	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Rt Hon Damian Hinds, Minister of State** **2. [redacted] Director General Chief Executive – HM Prison and Probation Service (formerly known as The National Offender Management Service)**
1	**CORONER** I am Ian Dreelan, Assistant Coroner for Birmingham and Solihull
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 21 June 2021 I commenced an investigation into the death of Floyd Everton CARRUTHERS. The investigation concluded at the end of the inquest. The conclusion of the inquest was; Conclusion of the Jury as to the death These are the points that the Jury have discussed and reached a unanimous decision based on the following:- 1. The fact the Mr Carruthers died of an infected heart valve and this was from a natural condition. 2. The fact that Mr Carruthers had probably had the infection for weeks if not months. 3. Based upon the evidence heard in court, on the balance of probabilities the source of infection was not contributed to by the pressure sores found on Mr Carruthers body. 4. A blood test was ordered on 15/05/2021 but was not carried out. Based upon the evidence heard in court a blood test may have shown markers of inflammation and possibly infection which could have prompted earlier intervention. 5. The Prison staff involved in delivering the regime on Lima Wing in relation to Mr Carruthers from 10/05/2021 - 29/5/2021 had 10 weeks basic training at the start of their service but had insufficient ongoing mandatory training and understanding of the matters contained in the National Offender Management Service, Adult Safeguarding in Prison Policy, PIS 16/2015 dated 31/3/19, to enable them to undertake their role in compliance with that policy. As per evidence heard in court there was no safeguarding training in place during the period of Mr Carruthers incarceration. 6. The Prison staff on Lima Wing and the HMP Birmingham Healthcare staff took insufficient steps to safeguard Mr Carruthers throughout the period 10/5/2021 - 29/5/2021. This includes insufficient record keeping, handover and escalation of events, such as missed meals and not leaving his cell. 7. There were failures of Prison staff to make a referral to healthcare in response to Mr Carruthers condition, as reflected in his overall pattern of behaviour and his presentation, between 25/5/2021-29/5/2021 As a result the Jury have reached a conclusion that death was contributed to by neglect.
4	**CIRCUMSTANCES OF THE DEATH** 1) Mr Carruthers was diagnosed with paranoid schizophrenia in 2003. 2) Mr Carruthers was under the care of the Mental Health Team and on the whole had a good rapport, however could become irritable if challenged on his mental health by mental health professionals. Mr Carruthers was self aware of his condition and learnt to manage it, it is noted that he heard voices as part of his paranoid schizophrenia diagnosis even when stable. Whilst

	compliant to taking his medication, Mr Carruthers was stable. Mr Carruthers compliance with medication over time decreased and he subsequently stopped taking his medication. 3) Mr Carruthers was not on medication at the time of arrest and subsequent transfer to HMP Birmingham. 4) Mr Carruthers was arrested on the 09/04/21 and was taken to Perry Barr Police Station. 5) Whilst in custody at Perry Barr Police Station, Mr Carruthers underwent a Mental Health Act Assessment on the 10/04/21 which determined he was fit to be interviewed and did not meet the criteria for detention under the Mental Health Act 1983. 6) Mr Carruthers arrived on remand at HMP Birmingham on 12/4/2021. He was sentenced to 66 days imprisonment on 6/5/2021. 7) Mr Carruthers underwent a reception medical screening at HMP Birmingham identifying his pacemaker. The resulting HMP Birmingham procedure is to raise a task, for a follow up on the pacemaker, this was not done. The reception medical screening did not identify Mr Carruthers mental health history or the Mental Health Act Assessment completed on the 10/4/2021. The HMP Birmingham procedure is a mental Health Nurse Review within 48 hours, this was not done. 8) A mental health nurse attended Mr Carruthers cell on the 7/5/2021, this was triggered by concerns raised by Mr Carruthers family, to conduct an assessment. The assessment was completed from outside Mr Carruthers cell and was around one minute long. Mr Carruthers declined to input, he was polite but abrupt and the Nurse deemed Mr Carruthers had capacity to refuse mental health input. 9) Mr Carruthers was moved to Lima Wing on 10/05/2021 to a double cell. At the time of his transfer to hospital he was a single occupant of this double cell. It is noted that Mr Carruthers had multiple cell mates during his time on Lima Wing. From evidence heard in court, having multiple cell mates does not trigger a Health Care review. 10) A blood test was ordered on the 15/5/2021, it is unclear why it was ordered and why it was not undertaken. 11) There is a general agreement that during Mr Carruthers time on the Lima Wing he presented as reserved, shy and polite; he kept himself to himself. 12) The regime on Lima Wing changed regularly due to Covid restrictions and government regulations. It is generally accepted that the regime included a morning meal, delivered to Mr Carruthers cell, a hot meal to be collected from the servery and association and medicine collection. 13) A summary of interaction between Prison staff and Mr Carruthers between the 25/5/2021 - 29/5/2021 based on limited CCTV and Prison Officer statements, shown during the inquest is as follows. Between the days of 25/5/21 and 29/5/2021, Mr Carruthers had multiple interactions with Prison Officers summarised as including food deliveries, unlocking of his cell and officers entering and leaving Mr Carruthers cell. The most notable event was when we last saw Mr Carruthers leave and return to his cell on the 25/5/21 having collected his hot meal. Following this we did not see Mr Carruthers leave his cell again. With regards to meals - we saw Mr Carruthers collect food once on the 25/05/21, had food delivered as customary between the 25/5/21 and 28/05/2021. Mr Carruthers did not have a hot meal on the 26/05/21 or 27/05/21 and his hot meals bought to him on the 28/05/21 and 29/05/21. Multiple statements show evidence of Mr Carruthers not wanting meals or association time. 14) Evidence from Prison Officer statements show no concerns or observations raised or logged for Mr Carruthers during his time on Lima Wing up until 29/05/2021. Evidence shows that Prison Officers failed to notice a pattern due to no written log of observations or events. 15) A Prison Officer raised concerns regarding Mr Carruthers' health on the 19/05/2021 based on his presentation and appropriately escalated to his Custodial Manager. A Hotel 2, high est escalation, call was made to Prison Healthcare staff, to attend which occurred 16) The Prison Nurse attended and conducted initial observations which promoted a 999 call. 17) Paramedics attended and followed appropriate care, allocating roles to facilitate transfer to hospital and highlighting to Prison Officers that Mr Carruthers required a time critical transfer to City Hospital to gain essential input from the cardiac team. 18) Following treatment in his cell, Mr Carruthers was transferred to an ambulance for transfer to City hospital. Significant delays occurred in the Sterile Area of HMP Birmingham whilst paperwork, personnel and handcuff procedure were complete - it did not contribute to the death of Mr Carruthers

	19) Upon presentation at City Hospital Mr Carruthers was extreamly unwell and was reviewed by the cardiac team. An ultrasound of the heart was used to quickly diagnose Mr Carruthers endocarditis and start treatment. 20) When Mr Carruthers was admitted to the Acute Medical Unit he was at the point of multiple organ failure with septic shock, acute renal failure, hepatic failure, and delirium probably related to sepsis and cerebral hypoperfusion. 21) Evidence suggests Mr Carruthers had staphylococcal endocarditus for weeks or potentially months prior to his hospital admission. Evidence suggests Mr Carruthers is likely to have developed sepsis in the 1-3 days prior to his hospital admission, leading to septic shock and multi-organ failure on admission to hospital. 22) Mr Carruthers acute medical review led to a plan to take Mr Carruthers to New Cross Hospital, Wolverhampton on 3/6/2021 with a view to open heart surgery. There he was reviewed by 2 Consultant Cardiac Surgeons who felt that with multiorgan failure he was very unlikely to survive open heart surgery at that point and he was therefore transferred back to City Hospital. 23) During this time, Mr Carruthers was in a critical condition, it was noted that Mr Carruthers was hand cuffed during the transfer from City Hospital to New Cross Hospital, at the recommendation of the Govenor) despite multiple conversations with the Prison Officers present. This showed a lack of consideration to Mr Carruthers medical condition and the true risk to Hospital staff and the public. 24) Following his return to City Hospital, he became more drowsy and less responsive over the following days. He passed away peacefully on the morning of 14/6/2021. Following a post mortem, the medical cause of death was determined to be: **1a Cardiac tamponade. Hypostatic pneumonia** **1b Haemorrhagic pericarditis** **1c Infective endocarditis (implanted electronic cardiac pacemaker for 2nd degree atrio-ventricular block).** **II**
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – 1. At the time Mr Carruthers resided in HMP Birmingham, National Offender Management Service, Adult Safeguarding in Prison Policy, PSI 16/2015 dated 31/3/19 was in force. This policy states at paragraph 1.10 (under the heading 'Mandatory Actions') "Governors must have systems in place to protect adult prisoners from abuse and neglect". At paragraph 2.4 the policy states "Neglect also includes self-neglect, which covers a wide range of behaviour such as neglecting to care for one's personal hygiene, health or surroundings and behaviour such as hoarding". My concern is that while there is a national policy dealing with safeguarding, to include instances of self-neglect, no adequate training exists at either national or local level to ensure the effective implementation of that policy. 2. While evidence was heard from prison staff detailing a number of potential escalation routes for what might be termed 'social isolation' (an instance, as with Mr Carruthers, where they had not left their cell for a period of days but had not declared they were self isolating), notably ACCT and CISP, none of the officers appeared aware of a corresponding process for raising safeguarding issues. The known escalation routes (ACCT and CISP) are more focussed on violence and self-harm, leaving at the very least a conceptual gap in how best to deal with injurious activity which is neither violent nor directly/obviously contributory to self-harm, such as self-neglect. My concern is that the existing safeguarding escalation process is either inadequate, inappropriately trained or both

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 2 March 2023. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:- Mr Carruthers' Family Birmingham Community Healthcare NHS Foundation Trust Birmingham & Solihull Mental Health NHS Foundation Trust I have also sent it to the Prisons & Probation Ombudsman, HM Inspectorate of Prisons and the Independent Advisory Panel on Deaths in Custody who may find it useful or of interest. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**5 January 2023** Signature:  **Ian Dreelan** **Assistant Coroner for Birmingham and Solihull**