

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ian Deavall, a prisoner at HMP Forest Bank, on 24 January 2023

A report by the Prisons and Probation Ombudsman

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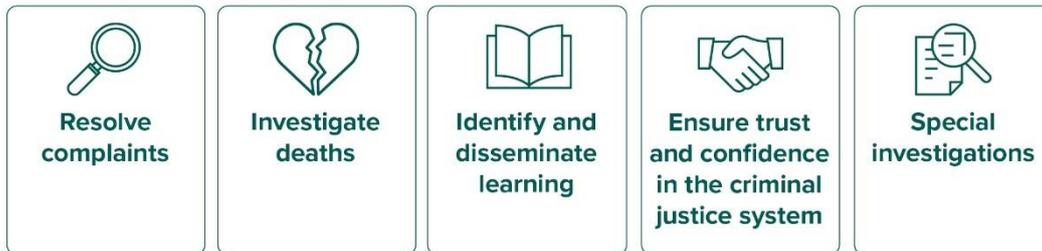
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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE



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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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Ian Deavall died of ischaemic heart disease on 24 January 2023, while a prisoner at HMP Forest Bank. He was 65 years old. I offer my condolences to Mr Deavall's family and friends.

Mr Deavall died less than three weeks after he arrived in prison. The clinical reviewer concluded the physical healthcare provided to him at Forest Bank was of a mixed standard and not wholly equivalent to that which he could have expected to receive in the community. Mr Deavall had a history of heart disease and, despite concerns about his physical health and requests for follow-up care, he was not clinically monitored in the time before his death, contrary to GP instructions.

The investigation also identified several issues with the management of the emergency response.

Adrian Usher
Prisons and Probation Ombudsman

March 2024

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Summary

Events

1. On 7 January 2022, Mr Ian Deavall was remanded in prison for sexual offences and taken to HMP Forest Bank.
2. Mr Deavall had a long history of heart disease. He was examined on reception, his health conditions noted, and he was prescribed his usual medications.
3. On 11 January, Mr Deavall told staff that he felt unwell. He was seen by a nurse after he had vomited, but his clinical observations were normal. The next day a nurse and GP reviewed Mr Deavall and requested further tests. The GP also asked that healthcare staff monitor Mr Deavall. He was given another appointment with a GP for the next day, and it was noted that he would need to be taken to the healthcare centre in a wheelchair as he was too physically unwell to walk. Mr Deavall did not attend this appointment and there is no evidence that staff followed up on his non-attendance. There was no evidence that further clinical observations were completed.
4. On 24 January, Mr Deavall's cellmate pressed the emergency cell bell to alert staff that he was unresponsive. Staff entered the cell and, despite resuscitation efforts, a prison GP declared Mr Deavall had died at 11.10am.

Findings

5. The clinical reviewer concluded that the physical healthcare that Mr Deavall received at Forest Bank was not wholly equivalent to that which he could have expected to receive in the community. Despite a GP requesting blood tests, an X-ray, and an ECG, none of these were completed. There is no evidence Mr Deavall had clinical observations between 15 January and his death.
6. When Mr Deavall was discovered unresponsive, a medical emergency code was not immediately called, and officers did not start CPR until a nurse arrived. Control room staff did not call for an ambulance immediately when a medical emergency code was radioed.

Recommendations

- The Head of Healthcare should ensure that there are robust communication and administrative processes to handover prisoner healthcare information and ensure that all clinical requests are completed in a timely manner.
- The Director and Head of Healthcare should ensure that:
 - control room staff call for an ambulance immediately when a medical emergency code is called; and
 - staff facilitate the access of ambulances and paramedics through the prison gate to ensure there are no unnecessary delays.

The Investigation Process

7. We were notified of Mr Deavall's death on 24 January 2023.
8. The investigator issued notices to staff and prisoners at HMP Forest Bank informing them of the investigation and asking anyone with relevant information to contact her. Nobody responded.
9. The investigator obtained copies of relevant extracts from Mr Deavall's prison and medical records.
10. NHS England commissioned a clinical reviewer to review Mr Deavall's clinical care at the prison. The clinical reviewer and investigator jointly interviewed six healthcare and prison staff in March 2023. The investigator also interviewed Mr Deavall's cellmate, an officer, the Head of Residence, and the Safer Custody Manager. The prisoner who conveyed the message to staff that Mr Deavall was unwell declined to be interviewed.
11. We suspended our investigation between 29 March and 27 September, awaiting Mr Deavall's cause of death.
12. We informed HM Coroner for Greater Manchester West of the investigation. He gave us the cause of death. We have sent the Coroner a copy of this report.
13. The Ombudsman's family liaison officer (FLO) wrote to Mr Deavall's son, his nominated next-of-kin, to explain our investigation and to ask if there were any matters he wanted us to consider. He had no specific questions.
14. Mr Deavall's wife contacted the Ombudsman's FLO. She wanted to know if Mr Deavall received appropriate care for his physical health and if the prison were aware of his medical history, which we address in this report. Other questions she asked were outside the remit of this investigation.
15. Mr Deavall's family received a copy of the initial report. They did not identify any factual inaccuracies.
16. The prison also received a copy of the report. They did not identify any factual inaccuracies.

Background Information

HMP Forest Bank

17. HMP Forest Bank holds adult men both on remand and sentenced and young prisoners between the ages of 18-21. The prison serves the courts of Greater Manchester and has an operational capacity of 1,460.
18. The prison is managed and run by Sodexo Limited, who were also responsible for the provision of primary healthcare services, including primary mental health services, inpatient facilities, and substance misuse services within the prison. Spectrum Community Health became the primary healthcare provider on 1 April 2023.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Forest Bank was in February 2022. Inspectors noted that in late 2021, HM Prison and Probation Service (HMPPS) was forced to issue Sodexo with a formal rectification notice over their concerns about the safety of prisoners and the conditions in which they were being held. Inspectors reflected this was a concerning step, but there was clear evidence that the company had responded quickly and positively. New priorities focused on improving safety had been identified, but still needed more development to ensure their implementation was sufficiently robust. Inspectors found more also needed to be done to make sure newly received prisoners were properly supported and inducted.
20. All new arrivals had a health screening and a COVID-19 risk assessment. The GP and substance misuse team reviewed patients with more complex needs on their first night, which was positive. Inspectors found that patients had good access to urgent same-day GP appointments and non-urgent appointments within 10 days, which was good. Inspectors found that medicines administration was appropriately recorded. Reasons for non-attendance were not always recorded, but prisoners who did not attend were consistently followed up.
21. In January 2023, inspectors completed an independent review of progress at Forest Bank. They found that improvements had been made to early days processes, although time out of cell for vulnerable prisoners in their first days in prison remained poor.

Independent Monitoring Board

22. 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 for the year to 31 October 2021, the IMB found the healthcare team had worked extremely hard in difficult conditions to deliver a service that is, possibly, in the current circumstances, better than what is available to the general public.

Previous deaths at HMP Forest Bank

23. Mr Deavall was the fourteenth prisoner at Forest Bank to die since January 2020. Of the previous deaths, eight were from natural causes, two were self-inflicted and

three were drug related. There have been two natural cause deaths since. We have previously recommended that control room staff request an ambulance as soon as a medical emergency is radioed.

Key Events

24. On 6 January 2023, Mr Ian Deavall was repatriated to the UK from America having spent several months in a Florida prison. On 7 January, he appeared at Manchester Magistrates' Court and was remanded in prison for sexual offences. Mr Deavall was taken to HMP Forest Bank and was due to appear in court again on 10 February. As it was his first time in prison in the UK, prison staff started suicide and self-harm prevention procedures (known as ACCT) when Mr Deavall arrived at Forest Bank.
25. At his initial health screen, a nurse noted Mr Deavall's physical health history; heart disease (which included having stents fitted to increase the flow of blood), high blood pressure, high cholesterol and that he had previously had a mini stroke. Healthcare staff obtained his medical records, which confirmed his medical history. All his clinical observations were noted to be within normal parameters. Mr Deavall did not have a history of mental health issues or substance misuse.
26. A GP at Forest Bank reviewed Mr Deavall and prescribed the medications to manage his physical health conditions. Mr Deavall was not allowed to have his medication in possession and needed to collect it each day from the medications hatch on the wing. Staff allocated Mr Deavall a cell on E Wing.
27. On 8 January, Mr Deavall had his second stage health screen. A nurse identified that he had a stent and no outstanding hospital or doctor appointments.
28. On 11 January, wing staff asked healthcare to assess Mr Deavall as he said that he was unwell and had vomited. At 4.40pm, a nurse went to Mr Deavall's cell and took his clinical observations; all were within normal parameters although his blood pressure was a little low. She returned 45 minutes later and repeated clinical observations and noted Mr Deavall's blood pressure had improved slightly. The nurse recorded that there were no immediate concerns and Mr Deavall was prescribed anti-sickness medication and paracetamol. She requested that Mr Deavall was monitored during the night. A nurse did review him and noted that Mr Deavall said he felt much better. He was added to the healthcare list to be reviewed the next day.
29. On 12 January, a nurse went to see Mr Deavall in his cell. He said he had vomited again several times during the night and was not able to keep food down. She referred Mr Deavall to the GP to investigate further.
30. Later the GP visited Mr Deavall in his cell with a healthcare assistant. The GP prescribed antibiotics for a possible chest infection and noted that blood tests, a chest X-ray and an ECG (electrocardiogram which records how the heart is functioning) should be requested. He stopped one of Mr Deavall's heart medications, as it also reduced blood pressure. He prescribed an anti-sickness medication. He tasked his GP colleague with reviewing Mr Deavall the next day and requested that a nurse should list him for the outstanding tests. He documented that Mr Deavall would require a wheelchair to convey him to his follow-up appointment because he was weak and unable to walk.
31. On 13 January, another GP noted in Mr Deavall's medical record that he did not attend the clinic appointment and so he would be re-listed, but there is no evidence

this happened. There is also no evidence that the outstanding tests were completed or that Mr Deavall's clinical observations were monitored.

32. On 15 January, Mr Deavall told prison staff he felt weak, dizzy, and had been vomiting. Wing staff contacted healthcare and a nurse examined Mr Deavall in his cell. His clinical observations were within normal parameters, although his blood pressure was again a little low. The nurse noted that Mr Deavall's blood pressure was being monitored regularly due to a change in his medication and that he had been added to the GP list as he had failed to attend his last appointment. There is no evidence that Mr Deavall saw a prison GP or had his physical observations checked between 15 January until the emergency response on 24 January.
33. On 23 January, during an ACCT case review, Mr Deavall said that he was unable to get up out of bed, that he had an ongoing headache and that he felt dizzy when he sat up. A mental health nurse who attended the review recorded in Mr Deavall's medical record that she had asked the wing manager to contact the duty nurse to ask them if they were aware of his health issues and to review Mr Deavall. She also noted that he was due to have blood tests later in the day. There is an entry which recorded that Mr Deavall refused to attend for these blood tests and for his weight and blood pressure monitoring. There is no evidence that a wheelchair was considered to take Mr Deavall to his appointment and no record of why he refused to attend the appointment.
34. Between 7 and 24 January, Mr Deavall made two calls to his son, totalling around 24 minutes. The investigator listened to these calls, during which Mr Deavall told his son that he felt unwell and weak. (All prisoners' telephone calls, except those that are legally privileged, are recorded, and prison staff listen to a random sample.)

Events of 24 January

35. CCTV shows that a group of prisoners on E Wing (including Mr Deavall and his cellmate) were unlocked at around 7.26am for morning association and locked in their cells around an hour later. Mr Deavall did not leave the cell, but his cellmate did.
36. Mr Deavall's cellmate said that at around 10.25am, Mr Deavall got up to use the toilet. He said he was surprised that Mr Deavall made his own way and did not ask for help as he usually did. He said Mr Deavall had been on the toilet for around five minutes when he asked if he was okay, and Mr Deavall 'grunted' in reply. Five minutes later, he said he checked on Mr Deavall but did not get a response. He went over and could see that he was breathing, but not responding. He said he moved Mr Deavall while he was still sat on the toilet to prop him up against the wall, so he did not fall.
37. At 10.52am, Mr Deavall's cellmate pressed the emergency cell bell. (When an emergency bell is pressed, a light comes on outside the cell and there is an audible noise in the wing office; HMPPS policy instructs that staff should respond promptly.)
38. Mr Deavall's cellmate told us that the cell bell was answered by a wing cleaner (another prisoner). He asked him to get a nurse as his cellmate was unwell and the cleaner said he would go to the office to alert staff. CCTV shows one of the cleaners went over to the cell briefly before switching off the cell bell. He returned to

chat with two other prisoners on the wing and, around a minute later, he got up and walked to the wing office, where he spoke to staff for about 30 seconds.

39. Just before 10.56am, a Senior Prison Custodial Officer (SPCO) went to Mr Deavall's cell. She unlocked the door, looked into the cell, and let Mr Deavall's cellmate out. The SPCO said Mr Deavall was sat on the toilet and was unresponsive. She did not check for a pulse and said that she radioed a code blue. (Code blue is medical emergency code used to indicate that a prisoner is unconscious or having breathing difficulties. The control room does not have a record of the SPCO's first radio call.) The SPCO said that she did not think staff had heard her radio transmission, so she locked the cell door and walked back to the wing office to get assistance. Around a minute later she returned to the cell and went in with a Prison Custody Officer (PCO). At 10.57am, the SPCO radioed a code blue, which was logged by the control room. Ambulance records and the prison's communications log show that a request for an emergency ambulance was made at 11.02am, five minutes later.
40. At 10.58am, healthcare staff arrived at Mr Deavall's cell carrying emergency medical equipment. Staff moved Mr Deavall to the landing where there was more space and they started cardiopulmonary resuscitation (CPR). A defibrillator was attached to him which indicated there was no shockable rhythm. A GP also responded to the emergency and, at 11.10am, he pronounced that Mr Deavall had died. Paramedics arrived at Forest Bank at 11.07am and reached Mr Deavall just before 11.15am.

Contact with Mr Deavall's family

41. The prison's family liaison officer and her deputy were appointed. They travelled to the home of Mr Deavall's son, who he had listed as his next of kin, to break the news of his death. Mr Deavall's funeral took place on 3 March 2023. The prison contributed to the costs in line with national policy.

Support for prisoners and staff

42. After Mr Deavall's death, the Director debriefed many of the prison and healthcare staff who responded to the emergency to ensure that they had the opportunity to discuss any issues arising, and to offer support. Healthcare held a separate debrief for all healthcare staff who responded.
43. The prison posted notices informing other prisoners of Mr Deavall's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected. A chaplain provided individual support to Mr Deavall's cellmate.

Post-mortem report

44. The post-mortem report concluded that the cause of Mr Deavall's death was ischaemic heart disease.

Findings

Clinical care

45. The clinical reviewer concluded that Mr Deavall received a mixed standard of care which was not wholly equivalent to the healthcare which he could have expected to receive in the community. We do not repeat all the recommendations in the clinical review report, but they should be addressed by the Head of Healthcare.

Assessment of Mr Deavall's physical health

46. When Mr Deavall complained of feeling unwell on 11 January, healthcare staff responded quickly, and he was later assessed in his cell. A GP saw him the next day, reviewed his medication and referred Mr Deavall for further tests. The clinical reviewer concluded the decision to stop one of Mr Deavall's medications, which could have further reduced his blood pressure, was the correct clinical decision.
47. Despite the GP requesting ongoing review of Mr Deavall's clinical observations, blood tests, a chest X-ray and heart monitoring, these did not happen. The GP also noted that Mr Deavall would need to be taken by wheelchair to the healthcare centre for follow up appointments, but there is no evidence this was facilitated. Mr Deavall was noted to have "refused" to attend. It is possible that he was not physically well enough to attend, but no one recorded a reason and the clinical reviewer found that the Head of Healthcare was unable to provide any further explanation. There is also no evidence his non-attendance was followed up. Mr Deavall was not examined or assessed by healthcare staff after 15 January.
48. During his ACCT review on 23 January, a mental health nurse noted that Mr Deavall was "unable to get up out of bed ... states he has an ongoing headache and when he sits up, he feels dizzy". The mental health nurse asked the chair of the ACCT review to contact the duty primary care nurse to review him, but there is no evidence this happened. We would have expected the mental health nurse to have contacted the duty nurse herself, as the issue related to healthcare, rather than expect prison staff to do this.
49. We found that the healthcare Mr Deavall received at Forest Bank was disjointed and requests were not followed up, which resulted in him having no contact with healthcare staff specifically about his physical health in the eight days before he died. We make the following recommendation:

The Head of Healthcare should ensure that there are robust communication and administrative processes to handover prisoner healthcare information and ensure that all clinical requests are completed in a timely manner.

Emergency response

50. PSI 03/2013, *Medical Emergency Response Codes*, requires all prisons to have a medical emergency response code protocol in place, the purpose of which is to ensure a timely, appropriate, and effective response to medical emergencies. When a medical emergency is discovered, staff should call the appropriate medical emergency code straightaway so that relevant staff, including healthcare staff, are alerted, the correct equipment is brought, and an ambulance is called immediately.

Ambulance delays

51. When the emergency code was radioed, the control room did not immediately request an ambulance (there was a delay of around five minutes), something we have identified in a previous investigation. Forest Bank responded to our previous recommendation and issued a Directors Instruction which included that it was a mandatory requirement for the communication room to call an ambulance immediately to attend the establishment as soon as a code is called. This has clearly not been sufficient, and the prison need to do more to ensure staff are aware of their responsibilities.
52. Paramedics noted on the ambulance record that once they had reached Forest Bank, they were delayed reaching Mr Deavall due to “security procedures at the prison”. The first ambulance arrived 11.07am, but did not arrive on E Wing until around six minutes later.
53. Director’s Instruction No.10 (dated March 2022) says that the Gatehouse should “prepare to receive the ambulance”. It does not provide any further detail of what this entails. While we appreciate that Forest Bank is a large site and several security gates need to be accessed, any delays can be crucial.
54. We recommend that:

The Director and Head of Healthcare should ensure that:

- **control room staff call for an ambulance immediately when a medical emergency code is called; and**
- **staff facilitate the access of ambulances and paramedics through the prison gate to ensure there are no unnecessary delays.**

Director and Head of Healthcare to note***Resuscitation***

55. A nurse said that when she arrived at his cell, Mr Deavall was still sat on the toilet, and she asked for him to be moved out of the cell onto the landing so there was more room to start resuscitation. The nurse said officers seemed unsure about what to do and so CPR was not started until she and her colleagues arrived, a delay of around one minute. When the SPCO entered Mr Deavall’s cell, she said she was unsure whether he had a pulse but did not check. She said Mr Deavall was very heavy and would have been difficult to move on her own. She said she did not feel confident enough to start CPR and believed that Mr Deavall was dead. An officer who assisted with moving Mr Deavall to the landing said he did not check for a pulse or start CPR but did not think Mr Deavall was dead.

Any delay did could be critical in future emergencies and it is important that staff are aware of their responsibilities.

Administered medication during resuscitation

56. The clinical reviewer found that once resuscitation had started, it was well coordinated by healthcare staff. However, an emergency response nurse administered 300mcg of adrenalin, via an EpiPen (usually used for an allergy response), into Mr Deavall’s thigh (intramuscular). While this medication would have

caused no adverse effect, adrenaline was administered inappropriately. The nurse was also not up to date with Immediate Life Support (ILS) training, which should have been completed before she was assigned the role of emergency response nurse.

57. The emergency response nurse was suspended by Sodexo Healthcare on 19 March 2023, pending an investigation. She resigned from her post on 23 March.

Body Worn Video Cameras

58. PSI 04/2017, Body Worn Video Cameras (BWVC), requires prison staff to use BWVCs during any reportable incident, including medical emergencies. It requires staff to start recording at the earliest opportunity, to maximise the material captured by the camera. BWVC's are an important source of evidence for PPO investigations, and wider learning for prisons following an incident.
59. Body worn video cameras were not activated when Mr Deavall was discovered unresponsive. We recognise that during an emergency event staff might forget to switch on their cameras, but someone managing the incident should have reminded staff this was necessary. The Director has since reminded operational staff that BWVC must be activated when responding to an incident.

Updating the ambulance service

60. A second ambulance arrived at Forest Bank around nine minutes after Mr Deavall had been declared dead. We found no evidence that anyone considered updating the control room with the change in Mr Deavall's status so they could inform the ambulance service. Given the pressure on ambulance service resources it is important staff consider updating the ambulance service.

Response to cell bells

61. When Mr Deavall's cellmate used the emergency cell bell to alert staff that he was unwell, a prisoner switched off the bell from outside of the cell.

Inquest

62. The inquest into Mr Deavall's death concluded in September 2024, and that he died due to ischaemic heart disease. The inquest found that Mr Deavall died because of a naturally occurring cardiac arrest. There was an admitted failure to arrange for him to be sent to hospital between 20 and 24 January for assessment however, on the balance of probabilities, this did not cause or contribute to his death.

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