

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Graham Birchwood, a prisoner at HMP Wayland, on 9 September 2019

A report by the Prisons and Probation Ombudsman

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Graham Birchwood died on 9 September 2019 from heart disease at HMP Wayland. He was 65 years old. I offer my condolences to Mr Birchwood's family and friends.

The clinical reviewer found that the care Mr Birchwood received at Wayland was not equivalent to that which he could have expected to receive in the community. Staff failed to put appropriate care plans in place to manage his heart disease, diabetes and high blood pressure.

Mr Birchwood was found dead on his cell floor on the morning of 9 September. There were signs that he had been dead for some time. I am concerned that the member of staff who carried out the roll check two and a half hours before, failed to see that Mr Birchwood was lying face down on his cell floor.

When staff did find him, they failed to call a medical emergency code which led to a delay in the emergency response. While it made no difference to the outcome for Mr Birchwood, any delay in a future medical emergency could be critical.

It is also disappointing that staff tried to resuscitate Mr Birchwood when he had clearly been dead for some time. This was inappropriate.

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

Sue McAllister CB
Prisons and Probation Ombudsman

March 2020

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Summary

Events

1. Mr Graham Birchwood was serving a 32-year sentence for murder. He arrived at HMP Wayland on 1 May 2019.
2. Mr Birchwood had several long-term health conditions including heart disease, diabetes and high blood pressure.
3. At 8.05am on 9 September, just before unlocking Mr Birchwood's cell, an officer looked through the observation panel and saw Mr Birchwood lying face down on the floor. The officer opened the cell door and tried to get a response from Mr Birchwood but he did not respond. The officer called for medical assistance over his radio.
4. Staff responded to the call for assistance and started cardiopulmonary resuscitation (CPR). When a more experienced nurse arrived at the cell, he could see that Mr Birchwood had rigor mortis and was clearly dead so he told staff to stop CPR. He called a prison GP who pronounced Mr Birchwood dead at 8.25am.
5. The post-mortem report found that Mr Birchwood died from ischemic and hypertensive heart disease. Diabetes was a contributory factor.

Findings

6. The clinical reviewer found that Mr Birchwood's care was not equivalent to that which he could have expected to receive in the community. She was concerned that no care plans were in place to manage his long-term conditions.
7. She was also concerned that staff attempted resuscitation on Mr Birchwood when he was clearly dead, which is against resuscitation guidelines.
8. Mr Birchwood had been dead for some time when he was found. We are concerned that the operational support grade (OSG) did not see that Mr Birchwood was lying on the floor when he carried out the early morning roll check at 5.30am. We are also concerned that the OSG refused to be interviewed by telephone.
9. We are also concerned that the officer who found Mr Birchwood unresponsive failed to call a medical emergency code blue, which meant that there was a delay in an ambulance being called and in the nurse bringing the correct medical equipment. It made no difference to the outcome for Mr Birchwood but any delay in future medical emergencies could be critical.

Recommendations

- The Head of Healthcare should ensure that all prisoners with identified long-term conditions have a specific personalised management plan in place, in line with NICE guidelines.

- The Governor and Head of Healthcare should ensure that all staff are given clear guidance on the circumstances in which resuscitation is inappropriate, in line with European Resuscitation Council Guidelines.
- The Governor should ensure that staff completing roll checks are aware of their responsibilities and they must satisfy themselves all prisoners are present and correctly accounted for, that they have not escaped, and are not obviously ill or dead.
- The Governor should arrange for this report to be shared with the OSG and for a senior manager to discuss our findings with him.
- The Governor should initiate an investigation into the OSG's refusal to be interviewed by telephone with a view to considering if disciplinary action is appropriate.
- The Governor should remind all staff that they are required to cooperate with PPO investigations in line with PSI 58/2010.
- The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including that they use the correct medical emergency code to communicate the nature of the emergency effectively.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Wayland informing them of the investigation and asked anyone with relevant information to contact her. No one responded
11. The investigator obtained copies of relevant extracts from Mr Birchwood's prison and medical records.
12. The investigator interviewed one member of staff on the telephone on 21 November 2019.
13. NHS England commissioned an independent clinical reviewer to review Mr Birchwood's clinical care at the prison.
14. We informed HM Coroner for Norfolk of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
15. One of the Ombudsman's family liaison officers contacted Mr Birchwood's son to explain the investigation and to ask if the family had any matters they wanted the investigation to consider. Mr Birchwood's son did not raise any issues but asked for a copy of the report.
16. Mr Birchwood's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.
17. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Wayland

18. HMP Wayland is a medium security training prison in rural Norfolk, near Thetford. The prison holds up to 1,017 convicted male prisoners. Care UK health provides healthcare services. There are no nurses on night duty.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Wayland was in June 2017. Inspectors found that new arrivals had an initial health care assessment which identified immediate issues, and appropriate referrals were made. A secondary, more in-depth health screen was undertaken the following day.
20. Inspectors also reported that prisoners with lifelong conditions were poorly managed. There were no nurse-led clinics for them as staff were not appropriately trained, and the GP service was not resourced to provide effective monitoring or oversight. They found that too many prisoners with lifelong conditions did not have care plans, and reviews were not undertaken routinely.

Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report improvements in some of the problems identified in their previous annual report, for the year to May 2018, the IMB reported that Virgin Healthcare [the healthcare provider at the time] continued to provide equivalent services to those provided in the community. The care of prisoners with long-term health conditions was now being provided by all the nursing staff, appropriate to their expertise, i.e. diabetes, cardiac, respiratory.

Previous deaths at HMP Wayland

22. Mr Birchwood was the third prisoner to die at Wayland since September 2017. Of the previous deaths, one was from natural causes and one was self-inflicted. There are no similarities between Mr Birchwood's death and previous deaths at Wayland.

Key Events

23. On 25 September 2008, Mr Graham Birchwood was remanded in custody charged with murder. In June 2009, he was sentenced to 32 years in prison. He was moved to HMP Wayland on 1 May 2019.
24. A nurse completed the initial reception health screen. She noted that Mr Birchwood had several chronic health conditions, including heart disease, diabetes and high blood pressure. She made a referral for him to see a prison GP.
25. On 3 May, it was noted that Mr Birchwood did not attend his secondary screening. A further attempt to see him was made on 7 May, but this was also unsuccessful. There were no further attempts to complete a secondary screening.
26. On 7 May, a prison GP reviewed Mr Birchwood's notes. She noted that Mr Birchwood had had a previous heart attack and that he had chronic kidney disease. She requested that he had a full set of blood tests, a urine test and an electrocardiogram (ECG – to monitor the electrical rhythms of the heart).
27. On 15 May, a nurse took Mr Birchwood's blood samples, urine test and completed an ECG.
28. On 17 May, a prison GP reviewed Mr Birchwood's blood profile, she noted that he had stage 4 chronic kidney disease (meaning severe kidney damage, the last stage before kidney failure). She also reviewed the ECG and noted that there were several abnormalities. She booked him an appointment with a prison GP, for 29 May. Mr Birchwood did not attend.
29. On 12 June, a prison GP saw Mr Birchwood to discuss his previous medical history. Mr Birchwood said that he was generally feeling better since being in Wayland. The prison GP said that as Mr Birchwood appeared to be well, a cardiology referral was not necessary at that time.

Events of 9 September

30. At approximately 5.30am on 9 September, an operational support grade (OSG) carried out the early morning roll check (count of prisoners on the wing). He reported no issues.
31. At approximately 8.05am, just before unlocking Mr Birchwood's cell, an officer looked through the observation panel and noticed that Mr Birchwood was lying face down on the floor. He opened the cell door and called to Mr Birchwood, but got no response. The officer said that Mr Birchwood felt cold and he thought he was dead. He called on his radio for medical assistance.
32. An officer arrived at the cell a few seconds later. He said that he could not find a pulse, and there were no signs of life. He thought that Mr Birchwood had been dead for some time because he was cold and rigor mortis appeared to have set in.
33. Moments later a nurse responded to the call for assistance. She said that when she arrived, Mr Birchwood had no pulse and was not breathing. She noted that

staff had started cardiopulmonary resuscitation (CPR). Staff gave different accounts of who instructed them to start CPR. Another nurse also responded and arrived moments later. He told the officers to stop resuscitation as Mr Birchwood was clearly dead.

34. A prison GP pronounced Mr Birchwood dead at 8.25am.

Contact with Mr Birchwood's family

35. On 9 September, shortly after Mr Birchwood had died, the prison appointed an officer as the family liaison officer (FLO). Mr Birchwood's relative was listed as his next of kin. The FLO and a prison manager went to Mr Birchwood's relative's house to break the news and offer support. When they got there no one was in so they went to Mr Birchwood's other relative's address and told her instead.
36. The prison paid for Mr Birchwood's funeral in line with national guidelines.

Support for prisoners and staff

37. After Mr Birchwood's death, the prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
38. The prison posted notices informing other prisoners of Mr Birchwood's death, and offered support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Birchwood's death.

Post-mortem report

39. The post-mortem report concluded that Mr Birchwood died of ischemic heart disease (heart problems caused by the narrowing of the arteries supplying the heart) and hypertensive heart disease (heart conditions caused by high blood pressure). Diabetes was listed as a contributory factor.

Findings

Clinical Care

40. The clinical reviewer considered that the care Mr Birchwood received at Wayland was not equivalent to that which he could have expected to receive in the community.
41. The clinical reviewer noted that there were no care plans in place to monitor Mr Birchwood's conditions, which is not in line with National Institute for Health and Care Excellence (NICE) guidelines. We note that HMIP expressed concern about a lack of care plans for prisoners with long-term conditions when they inspected Wayland in 2017.
42. The clinical reviewer was also concerned that staff initiated CPR, which was inappropriate because Mr Birchwood had clearly been dead for a long time as he had rigor mortis.
43. We make the following recommendations:

The Head of Healthcare should ensure that all prisoners with identified long-term conditions have a specific personalised management plan in place in line with NICE guidelines.

The Governor and Head of Healthcare should ensure that all staff are given clear guidance on the circumstances in which resuscitation is inappropriate, in line with European Resuscitation Council Guidelines.

Roll check

44. Rigor mortis was present, indicating that Mr Birchwood had been dead for some time when he was found face down on the floor of his cell at 8.05am on 9 September. It is highly likely that he was dead, and in the same position on the floor, when the roll check was carried out at 5.30am.
45. The investigator watched the CCTV footage of the roll check. It shows the OSG looking very briefly through the observation panel. He did not appear to use a torch, despite it being dark. The investigator arranged to interview the OSG by telephone, but she was unable to get through to him at the prearranged time. She tried to rearrange a telephone interview but the OSG refused, saying he wanted to be interviewed in person.
46. We would expect a roll check to identify if a prisoner is obviously unwell or dead. We are concerned that the OSG's check was not sufficient to identify if there were any immediate concerns. We consider it highly likely that Mr Birchwood was lying face down on his cell floor at the time of the check, but this was not identified. We make the following recommendations:

The Governor should ensure that staff completing roll checks are aware of their responsibilities and they must satisfy themselves all prisoners are present and correctly accounted for, that they have not escaped, and are not obviously ill or dead.

The Governor should arrange for this report to be shared with the OSG and for a senior manager to discuss our findings with him.

47. We are very concerned that the OSG refused to be interviewed by telephone. Section 5 of Prison Service Instruction (PSI) 58/2010, The Prisons and Probation Ombudsman, allows the PPO's investigators to conduct interviews with staff. It provides that staff can be accompanied by a friend or union representative and that anything said will not be held against them in any disciplinary proceedings without their consent. Section 1.7 obliges governors to ensure that staff comply with section 5 when the PPO are carrying out investigations or enquiries. It is for the PPO to decide what form the interview should take – in person, by video-conference, or by telephone (accompanied by a friend or union representative if they wish) – and we consider that an officer is not acting in line with PSI 58/2010 if he or she refuses to be interviewed. We recommend:

The Governor should initiate an investigation into the OSG's refusal to be interviewed by telephone with a view to considering if disciplinary action is appropriate.

The Governor should remind all staff that they are required to cooperate with PPO investigations in line with PSI 58/2010.

Emergency Response

48. Prison Service Instruction (PSI) 03/2013, Medical Emergency Response Codes, requires prisons to have a local protocol which gives guidance on efficiently communicating the nature of a medical emergency. It directs that staff should use a code blue (or code one) for any emergency where a prisoner has symptoms including unconsciousness and fitting.
49. When an officer went to Mr Birchwood's cell he found him lying on the floor. When the officer could not get a response from Mr Birchwood he used his radio to call for medical assistance. When the officer was asked at interview why he did not call a code blue, he said that it was a spur of the moment reaction, and he is aware that he should have called a code blue.
50. We consider that the officer should have called a code blue as soon as he realised that Mr Birchwood was not responding. This caused a short delay in calling an ambulance and meant that when the nurse responded to the call for medical assistance she did not know which equipment she needed to bring. We are satisfied the delay did not affect the outcome for Mr Birchwood, who was dead when found, but any delay in a future medical emergency could be crucial. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including that they use the correct medical emergency code to communicate the nature of the emergency effectively.

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