Investigation into the circumstances surrounding the death of a man at outside hospital in July 2010, while in the custody of HMP Forest Bank

Report by the Prisons and Probation Ombudsman for England and Wales

June 2011

This is the report of an investigation into the death of a prisoner at HMP Forest Bank. The man died in July 2010 at outside hospital. I offer my sincere sympathy and condolences to the man's family and all those affected by his loss.

The man was sentenced to two years imprisonment at a crown court on 8 January 2010. He was taken to Forest Bank and, following a reception healthscreen, was immediately admitted to the healthcare ward. He had several serious health problems including diabetes, prostate cancer, heart disease and kidney failure, for which he was prescribed a number of medicines. The man was physically frail and largely confined to a wheelchair, although he could walk short distances with the help of a Zimmer frame.

The investigation was carried out by two of my investigators. An independent review of the man's medical care in custody was carried out by a clinical reviewer on behalf of Salford Primary Care Trust. I am most grateful to him for his assistance.

I would also like to thank the Director and staff of Forest Bank for their full and ready co-operation during the course of the investigation. I am especially obliged to one particular prison liaison for her help liaising with my investigators.

The man was found to be unresponsive in his bed in the morning of his death. Staff attempted resuscitation and he was immediately taken to hospital by ambulance. His death was pronounced just over an hour later. At the time of writing, I have not had sight of the post mortem examination but I am aware that a preliminary cause of death has been recorded as natural causes which could have been due to a number of the man's illnesses.

Both the clinical reviewer and my investigator have concluded that the man received a high level of care, which was comparable to that which he would have received in the community.

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 **June 2011**

CONTENTS

SUMMARY

Having been sentenced to two years imprisonment on 8 January 2010, for offences he had committed in the 1960s, the man was taken to Forest Bank. Once assessed by a nurse, he was immediately admitted to a ward in the healthcare centre due to his serious medical conditions and age. He remained as an inpatient throughout his time at the prison, aside from a period of a few days when he was moved to a residential wing.

The man had been diagnosed with prostate cancer, oedema, angina, diabetes, heart disease and chronic kidney failure among other conditions. He was prescribed a number of medications and was already physically very frail when he arrived at the prison. He was able to walk only short distances with the assistance of a Zimmer frame.

Throughout his time at Forest Bank, the man's wife visited him regularly and he also had regular contact with his personal officer. He had frequent appointments at outside hospital and his diabetes was treated by a specialist nurse in the prison. The man was also monitored every day as his mental health deteriorated due to frequent urinary infections. He was often confused, believing himself to be in hospital and his wife to be in the building.

Due to urinary retention, the man had a catheter and he sometimes needed the help of nurses. Prison staff also helped him with some of his daily living tasks. His physical illnesses also meant he was at risk of falling, which he did with increasing frequency. As a result, in June, he was moved from a single cell to a four bedded ward where he had more space to move around.

The man was admitted to outside hospital on 18 June, as an emergency, after falling over. Prison staff asked the rapid response team to assess the man to determine what equipment he needed in the prison to assist him. He returned to the prison four days later after a toilet frame had been installed in healthcare. The rapid response team assessed him again on 28 June and more equipment was obtained to make him comfortable.

In the morning of the eve of the man's death, he was found to be unresponsive on his bed. Staff immediately telephoned an ambulance and paramedics arrived a short time later. They treated the man with glucose as they thought he had suffered a hypoglycaemic episode (related to his diabetes). Following further medical checks, he was considered fit enough to remain in the prison.

The following morning the man was again found by staff to be unresponsive. He had stopped breathing and staff tried to resuscitate him. Their efforts continued following his transfer to hospital in an ambulance but at 7.19am a doctor confirmed his death. A debrief was held at the prison and the prison care team offered support to staff.

Both my investigator and the clinical reviewer conclude that the man received a level of care comparable to what he would have received in the community. Staff made good use of the resources they had and were very considerate of the man's comfort and health. Although the man's wife was satisfied overall with the way she was

treated, she asked why there was no one from the prison at the hospital to meet her after her husband's death. I believe this could have been handled more sensitively and discuss this in the report. However, I make no formal recommendations.

THE INVESTIGATION PROCESS

1. The investigation was opened on 13 July 2010, when the investigator issued notices to staff and prisoners. The notices announced the investigation and included an invitation to those who wished to submit information related to the man's death to make themselves known to the investigator. No one came forward as a result.

2. The investigator was given access to the man's prison files, including the medical record. She visited Forest Bank with another investigator on 10 August and interviewed one member of staff.

3. An independent clinical review of the man's health needs whilst he was in custody was carried out by a clinical reviewer on behalf of Salford Primary Care Trust.

4. One of my family liaison officers wrote to the man's wife on 21 July to advise her of the investigation and invite her to raise any matters she wished to be addressed. On 26 August, both my family liaison officer and my investigator visited the man's wife. She said that she had generally been treated very well by the prison but she had three main concerns. She firstly wanted to know why her husband was handcuffed when he was at the outside hospital. Secondly, she asked why no one from the prison had waited for her arrival at the hospital following his death, so she could better understand what had happened that morning. Lastly, she wanted to know whether he had been given the correct anti-cholesterol medication. This was because she was aware that hypercholesterolaemia (high levels of cholesterol in the blood) was listed on the preliminary post mortem report.

5. The man's wife received a copy of the draft report as part of the consultation process. I hope that the findings of my investigation address the initial issues she raised and helps her to better understand the circumstances of her husband's death. His wife also made a number of observations after reading the draft report to which I have responded by letter.

HMP FOREST BANK

6. HMP Forest Bank accepts remand and sentenced adults and remand young offenders from courts in North-West England. It is a category B prison. On arrival into prison, prisoners are risk assessed and given a category based on their offence and the risk that they pose to the public should they escape. Category B prisoners are those for whom the highest security conditions are not necessary but for whom escape must be made very difficult.

7. Forest Bank has an operating capacity of 1,424. It is privately run and has been contracted to a private company, Kalyx, for 25 years. Forest Bank Healthcare has a 20 bed in-patient facility, including two 4 bed wards and a 2 bed observation room. There is 24 hour nursing care and the general practitioner (GP) service is provided by a local agency.

8. HM Chief Inspector of Prisons conducted an unannounced full inspection of Forest Bank in September 2007. An unannounced full follow up inspection took place between 29 June to 9 July 2010, in which the inspectorate found that the standard of healthcare had improved since the previous inspection and concluded, “Forest Bank is a good local prison and a number of improvements were evident since our last inspection.”

9. An IMB is appointed to each prison by the Secretary of State for Justice. Its members are independent of the National Offender Management Service (NOMS) and the prison’s management team. Each IMB is required to produce an annual report to the Secretary of State, highlighting good practice and areas of concern.

10. Forest Bank’s latest IMB report covers the period December 2008 to December 2009. The Board commented that it had been ten years since Forest Bank first opened and they were impressed by the commitment of staff to running a safe prison which reduced re-offending. However, they also considered that there were problems with healthcare, particularly with appointments to see the doctor, medication and prescriptions. They noted, however, that waiting for routine appointments to see the GP had been reduced.

11. NOMS is responsible for the management of prisons in England and Wales. Every three months it publishes an assessment of each prison’s performance against 34 measures. Prisons gain a rating of between one (serious concerns) and four (exceptional performance). Forest Bank has scored three (good performance) for the last four quarters.

12. The man’s death was the seventh to have occurred at Forest Bank since April 2004, when my office began investigating all deaths in prison custody in England and Wales. Two of the previous deaths were due to natural causes, two were self-inflicted, one was due to a drug overdose and one was a result of injuries inflicted during an assault. There are no significant similarities between these deaths and that of this man.

KEY EVENTS

13. Having left school at the age of 14, the man joined the Territorial Army and later served in the army during the Second World War. Once he returned from active service in 1945, he became an apprentice joiner and continued working in this profession until his mid-seventies. He married his wife when he was 28 years old and had three children, one of whom died at the age of 33. Prior to his imprisonment, he had been retired for a number of years and had regular contact with his two surviving children and five grandchildren.

14. On 8 January 2010, the man was sentenced to two years imprisonment at a crown court for offences which he had committed in the 1960s. He had no previous convictions and had therefore never been in prison before. He was taken to HMP Forest Bank and arrived at 7.30pm that evening.

15. Following a routine reception healthscreen with a nurse, the man was immediately admitted to ward three in healthcare because of his age and physical condition. The nurse also referred him to a doctor the following day for a more detailed assessment.

16. The man had several serious medical conditions. They included type two diabetes (a metabolic disorder characterised by high blood glucose), oedema (fluid retention) in both legs, prostate cancer, ischaemic heart disease (reduced blood supply to the heart muscle) with angina (chest pain), chronic kidney failure, an abdominal aortic aneurism (swelling of the aorta) and pancytopenia (reduction in red and white blood cells). As a result he was physically very frail and mainly confined to a wheelchair.

17. Having been assessed by the doctor, the man was prescribed aspirin (an analgesic and anti-inflammatory), atorvastatin (to lower blood cholesterol), isosorbide mononitrate (to treat angina by lowering blood pressure), nicorandil (also to treat angina), omeprazole (to block the production of stomach acid), glycoside (to treat heart failure) and ferrous sulphate (an iron supplement).

18. Throughout his time at Forest Bank, the man received regular visits from his wife. At her request, she was allowed to visit him three times a week for an hour, rather than weekly for three hours as was usually the case. (I judge that this was a kind arrangement which was sympathetic to the couple's age.)

19. A Prison Custody Officer (PCO) who worked in healthcare was the man's personal officer. (The personal officer scheme was introduced so that prisoners are given a named officer that they can approach for advice or assistance.) He met the man regularly to discuss any concerns. On 17 February, he noted that the man's mental health had deteriorated due to a urine infection and he had been having visual and auditory hallucinations. The man sometimes believed that he was in hospital and his wife was there. Healthcare staff continued to monitor his condition daily.

20. On 19 February, the man moved from the healthcare centre to G1 wing to create some space for another prisoner. However, he returned two days later as he was not considered fit enough to remain on a normal residential wing.

21. At the request of the criminal appeal office, a consultant psychiatrist assessed the man on 8 March. He noted that he was suffering from:

> "Myelodysplasia resulting in anaemia and thrombocytopenia (meaning that he has low haemoglobin causing fatigue and an increase risk of bruising). Myelodysplasia is a pre-leukaemic condition of the bone marrow. He has carcinoma of the prostate gland causing urinary retention, for which he self-catheterises. He suffers from type 2 diabetes mellitus which is controlled through medication and diet. He has a 6cm aortic aneurism and generalised osteoarthritis affecting his back, hands and lower limbs. He also suffers from hypercholesterolemia."

The doctor concluded that these multiple physical health problems resulted in him being physically frail and at risk of falling. He also assessed him as "globally cognitively impaired, suggestive of a dementing illness of moderate severity".

22. On 31 March, the man's appeal against his conviction was dismissed. Staff spent some time explaining this to him to ensure that he understood the implications of the verdict and how long he had left to serve at the prison.

23. A healthcare report completed by a registered mental nurse (RMN) summarised the man's healthcare at the prison. His diabetes was being monitored by a healthcare specialist diabetic nurse. His oedema made it difficult for him to walk, although he managed short distances with the aid of a Zimmer frame. He had regular appointments with the psychogeriatrician (a psychiatrist specialising in the treatment of elderly people) at outside hospital. Due to urinary retention, the man had a catheter to allow for the withdrawal of urine from his bladder and sometimes needed the help of nurses. Prison staff also helped him with some of his daily living tasks.

24. The man's mental state was compromised by frequent urinary tract infections. He also fell over on a number of occasions due to his ill health. He had occupied a single cell which allowed him to move about by holding on to furniture. However, this also meant that he often tripped over due to the lack of space. Therefore, in mid-June, healthcare staff decided to move him to a four bedded ward to allow him more room to move around. He did not share the ward with any other prisoners.

25. Regular safety assessments and care plans were completed and documented in the medical record. For example, by June, this included encouraging the man to get out of bed in the morning to encourage him to dress, wash and take care of his catheter. Daily observations of his oedema and wound healing were also made at the same time by healthcare staff. The man was encouraged to move around the healthcare centre to promote his flexibility

and balance, help with fluid management and improve his confidence and motor skills. He was also supported to undress himself at night when further healthcare observations were made.

26. On 18 June, at around 9.00am, the man was admitted to outside hospital as an emergency. He had fallen over in the prison, could not stand up and appeared confused and drowsy. Prison staff were concerned that he should not be discharged from hospital unless he was able to walk independently. They asked the rapid response team to assess the man and recommend equipment to assist him in prison. As a result, he returned to the prison four days later, once a toilet frame had been installed in the healthcare centre. The discharge medication no longer included atorvastatin, which had been used to treat his high cholesterol levels. The decision to withdraw this medication is discussed later in the report.

27. On 28 June, the rapid response team made another assessment of the man at the prison and ordered a pressure sore mattress, cushion and shoes to assist in making him more comfortable.

28. In a healthcare update report, the registered mental nurse (RMN) wrote that the outside hospital's physiotherapy department had recently carried out a full needs analysis regarding the man's ongoing treatment needs. The report concluded that generally he could undertake daily living tasks on his own and could walk with limited assistance. A specialist elderly care nurse completed a more comprehensive assessment at the prison including updating the Waterlow assessment (to assist care and prevent bed sores and ulcers).

29. Healthcare staff tried to transfer the man to a specialist elderly unit at HMP Wymott. However, this could not be accommodated as Wymott did not have 24 hour nursing care.

30. On the eve of the man's death, at around 8.00am, healthcare staff noticed that the man was unresponsive in his bed, with drooping on the left side of his face. They immediately telephoned an ambulance. Paramedics arrived a short time later and assessed that he had suffered a hypoglycaemic episode (related to his diabetes) and therefore treated him with glucose so that his condition improved. They also carried out an electrocardiogram to measure electrical activity in the heart) and once the man was stabilised, paramedics decided that he did not need to go to hospital. Staff decided to monitor his food and drink intake to determine the reason for the recent hypoglycaemic episodes, since this had not been the first one, although it was the most serious.

The day of the man's death

31. The man's personal officer began his shift at 8.00pm on the eve of the man's death. Since he was aware of the man's medical difficulties, he checked him every hour throughout the night until 5.15am. A prison custody officer began his shift at 6.00am on the day of the man's death. During a handover between the two officers, the prison custody officer that had just begun his

shift noticed that the man's side bed rail was not correctly adjusted. When the officers went to investigate further they found that the man did not respond and the prison custody officer who had just began his shift immediately called a registered mental nurse (RMN) to him. The nurse could not detect a pulse and the prison custody officer therefore called a "code yellow two" over the radio, which meant that a prisoner was unresponsive.

32. Whilst the mental health nurse went to get the resuscitation bag and defibrillator, a further nurse also arrived at the ward, collecting the emergency bag on her way. (A defibrillator is a portable electronic device which measures electrical activity in the body and advises on the action to be taken.) The nurses attached the defibrillator to the man which advised that no shock should be given. They immediately began cardiopulmonary resuscitation (CPR). Other staff, including the night orderly officer and his assistant, who were carrying radios Oscar One and Oscar Two, respectively, also arrived in the ward. (The night orderly officer is in charge of the prison at night and Oscar One and Two are the emergency response radios). At 6.13, Oscar One used his radio to ask for an ambulance and the communications department did so immediately. Further nursing staff attended. They continued CPR on the man in rotation, so that no one became tired.

33. The paramedics arrived at 6.27am and continued CPR. The man was taken by ambulance to outside hospital Accident and Emergency Department. Following a routine risk assessment, he was escorted by two officers, without any handcuffs.

34. The person in the prison who was carrying radio Victor One (which meant he had managerial responsibility for dealing with any emergencies), arrived in the command suite by 7.00am. Having been made aware of the man's condition, he telephoned the Prison Chaplain at home and asked him to go to the hospital. Victor One told my investigator that he chose this chaplain as the family liaison officer (FLO) as he was an experienced member of staff. He was also the chaplaincy manager and had recent contact with the man and his wife.

35. Hospital staff continued CPR until 7.19am, when a doctor pronounced the man's death. The Prison Chaplain arrived at 7.35am. He went to see the man's body, collected his personal belongings and then returned to the prison with the two escort officers. On his arrival back in the prison, he telephoned the man's wife. He told her of her husband's death and advised her to take a taxi to the hospital. She did so and was met by the police. The Director wrote a letter of condolence to the man's wife later that day.

36. A debrief was held and the prison care team attended the healthcare department and spoke to all the staff involved.

ISSUES

Clinical care

37. The clinical reviewer concludes the following regarding the man's clinical care:

> "It appeared to be obvious from admission that [the man] had on-going serious health concerns. During his stay at Forest Bank, [the man] had been seen extensively by multiple members of the healthcare team on an extremely regular basis. He had also been seen by specialist clinicians including Haematology, Urology, Diabetes and Psycho-geriatrics from secondary care services.
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> "He had attended on several occasions outside hospital both as an inpatient and as an outpatient to address his multiple health concerns. I note also that staff at Forest Bank had attempted to relocate [the man] to a setting more appropriate to someone with severe health concerns. However, this unfortunately could not be achieved as appropriate local accommodation was not available. It would have been inappropriate to place [the man] further afield as this would have made it very difficult for his wife to visit him.
>
> "I do not have any specific concerns regarding the immediate care prior to death and the attempts at resuscitation … The care that [the man] received was appropriate and would compare extremely favourably with what he would have received in the community."

38. The man's wife asked whether he had been given the correct medication for his high cholesterol levels. Having originally been prescribed atorvastatin when he arrived at the prison, when the man was discharged from outside hospital on 18 June, this medication was withdrawn by hospital specialists. The clinical reviewer concludes that this decision was appropriate since statin medications are linked to pancytopenia, with which the man had also been diagnosed.

39. My investigator concurs with the clinical reviewer's opinion and believes that the man was afforded a good level of care which met his complex health needs whilst at Forest Bank. A great deal of individual attention was given to his health, comfort and welfare whilst at the prison.

Consideration for early release on compassionate grounds (ERCG)

40. Prison Service Order (PSO) 6000 says ERCG may be considered when

> "a prisoner is suffering from a terminal illness and death is likely to occur soon. There are no set time limits, but three months may be considered to be an appropriate period. It is therefore essential to try to obtain a clear medical opinion on the likely life expectancy. The Secretary of State will also need to be satisfied that the risk of re-

offending is past and that there are adequate arrangements for the prisoner's care and treatment outside prison."

41. Although the man had multiple health concerns, he had not been diagnosed with a terminal illness or given a likely life expectancy and therefore ERCG could not be considered.

42. Staff tried to transfer the man to a specialist elderly unit at HMP Wymott, but were unsuccessful since the prison did not have the necessary 24 hour nursing care. The man's wife visited her husband three times a week and it would therefore not have been appropriate to consider a transfer to a prison further away than Wymott. In the circumstances, I conclude that staff met the man's needs as best they could.

Family Liaison

43. The man's wife asked why no one from the prison was at the hospital to meet her, after she had been told of her husband's death over the telephone. She said that she would have appreciated speaking to a member of staff from the prison about what had happened that morning before her husband was admitted to hospital.

44. Victor One appointed the Prison Chaplain as the FLO as he was a Roman Catholic Chaplain and had contact previously with the man and his wife. The Chaplain had not been trained as a FLO and my investigator has not had access to a family liaison decision log. Prison Service Order (PSO) 2700 has supplementary guidance for FLOs. It says:

> "Traditionally Governors have asked a Chaplain to break the news of a death to a family. Chaplains are trained and experienced in bereavement issues and are ideally suited to this task. There is nothing in this guidance to prevent this practice continuing … It would not usually be appropriate for a Chaplain to take on all of the tasks of the Family Liaison Officer set out in this guidance document (returning property, attending the inquest etc) and in drawing up their contingency plans Governors should consider how to make best use of the Chaplaincy team following a death in custody."

45. The PSO goes on to say that a prisoner's next of kin should be informed face to face as soon as possible following their death and that:

> "Using the telephone is too impersonal to use in delivering news of a death to the family and should be used only as a last resort. There may be no one nearby to support the family ... However the news is broken and especially if this is not done face to face by the prison, there should be an early follow up by the prison."

46. Appointing the Prison Chaplain to break the news of her husband's death to his wife seems an appropriate decision in the circumstances. Given the man's ill health, I can also understand that it would have been difficult for the

Prison Chaplain not to explain the circumstances of his call when he telephoned the man's wife. He advised her to take a taxi to the hospital which was good practice. However, given that she was not told of her husband's death in person, it would have been preferable for someone from the prison to meet her at the hospital, to offer support role as well as provide answers to any questions. Furthermore a trained FLO should also have been appointed to assist her, as per the above guidance. However, aside from not being met at the hospital, the man's wife said she had been treated well by the prison and I make no criticism of the Prison Chaplain's contact with her.

47. Although I do not make a formal recommendation in this regard, I suggest that the Director ensures that staff appointed as FLOs are given the relevant training and that appropriate support is offered to a prisoner's next of kin.

CONCLUSION

48. The man went into prison when he was elderly, with a number of serious health concerns, already frail and largely wheelchair bound. He was immediately admitted to the healthcare ward and, aside from brief periods of a few days on a residential wing in the prison and a four day admission to outside hospital, he remained there until he died around six months later.

49. Both the clinical reviewer and my investigator have found that the man received a high level of care, which favourably compares to what he could have expected to receive in the community. My investigation has found several examples of sensitive arrangements being made for the man and his wife, which I hope made their separation at the end of their marriage easier to bear. I trust that the Director of Forest Bank will look sympathetically at the comments of the man's wife about the family liaison and so I do not make any formal recommendations.