

**Investigation into the circumstances surrounding the
death of a prisoner at HMP Birmingham
in February 2007**

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

August 2007

This is a report into the circumstances surrounding the death of a prisoner at HMP Birmingham in February 2007. He was 46 years old when he died, apparently from natural causes.

The man had been received into HMP Birmingham on 16 October 2006 after being remanded into custody by Wolverhampton Crown Court. He was seen by a member of healthcare staff shortly after arriving at the prison, and it was noted he was suffering from a migraine and had broken his ankle three months previously. The following day, he underwent a full health assessment which did not identify any health problems. Thereafter his contact with healthcare staff was limited.

In the early afternoon of 1 February 2007, the chaplain was told that the man's mother had died. But before the man could himself be told, he complained that he was feeling poorly. A nurse was called to assess him and she arrived with a colleague within minutes. The man spoke of pains in his chest and described a burning sensation in his throat. The nurses could not find the origin of the pain and the man admitted that he had previously suffered similar problems after eating curry or chips. He said he had eaten chips for lunch. A precautionary appointment was made with the prison doctor later in the day.

Shortly afterwards, whilst on his way to the healthcare centre, the man collapsed on B Wing. Nursing staff attended quickly and an ambulance was called. Sadly, despite concerted efforts by prison staff and paramedics, it was not possible to revive him. He was taken to hospital and pronounced dead at 3.23pm.

The death of a loved one is always distressing, and the man's family suffered two bereavements on the same day. I would like to add my sincere condolences to those already expressed by one of my Family Liaison Officers.

This investigation has been undertaken by a member of my team. I would like to thank the Governor of Birmingham and his staff for their co-operation and active participation. Special thanks go to one of the senior managers for making the arrangements for my investigator's visit.

The Head of Healthcare at HMP Birmingham conducted a review of the care the man received whilst in prison and I thank her for her contribution to the investigation. Her clinical review makes two recommendations which I endorse, although I should add that I do not believe either could have prevented the man's death. I make one recommendation of my own regarding the commendable efforts by staff to revive the man after he collapsed.

I intend no criticism whatsoever of the clinical reviewer, nor of the PCT whose practice is in line with that applied following other serious incidents. However, I should say that I personally believe that clinical reviews should not be commissioned from those directly responsible for the delivery of healthcare in the prison concerned. I draw this to the attention of those in the Department of Health responsible for prison healthcare.

Stephen Shaw CBE
Prisons and Probation Ombudsman

August 2007

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SUMMARY

On 16 September 2005, the man who is the subject of this report was released from prison on licence. He was supervised by the probation service and accommodated at an approved premises (a hostel). His period of supervision was due to end on 27 July 2006. However, in June 2006 he committed two burglaries. On 16 October, he appeared at Wolverhampton Crown Court and was remanded into the custody of HMP Birmingham.

Upon arrival, the man was subject to a basic health screening when it was noted that he suffered from allergies and had broken an ankle earlier in the year. He complained of a migraine and was referred to the doctor who saw him the next day and prescribed paracetamol. He was also seen by a nurse who noted that he was allergic to penicillin. No other health problems were identified and he did not come to the attention of healthcare staff again until the day he died.

On 30 January 2007, the man appeared at Wolverhampton Crown Court and was sentenced to a total of four years' imprisonment. After the court hearing he returned to Birmingham to start his sentence.

During the morning of 1 February, the man provided a sample to the Voluntary Drug Testing team which subsequently tested negative for illicit drugs. At lunchtime he returned to his cell where he ate a meal which included chips. At 12.30pm, the man's sister telephoned the prison chaplaincy to tell them that the man's mother had died earlier that day. The chaplain assured her that he would pass on the sad news after lunch.

When the chaplain went to the wing around 1.25pm, he found the man in his cell suffering from chest pains. He told wing staff who promptly summoned healthcare assistance. Two nurses arrived and examined him. He mentioned that he had suffered similar pains previously after eating curry and fish and chips, and reported that he had eaten chips for lunch. The nurses examined him and found that he was experiencing raised blood pressure. They arranged for him to be added to the doctor's list for that afternoon.

Whilst being escorted to his doctor's appointment, the man collapsed on B Wing. Wing staff called for immediate healthcare assistance and a nurse arrived within minutes. She requested an ambulance and a call was promptly made to the emergency services. The nurse was quickly joined by healthcare colleagues who started cardio pulmonary resuscitation (CPR). A defibrillator, brought to aid resuscitation, was set up. Over the course of the next 15 minutes, 16 electrical shocks were administered. CPR continued until a paramedic arrived shortly before 2.30pm. Ten minutes later, an ambulance arrived.

The man was removed from the prison at 3.09pm and taken to the Accident and Emergency Department of the nearby City Hospital. Sadly, hospital staff were unable to save the man who was pronounced dead at 3.23pm. He was 46 years old.

THE INVESTIGATION PROCESS

1. My investigator considered the man's prison documentation, including his clinical records, before formally opening the investigation on 26 April 2007.
2. Prior to my investigator arriving at Birmingham, notices were issued to staff and prisoners announcing the investigation and inviting anyone who had information relevant to the man's death to make themselves known to the investigator. In the event, nobody came forward. Taped interviews were carried out with two members of the healthcare.
3. One of my Family Liaison Officers contacted the man's next-of-kin (his son) to offer him the opportunity to participate in the investigation process. He did not raise any particular concerns about the circumstances surrounding his father's death, but did ask to see this report. I hope it answers any outstanding questions he may have.
4. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of the 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.
5. The Head of Healthcare at HMP Birmingham, conducted a review of the care the man received whilst in prison on behalf of the Heart of England Primary Care Trust (PCT).

HMP BIRMINGHAM

6. HMP 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. It holds 1,450 prisoners.
7. 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. 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 and nurses. There is an in patient facility which is staffed by registered mental health nurses and discipline officers during the day, and a nurse and discipline officer at night. They provide care for patients with primary mental health needs and those with primary physical health needs requiring 24 hour nursing care.
8. The prison was last inspected by HM Chief Inspector of Prisons, Ms Anne Owers, 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 be better coordinated.
9. The man who is the subject of this report was the tenth prisoner to have died at Birmingham since I assumed responsibility for investigating deaths in custody in April 2004. Since then another prisoner has died. The man's death is the seventh apparently attributable to natural causes. I have identified no common themes between these deaths.

KEY FINDINGS

10. The man was remanded into custody on 16 October 2006 by Wolverhampton Crown Court. He was taken to Birmingham by the prisoner escort service. Upon arrival he was subject to a basic health screening which was completed by a Healthcare Assistant. On the first reception health screen form, the Healthcare Assistant recorded that the man had broken his left ankle in June and that he had problems with allergies. She also noted that he was currently suffering from a migraine and referred him to the doctor.
11. The following day, the man was seen by a nurse who completed a general health assessment. It was noted that he was allergic to penicillin, but no other health problems were identified. He was also seen by the prison doctor because of his migraine. The doctor prescribed paracetamol which the man was allowed to keep in his possession and take when required.
12. Over the next three months, the man integrated himself into prison life and managed to obtain work as a cleaner on the landing of his wing. He participated in Birmingham's voluntary drug testing scheme and provided negative samples on 20 November and 1 December. The sample he provided on 14 December tested positive for opiates. He was referred to the Counselling, Advice, Referral, Assessment and Throughcare (CARAT) team, which works with prisoners with substance misuse problems, and his work supervisor was informed. On 8 January 2007, he again provided a negative sample.
13. On 30 January 2007, the man appeared at Wolverhampton Crown Court and was sentenced to three years' imprisonment for the burglaries. He also received an additional 12 months imprisonment for breaching his licence, meaning his earliest release date would be 15 October 2008. He was returned to Birmingham after the court hearing.
14. During the morning of 1 February, the man again provided a sample to the Voluntary Drug Testing team. The sample subsequently tested negative for illicit drugs. At lunchtime he returned to his cell, where he ate a meal which included chips.
15. At 12.30pm, one of the chaplains at Birmingham received a telephone call from the man's sister telling him that their mother had died earlier that day. The chaplain offered his condolences and assured her that he would tell the man the sad news as soon as the lunch period was over.
16. At 1.25pm, the chaplain went to A Wing and told the senior officer that he was going to take the man to the chaplaincy to tell him about his mother's death. The chaplain made his way to the man's cell, A2-26, and asked him to accompany him. The man told the chaplain that he was having pains in his arms, shoulders and chest. The chaplain told a prison officer that the man was in pain and the officer used his radio to request healthcare assistance. Two Registered General Nurses (RGNs), who were in the nursing station on B Wing next door, responded. They arrived at the man's cell within a couple of minutes

and spoke to him. The man confirmed he was experiencing pains in his chest and described a burning sensation which started in his chest and moved up to his throat. One of the nurses asked the man whether there was a history of hypertension or heart attacks in his family. He said there was not. The nurse enquired into whether he was currently taking medication, which he denied. The man mentioned to the nurses that he had previously experienced pain of a similar nature after eating curry and fish and chips. He said he had eaten chips for lunch an hour or so earlier.

17. The nurse carried out some basic health checks, examining his tongue and the base of his nails to see if there was any evidence of impaired blood flow. She did not find anything of concern but continued to examine him, checking his blood pressure and oxygen saturation levels. His oxygen saturation level was at the lower end of the normal range, and his blood pressure was significantly higher than it should have been. When the nurse repeated the blood pressure check a minute later, the reading suggested it was increasing. This concerned the nurse, who left the man in the company of the nurse who had accompanied her and telephoned the doctor for advice.
18. The nurse told the doctor that she had examined the man and was concerned by his rising blood pressure and chest pains. The doctor asked the nurse what she thought needed to be done, and she said that she thought the man should be examined by a doctor. The doctor said that he was the only doctor on duty and had a room full of prisoners waiting to be seen, so he asked her to make a professional judgement on the man's condition. The nurse told the doctor that she could not make a decision, which is why she telephoned him in the first place. In the end, the nurse became frustrated at the doctor's refusal to make a decision and asked the nurse that had initially accompanied her to speak to him instead. The second nurse reiterated the man's symptoms to the doctor and insisted that he be examined today. The doctor asked her whether the man was capable of getting to the outpatients department, and she said that he was.
19. After putting the telephone down, the nurses told the principal officer in charge of A Wing that the man had an appointment in the outpatients department and asked him to arrange for his transfer. As the man looked physically capable of walking, the nurses left him in the hands of the wing staff. One of the nurses returned to B Wing to write in the man's medical records, and the other left the prison as it was the end of her shift.
20. Around 2.00pm, a prison officer arrived on A Wing to collect prisoners with outpatient appointments in the healthcare centre. As the man's appointment had only been arranged minutes earlier, his name was not on the officer's list. The officer telephoned the healthcare centre to confirm that the man had an appointment. After receiving confirmation, the officer went to the man's cell. He observed the man sitting on a chair and noted that he looked in pain. The officer asked the man whether he was able to walk to the healthcare centre. He replied that he was. The man and the officer walked onto B Wing. As the officer had to collect another prisoner on B Wing, he left the man temporarily on the B2 landing. It was just after 2.05pm.

21. Another prisoner was also on the landing where he was talking to a member of the CARATs team. At the conclusion of their conversation, the prisoner turned to return to his cell and saw the man who is the subject of this report fall to his knees. The prisoner saw the man extend his right arm towards the ground, and went up to him to ask if he was alright. The man did not reply so the prisoner shouted to an officer who was patrolling the B2 landing and told him that the man had collapsed. The officer quickly made his way towards the man whilst using his radio to ask for immediate healthcare assistance. As he reached the man, the officer saw him start physically shaking. The officer thought that the man was experiencing an epileptic fit, so he and the prisoner manoeuvred him into the recovery position.
22. Having returned to the nursing station on B Wing to write in the man's medical notes, the nurse arrived at the B2 landing just seconds after the call for immediate healthcare assistance went out over the radio. She saw the man lying on his back on the floor next to a snooker table. She called out his name, but he did not respond. She examined him and noticed that his face had turned bluish in colour. She asked a healthcare colleague, an agency nurse who had arrived on the B2 landing shortly afterwards, to go to the B3 nursing station to bring oxygen and the blue medical bag. She asked the officer who had noticed the man collapse to summon an ambulance which he did via the prison's communications unit. Birmingham's incident log shows that the emergency call was made at 2.19pm.
23. When the agency nurse reached the nursing station, she told her colleagues that there was a medical emergency on B2 and five of them responded. A call was made to doctor to tell him that a prisoner had collapsed. The nurses made their way to B2 carrying oxygen, an automated defibrillator, the blue medical bag and various other medical supplies. Oxygen was immediately given to the man but apparently had little impact on his condition. Cardio pulmonary resuscitation (CPR) was started, with chest compressions being given at a rate of 30 for every two respirations. The defibrillator was attached. It indicated that electric shocks were to be administered.
24. The doctor arrived and observed the first set of shocks being given. After a few shocks, the man started breathing again. However, his breathing was extremely laboured and, after a minute or so, he stopped again. CPR was immediately restarted and the defibrillator indicated that further electric shocks should be given.
25. For the next 15 minutes, CPR was given by staff and electric shocks continued to be administered in accordance with the instructions of the automated defibrillator. In total, 16 electric shocks were given. Subsequent analysis of the defibrillator's internal computer showed that the shocks were effective in maintaining the man's life for longer than would otherwise have been the case.
26. Having been told by staff that the man had collapsed and was being treated by medical staff, a governor spoke to the chaplain and asked him to contact the man's family to tell them what was going on. The chaplain did this by telephone.

27. At 2.27pm, a paramedic arrived at the prison and assisted nursing staff attempt to revive the man. The paramedic, assisted by two nurses, inserted an intravenous saline drip into the man's arm in order to rehydrate him. CPR continued throughout.
28. At 2.38pm, an ambulance arrived at the prison. The crew made their way to B2 and assumed responsibility for caring for the man. The assembled nursing and prison staff assisted the ambulance staff and the paramedic make the man as comfortable as possible. They then took him to hospital in an emergency ambulance at 3.09pm, accompanied by two prison officers. The chaplain telephoned the man's family again to tell them that he was being taken to the nearby City Hospital.
29. The man was taken to the Accident and Emergency Department and was immediately attended to by hospital staff. At 3.23pm, the prison escort staff were told that the man had been pronounced dead. They contacted the prison which activated its contingency plan for dealing with a death in custody. The man's family were informed of his death by a senior manager at Birmingham.
30. Staff who were directly involved in the attempts to resuscitate the man participated in a 'hot debrief' and were offered support by the staff welfare team and colleagues. Prisoners who had witnessed the man's collapse and the attempts to revive him were spoken to by staff and given the chance to speak to Listeners (prisoners trained by the Samaritans to support those in emotional distress).
31. As the man became ill and the attempts to resuscitate him were unsuccessful, he did not learn that his mother had died earlier in the day.
32. He was 46.

ISSUES

Clinical response to the man's chest pains

33. Prior to the day of the man's death, nothing in his medical history indicated that he was likely to suffer a fatal cardiac arrest. When he was received into the prison six months earlier, he suffered from migraine and mentioned that he had a problem with allergies. He had broken his ankle some time previously but there is no evidence to suggest that this was troubling him unduly. His physical health was unremarkable.
34. The pains the man described to one of the nurses at 1.33pm on 1 February were apparently similar to digestive pains he had experienced previously after eating curry and fish and chips. I am pleased to learn that the nurses carried out a comprehensive medical examination even after the man had mentioned that he had eaten chips an hour or so earlier, and that they acted on the warning signs appropriately. The clinical reviewer comments that registered nurses should have been competent to assess his condition and been confident to express a clinical opinion.

A training needs assessment should be completed for all nursing staff and appropriate training packages implemented. Particular emphasis should be given to developing triage and emergency response skills.

35. The nurses appropriately asked the doctor's advice, but he was busy attending to other patients and no other doctors were in the prison. The doctor offered little in the way of advice to the first nurse who spoke to him, and it would appear that only the second nurse's persistence meant the man was added to the GP list for that day. It is the clinical reviewer's opinion that, although the nurse had no difficulty contacting the doctor, there is no protocol to support her request for the doctor to attend.

A protocol to enable nursing staff to access medical advice should be written and implemented.

36. Given that the man subsequently died, it would be possible to criticise the nurses for not calling the emergency services straightaway. However, it should be remembered that the man's appearance was satisfactory, he talked without any sign of discomfort and, although his blood pressure was high, it was not life threatening. He denied any family history of heart disease or high blood pressure (which are known risk factors for cardiac arrest). Overall, I suggest that his physical condition caused concern, but was not critical. Consequently, arranging for him to be seen by a doctor in due course was an appropriate response.
37. It appears that the man's health deteriorated rapidly, culminating in his collapse on the B2 landing whilst on his way to the outpatients department. An officer immediately summoned healthcare assistance and two nurses arrived as quickly as could be expected. Five other nurses arrived minutes later, followed by the doctor, discipline staff and senior managers. If anything, too many staff

attended, although there is no evidence to suggest that this had a detrimental impact on attempts to revive the man. The defibrillator reading, produced after the man was taken to hospital, showed that CPR had effectively supplied oxygen to the muscles in the heart for a considerable amount of time. I believe that the concerted efforts of staff to revive the man over a period of 30 minutes increased his chances of survival. These efforts should be recognised and commended by the Governor.

The Governor should commend those staff involved in the attempts to resuscitate the man who died .

38. As a housekeeping matter, the clinical reviewer comments that all clinical staff should have up to date training in record keeping, and clinical notes should be audited regularly.

RECOMMENDATIONS

To the Governor

1. The Governor should commend those staff involved in attempting to resuscitate the man who died .

To the Heart of England Primary Care Trust

2. A training needs assessment should be completed for all nursing staff and appropriate training packages implemented. Particular emphasis should be given to developing triage and emergency response skills.
3. A protocol to enable nursing staff to access medical advice should be written and implemented.

I also draw attention to my comments in my foreword to this report on the commissioning of clinical reviews.