58. Overall, the clinical reviewer notes that the medical and nursing care provided to the man during his short time at Birmingham was appropriate.

CONCLUSION

59. By the time he arrived at Birmingham, the man had already survived four heart attacks. He had a medical history of essential hypertension, ischaemic heart disease and heart failure, alcoholism and depression. He had recent hip surgery, was walking with the aid of walking sticks and was awaiting surgery for a hernia. He was taking a regime of medications, but continued to smoke. No symptoms became apparent in the short period between his reception at Birmingham and his death.

60. The clinical review found that, although his INR levels were not consistently stable because of errors dispensing his warfarin, this was not a factor linked with his death. However, procedures for administering of medication need to be addressed. The clinical reviewer also concludes that during his time in Birmingham, on the whole, his medical and nursing care seems to have been appropriate.

61. On the morning of his death, he received immediate resuscitation by the duty nurse, including application of a defibrillator. The paramedics arrived promptly and took him to hospital where resuscitation continued but he was pronounced dead shortly after arrival. I am pleased that his family felt well supported by the prison's liaison officer.

RECOMMENDATIONS

1. The Head of Healthcare should review reception procedures to ensure that prisoners with chronic diseases are identified and a doctor's appointment is booked.

   Accepted - System 1 ensures chronic disease registers are generated and monitored. A GP appointment is generated on the night of reception for prisoners.

2. The Head of Healthcare should ensure that alcohol intake levels are recorded accurately on EMIS.

   Accepted - This will now be completed but will be on the System 1 database which now replaced EMIS at HMP Birmingham.

3. The Head of Healthcare should review the drug prescription and administration policy to ensure there is no duplicate administering of supervised medications.

   Accepted - Duplicated administering is more likely to occur with the current paper based system rather than an electronic system. The Governor and Head of Healthcare are currently pursuing an electronic administration system which would minimise/eradicate and duplication of occurrences.

4. The Head of Healthcare should review the drug prescription policy to ensure that, when doses of medication are missed, they are followed up and that staff record why the medication was not issued.

   Accepted – in place.