

**Investigation into the circumstances surrounding the
death of a man in March 2010 whilst in the custody of
HMP Birmingham**

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

August 2010

This report considers the circumstances of the death of a man in March 2010 whilst a prisoner at HMP Birmingham. He was 66 years old when he died. A post mortem showed that he died from heart disease.

I offer my sincere condolences to the man's family and friends for their loss. One of my Family Liaison Officers contacted his family at the start of the investigation.

The investigation was carried out by one of my colleagues. We would like to thank the Governor and his staff for their co-operation during the course of our enquiries.

I also thank the local Primary Care Trust (PCT) for appointing a clinical reviewer. As the man died from natural causes, the findings of the clinical review play an essential part in my report. The review judges that the standard of care he received whilst in custody was equitable to what he could have expected in the community.

I conclude that the man was treated appropriately by staff at Birmingham. My report includes one recommendation to the Governor, concerning the procedure for the arrival and departure of emergency ambulances at the prison.

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

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SUMMARY

On 10 March 2010, the man appeared at Crown Court and was remanded into custody for sexual offences and sent to HMP Birmingham. He told healthcare staff that he was diabetic and suffered from angina attacks. He also told the nurse that he had been admitted to a psychiatric hospital in the past but was not taking any psychiatric medication at that time.

The man said that he would refuse all his medication and did not intend to eat or drink anything as he felt he had lost the will to live. It was noted that he was prescribed medication for diabetes, heart disease, angina and arthritis. It was also noted that he was unable to walk any distance and used a wheelchair, so a flat location in the prison was needed. He was closely monitored by staff and encouraged to eat and take his medication.

By 13 March, the man had decided to take his medication and had started to eat his meals. Staff continued to monitor him to ensure that this continued. Five days later a prison doctor saw him and assessed that, due to his physical health, it was appropriate to admit him as an inpatient to healthcare as soon as possible.

A senior management meeting was held on 29 March to discuss the man's mental and physical health. Due to the reduction of available beds in healthcare, it had not been possible to admit him. The decision was taken to contact other prisons with appropriate inpatient facilities to see if they could take him. Other establishments were contacted but none could accommodate him at that time.

On 31 March, at approximately 7.00am, the man called for assistance as he complained of chest pains and shortness of breath. Nurses responded to the call for medical assistance and, after an initial assessment, requested an emergency ambulance. Paramedics arrived and took him to hospital. Later that afternoon he went into cardiac arrest and, despite the efforts of hospital staff, he died at 4.15pm.

The Governor of Birmingham visited the man's wife in person later that evening to break the news of his death. In the days that followed the prison family liaison officer maintained contact with her. I judge that Birmingham appropriately followed Prison Service Order (PSO) 2710 "Follow up to death in Custody" and offered financial assistance towards funeral expenses.

I am satisfied that the standard of care that the man received ensured that his multiple conditions were appropriately treated. However I make one recommendation concerning the procedure for dealing with the arrival and departure of emergency ambulances to and from the prison.

THE INVESTIGATION PROCESS

1. The investigation was opened on 31 March 2010 by an investigator. He issued notices that included an invitation to those who wished to submit information relating to the man's death to make themselves known. No prisoners came forward as a result. He visited Birmingham on 12 April and was given a copy of the man's prison records. He returned to Birmingham on 6 and 25 May to interview five members of staff.
2. The local PCT appointed a clinical reviewer to undertake a clinical review of the care the man received whilst at Birmingham. I am grateful to him for undertaking this timely review. The investigator discussed aspects of the man's treatment with both staff at Birmingham and with the clinical reviewer.
3. HM Coroner was notified of the investigation and provided the investigator with the results of the post mortem. The Coroner will receive a copy of my report into the man's death to assist with his inquiry.
4. One of the family liaison team contacted the man's next of kin at the beginning of the investigation. The next of kin told the family liaison officer that they did not want any involvement with the investigation nor to receive a copy of the report.

HMP BIRMINGHAM

5. HMP Birmingham is a large local prison serving the courts of Birmingham and much of the West Midlands. It holds up to 1,450 adult male prisoners, both on remand and sentenced. The prison has undergone significant improvement over the last few years, including the building of a new healthcare centre.
6. HM Chief Inspector of Prisons last conducted a full follow up announced inspection of the prison in December 2009. The Chief Inspector noted that, since the last full inspection in February 2007, “while some progress had been made, there was still a considerable amount to do to ensure a safe, decent and effective prison”. Relationships between staff and prisoners were found to be “a considerable weakness”.
7. Healthcare provision at the prison was found to be “mostly satisfactory”. It was largely delivered from a “modern, purpose-built unit” by three distinct groups of staff working in primary care, in-patient care and visiting specialists. Relationships between healthcare staff and prisoners were identified as good, particularly on the in-patient wards. All in-patients had a care plan and a named nurse and officer.
8. The healthcare unit has two inpatient wards each containing 15 large single cells. Ward one is designated for prisoners with physical illness/disability and ward two is solely for prisoners with mental health needs. During the period the man was at Birmingham there were five cells not available due to vandalism by prisoners. This therefore severely restricted the inpatient capacity.
9. All prisons are also monitored by an Independent Monitoring Board (IMB), members of which are drawn from the local community. They have full access to each prisoner and every part of the establishment. The last annual report by the Birmingham IMB covers the period July 2007 to June 2008. The Board noted that overcrowding within the entire prison system, and at Birmingham specifically, remained a concern. Healthcare provision was recognised as having gone through significant changes over the year. The Board highlighted that healthcare facilities at Birmingham were viewed as both a local and national resource and that, as a result, “more robust partnerships” were necessary. Overall, however, the Board was “impressed ... with the dedication and professionalism of the staff”.
10. The rules that govern all aspects of running a prison are set out in a series of documents called Prison Service Orders, (or PSOs). PSO 2700 – ‘Suicide prevention and self-harm management’ details prison procedures for looking after prisoners at risk of suicide or self harm. Assessment, Care in Custody and Teamwork (ACCT) is the system used by prisons to identify, monitor and support prisoners at risk of self harm. The ACCT process is used in all prisons in England and Wales. Any member of staff can start the ACCT process, by raising a ‘Concern and Keep Safe form’, explaining the reasons for their concern. An ‘Immediate Action Plan’ is written by the manager of the wing

where the prisoner is located and within 24 hours an ACCT assessment is carried out by a member of staff who has the required training.

11. After the ACCT assessment has taken place, a multi-disciplinary ACCT case review is held to determine what measures can be taken to monitor and support the prisoner effectively. The prisoner attends the case review and is encouraged to contribute to the decisions being made. An ACCT CAREMAP is drawn up with details of each of the actions required to keep the prisoner safe and identifies who is responsible for carrying out each action. Case reviews are held at regular intervals, usually monthly, to review the actions and the prisoner's level of risk.
12. The man's death is the fourth death to occur at Birmingham since January 2010. The other three deaths were self inflicted and there are no similarities with this death.

KEY FINDINGS

13. The man was born in October 1943 and lived in the Lichfield area. He was married and had one son and one daughter. He had a history of illness that included angina, heart disease, diabetes, obesity and he had suffered from mental illness. He was 66 years old when he died.
14. On 10 March 2010, the man appeared at Crown Court and was remanded into custody for sexual offences and sent to HMP Birmingham. On arrival the reception nurse conducted a health screen assessment with him. A first reception health screen takes place every time a prisoner arrives at a prison. It determines any immediate physical and mental health conditions that require treatment, substance misuse matters that need to be addressed, and any risk that the prisoner may pose of harming himself or attempting suicide. He told the nurse that he was diabetic and suffered from angina attacks. He also told the nurse that he had been admitted to psychiatric hospital in the past but was not taking any psychiatric medication at that time.
15. The reception nurse recorded in the medical records that the man was registered with a general practice in Lichfield. The nurse also recorded his medication as metformin (for diabetes), glicazide (for diabetes), duloxetine (for diabetes), isosorbide (for heart disease), atorvastatin (for high cholesterol), frusemide (for congestive heart failure), ramipril (for high blood pressure and congestive heart failure), bisoprolol (for cardiovascular disease), amlodipine (for angina), glyceryl trinitrate (GTN) Spray (for angina), prednisolone (for arthritis), omeprazole (for gastric conditions), peptic acid (for stomach ulcers), co-codamol (for mild to severe pain) and aspirin.
16. The nurse further recorded in the medical records that the man said that he would refuse all medication and did not intend to eat or drink anything as he felt he had lost the will to live. An ACCT document was opened and noted that his intention was to harm himself by refusing food and medication. The nurse also noted that he was unable to walk any distance and used a wheelchair, so a flat location in the prison was needed.
17. The next day a review of the ACCT was undertaken involving a Senior Officer (SO), the prison chaplain and the man. The man said that he had no intention of harming himself or attempting to commit suicide, he simply refused all medication and food. The consequences of this decision were explained to him, but he was still adamant that he would not eat or take any medication. Consequently it was decided to check on him twice an hour during the day and once an hour at night.
18. That same day a nurse saw the man and recorded that his weight was 145kg, he had a pulse of 119 and blood pressure of 185/102, which was high. (The normal range for blood pressure is 100/70 to 140/90, although this does vary throughout the day depending on the individual's activities. A blood pressure reading of greater than 140/90 is classed as high and a reading of 90/60 or below is classed as low.). The nurse entered in the medical records that his

high blood pressure was discussed with a prison doctor but there was nothing healthcare staff could do if he refused to take his medication.

19. The following day a second nurse saw the man and recorded his blood pressure as 150/98 with a pulse of 88. The nurse noted that he still refused to take his medication, food and drink. He told the nurse that his urine was very concentrated. The nurse explained to him that this was because he was not drinking and advised him to drink water. The nurse told him that she would make an appointment for him to see the doctor.
20. On 13 March, a further review of the ACCT took place conducted by a second SO with the man in the presence of an officer. It was recorded that he had decided to take his medication and had started to eat his meals. The assessment was that the level of observation would continue to ensure he did take his medication and meals.
21. A third nurse responded to an emergency call to attend to the man on 17 March. He told the nurse that he had experienced chest pain in his left side and some numbness in his left arm. He said that he had used his GTN spray just before the nurse arrived and the pain had eased. The nurse recorded his blood pressure as 130/99 with a pulse of 99. The nurse advised him to inform staff immediately if these symptoms reoccurred or worsened. He told the nurse he would use his medication from now on.
22. The next day the man saw the prison doctor, who noted that he was very low in mood. He told the doctor that he had not experienced any more symptoms from the day before and said that he was going to take all his medication from now on. The doctor assessed that, due to his physical health, it was appropriate to admit him as an inpatient on ward one as soon as possible.
23. Later that morning a third SO reviewed the ACCT with the man in the presence of a second officer. It was noted that he had continued to take his meals and medication and said that he would continue to do so. He said that he wanted to die naturally and quietly and had no more thoughts of harming himself. The SO recorded that the level of observations could be reduced to conversations (regular verbal contact) only but this would be subject to review.
24. That same afternoon a fourth nurse, a member of the mental health team, saw the man. He told the nurse that he had been admitted to a psychiatric hospital in 1995 and had a history of depression. The nurse noted that he was due to attend court the next day but did not wish to go. The nurse was in agreement with the prison doctor regarding his planned admission to healthcare and said that he would be monitored by the mental health team.
25. On 19 March, the man appeared at Crown Court, was further remanded into custody and returned to Birmingham.
26. Two days later a fifth nurse saw the man and recorded that his blood pressure was 132/87 with a pulse of 92. He told the nurse that he felt dizzy and had vomited. He had been unable to digest any food or drink. The nurse noted

that he was anxious about appearing in court the next day. The nurse advised him to have regular sips of water and if his symptoms persisted, to tell staff immediately. The nurse also made a referral for him to see the doctor.

27. On 22 March, the man appeared at Crown Court and was again remanded into custody and returned to the prison.
28. Three days later he failed to attend the appointment with the doctor which was arranged by the fifth nurse. There is no entry made in the medical records as to the reason for this or that any follow up action had been taken.
29. The fourth nurse conducted a review with the man on 29 March. The nurse noted that he was lethargic and not interested in his surroundings. He said that "I would be happy if I had not woken up this morning". The nurse also participated in the ACCT review conducted by the third SO. It was agreed that, due to his low mood, it was appropriate to continue to monitor him with no change to the level of observation.
30. Later the same day there was another senior management meeting held to discuss the man's mental and physical health. A sixth nurse recorded in the medical record that his health had deteriorated and that due to the severe reduction of available beds in healthcare, just prior to his arrival at Birmingham, there had been no admission to ward one as planned. This was the first discussion concerning his care following the prison doctor's recommendation to admit him to healthcare. Other prisons with appropriate inpatient facilities were contacted to see if they were able to accommodate him. The sixth nurse contacted HMP Hewell, HMP Dovegate and HMP Liverpool but none of these establishments could accommodate him at that time. However the nurse noted that Hewell might be in a position to take him in the next few days.

Events of 31 March

31. At approximately 6.50am an officer responded to the man's call for assistance as he complained of being short of breath and had chest pains. A nurse also responded to the call and, after initial assessment, the use of oxygen and GTN spray, decided that an emergency ambulance was required. The call for the ambulance was made at 7.10am and the paramedics arrived at 7.30am.
32. The paramedics agreed with the nurse's assessment that he needed to be admitted to hospital. A risk assessment was completed authorising an escort of two officers and the use of a restraints which were to be removed for treatment purposes. The second SO said at interview that she had obtained clearance for the ambulance to leave the prison and it was ready to leave at approximately 8.15am.
33. A Principal Officer (PO) superseded that decision and did not allow the ambulance leave the prison until movement of prisoners for work and education had taken place. At interview the PO said that, from his recollection, there was no urgency for the ambulance to leave the establishment.

34. The paramedic confirmed to the investigator that the ambulance was ready to leave the prison at 8.15am but he was told that it had to wait until all the prisoner movements had taken place. The ambulance eventually left the prison at 9.00am.
35. The man was taken the short distance to the hospital where, following initial assessment in the emergency department, he was admitted for further tests and treatment. At 3.50pm his health rapidly deteriorated and he went into cardiac arrest. Despite the best efforts of the hospital staff, the hospital doctor pronounced him dead at 4.15pm.
36. Due to the time of the man's death the Governor spoke individually to the staff involved in the emergency response and the escorting officers to debrief them and made the services of the Care Team available. Prisoners were informed of his death and support was made available through the chaplaincy.
37. The Governor visited the man's wife in person later that evening to break the news of her husband's death. In the days that followed, the prison family liaison officer maintained contact with her. Birmingham appropriately followed Prison Service Order (PSO) 2710 "Follow up to death in Custody" by offering financial assistance towards funeral expenses.

ISSUES

Clinical care

38. The man entered custody on remand with several existing health problems. He took the initial decision to exercise his right to refuse to take his medication, meals and fluid. As a result he was appropriately monitored by prison and healthcare staff who used the ACCT process. During his short time at Birmingham staff successfully encouraged him to take his medication and meals.

39. The clinical review makes the following comments concerning the man's clinical care:

“He suffered with arthritis, diabetes and ischaemic heart disease on a background of refusing his medications.

“His nursing and medical care of his multiple health problems was managed adequately and he was referred appropriately to the primary mental health service.

“Admission as an inpatient earlier may have improved his medical and nursing care but may not necessarily have altered or prevented his death.”

Emergency ambulance

40. Evidence from the prison gate log for 31 March showed that the emergency ambulance arrived at 7.30am and departed for the hospital at 9.00am. The clinical review specifically comments on the delay in the ambulance leaving the prison as follows:

“Following paramedic confirmation of intention to move the man to hospital, he was transferred on to ambulance ready for departure at 8.15am.

“... there appeared to be a delay at the prison in transferring him to A&E. However, he died some six to eight hours after being admitted to hospital, so this delay may not necessarily have altered or affected his death.”

41. Once the clinical decision had been made to admit the man to hospital there should have been nothing that prevented the ambulance from leaving once the paramedics were ready to depart. I find it unacceptable that the ambulance had to wait some 45 minutes before it was allowed to leave the prison. Even though the delay did not impact on him, it meant that a valuable health service resource and professional paramedic team were not available to respond to other emergency calls in the community.

The Governor should review the operational procedure for dealing with the arrival and departure of emergency ambulances to prevent unnecessary delays.

CONCLUSION

42. I judge that attention was paid to the man's health needs and appropriate treatment was provided in the short time that he was in custody. The standard of care that he received from whilst at Birmingham ensured that his multiple conditions were adequately managed. His care might have been further improved by admission to healthcare or an earlier attempt to obtain a transfer to an establishment with healthcare facilities. However I am satisfied that this did not contribute to his death. I also recognise that although he exercised his right to refuse both medication and food, it is pleasing to note that staff successfully encouraged him to change his mind.
43. I am, however, concerned about the delay in the departure of the ambulance from the prison to the hospital. I concur with the clinical reviewer that the delay may not have affected the outcome nevertheless it is not acceptable.
44. I believe that the man was treated with dignity and respect during the time he was at Birmingham. Following his death Birmingham appropriately followed the guidance given in PSO 2710, "Follow up to death in custody".

RECOMMENDATIONS

1. The Governor should review the operational procedure for dealing with the arrival and departure of emergency ambulances to prevent unnecessary delays.