Circumstances surrounding the death of a prisoner at HMP/YOI Forest Bank, in November 2005

Report by the Prisons and Probation Ombudsman for England and Wales

September 2006

This is the report of an investigation into the death of a man. The man died, at the age of 52, in November 2005 at HMP/YOI Forest Bank. This is a tragic case, as the clinical review concludes that the man's death was potentially avoidable if he had been given appropriate medical treatment at an early stage.

The man said that he had no next of kin and the prison has been unable to trace any members of the man's family.

An investigator from my office conducted the investigation. I regret the time it has taken to produce this report.

I am grateful for the assistance my investigator received from the staff and management of Forest Bank. I wish to acknowledge too the help of the Greater Manchester Police who carried out their own enquiry into the man's death and shared information. My thanks also go to the Head of Operations from Salford Primary Care Trust, who provided a clinical review.

I make no recommendations of my own in this report, but fully endorse those in the clinical review. These reflect the reviewer's concerns about the quality of medical care, recording of information, staff response to emergency call bells and communication with the local hospital.

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Prisons and Probation Ombudsman
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SUMMARY

This is the report of an investigation into the death of a man. The man was aged 52 when he was found dead, at 7.50am on 4 November 2005, in the Healthcare Centre of HMP/YOI Forest Bank.

The investigator reviewed the man's prison records and spoke informally to both prison staff and prisoners. A review prepared by Salford Primary Care Trust on clinical matters.

The man had been at Forest Bank since 15 September 2005. During that time he underwent investigations into his weight loss and abdominal pain. The first blood tests results taken on 19 September provided sufficient evidence for the doctor to make an urgent referral to hospital. However, his subsequent treatment was subject to a series of unexplained delays.

As his condition was getting worse, the man was moved to the Healthcare Centre on 31 October and located in a four bedded ward, albeit on his own. At 6.15am on 4 November, the man pressed his emergency call bell. Staff looked at the man through the observation window, but as he appeared to them to be alright, they did not enter the ward. At 7.50am, he was found dead on the floor of the bathroom.

The post mortem report gave the cause of death as gastrointestinal haemorrhage due to a gastric ulcer. The clinical review concluded that, given appropriate treatment, the man's death might have been avoided.

This report focuses on the man's time in prison custody and evaluates the systems in place to establish whether they were (and are) fully effective.

INVESTIGATION OUTLINE

1. The investigation into the man's death was led by one of my investigators. He visited the prison and saw the areas where the man had been, including the Healthcare Centre and the wing on which the man had previously been located.

2. He issued a notice to staff and prisoners inviting anyone with information relating to the man's death to make themselves known to the investigator.

3. My investigator also spoke to the Chair of the Independent Monitoring Board (IMB), the Prison Officers' Association (POA), one of the prison chaplains, and various other members of staff, including the Healthcare Manager. My investigator spoke informally to staff and prisoners who knew the man and were involved in the events surrounding his death.

4. The prison gave my investigators full access to all the documentation surrounding the man's time in prison. The police also provided copies of the documents and statements in their possession. My investigators obtained some further information from probation and court services.

5. Salford Primary Care Trust convened a panel to facilitate a clinical audit of the man's care while in prison. The PCT conducted a number of interviews with staff. In cases such as this, interviews are normally conducted jointly. However, these interviews were conducted solely by the PCT, as my investigator was unavailable at the time.

BACKGROUND

HMP/YOI Forest Bank

6. Built on the former Agecroft Power Station in Salford, Forest Bank was opened in January 2000 and is managed by United Kingdom Detention Services (UKDS)[1]. It has a maximum population of 1,064 male adult and young offenders, mostly held in single cells. The population is a mixture of convicted and unconvicted prisoners. There have been two other deaths at Forest Bank since it opened, one of which was self-inflicted.

7. The prison serves the Magistrates' and Crown Courts in the Greater Manchester area. The establishment comprises six house blocks each with identical two-storey wings radiating from a central hub. Each wing is designed to hold up to 65 prisoners (rising to 85 if the jail is overcrowded). Purposeful Activity is provided for approximately 800 prisoners in a variety of industrial workshops, courses, education classes, catering, and other types of employment such as cleaning, gardening and orderlies.

8. In June 2002, Forest Bank underwent a full inspection visit by Her Majesty's Chief Inspector of Prisons. The relevant recommendations (which have subsequently been implemented) of the report of that inspection were that:

   - there should be an overall safer custody strategy, linking reception and induction, detoxification, anti-bullying and health issues in order to deal with all elements of potential vulnerability,

   - detoxification procedures should be in accordance with the relevant Prison Service Order,

   - all prisoners held in the healthcare unit should have care plans.

[1] On 12 October 2006, UKDS changed its company name to Kalyk.

Healthcare Centre

9. The Healthcare Centre provides 24-hour medical and nursing cover and inpatient facilities for up to 25 prisoners. The healthcare team offer a wide range of primary care services.

10. The Primary Healthcare Team are all employees of UKDS and there is a 60/30 split between General and Psychiatric Nurses. There is a full time Locum Medical Officer cover. The doctors at Forest Bank provide a 24 hour medical call service to respond to emergencies.

11. For emergencies, the prison operates a local call system. If emergency medical assistance is required, the member of the healthcare team designated as the emergency response (Hotel 2) attends the emergency, assesses the situation and commences any treatment, before deciding on the next course of action. Hotel Two is available 24 hours a day and is contactable from the communications room, via the UHF radio.

12. Staff detailed to work in the Healthcare Centre at night are not issued with prison security keys. Night staff all carry a sealed pouch, with a cell key in, so access to cells can be made quickly in the event of an emergency. If a door needs to be unlocked for a routine purpose, the Duty Manager is contacted.

13. There is a detoxification facility that provides accommodation for up to 86 prisoners. Of the total accommodation available in the unit, 16 beds are retained for those who require the closest supervision. Healthcare staff work alongside three key workers who are assigned to the unit. A Counselling, Assessment, Referral, Advice and Throughcare service (CARAT's) is also provided for prisoners with substance misuse problems.

14. Links have been established with Salford University to allow postgraduate students to work on the healthcare unit as a placement within their training syllabus. As part of this link, a reciprocal arrangement with regard to training has been implemented.

Progress in Healthcare since the man's death

15. The Healthcare service at HMP Forest Bank has been and continues to be a developing service which is making significant changes and positive contribution to the health and well being of prisoners. The Prison Senior Management Team is fully supportive in driving forward the changes to modernise prison health. There is recognition and renewed philosophy that healthcare is an integral part of prison life and that good healthcare and health promotion can enable individuals to function to their maximum potential on release.

16. An effective and mutually supportive partnership between HMP Forest Bank and Salford PCT is well developed. This collaborative approach encourages the sharing of information and professional expertise. The PCT were invited to participate in the process for recruitment of clinicians to secure an appropriate contract for the provision of Primary Medical Care service to HMP Forest Bank. This process was successful and the service is now provided by a local GP practice that welcomes the challenge and is committed to working with the healthcare team to provide consistent quality care with effective treatment outcomes.

17. An experienced Head of Healthcare has been appointed since the mans death, and has provided the healthcare service with a clinical focus and development plan, which has already provided as improvement in patient care and professional nurse development.

18. A review of the nursing skill mix and work profile has identified training needs and opportunities for development. The revised structure facilitates the management of nurse led clinics where early detection and treatment of ill health will improve patient experience and treatment outcomes. There is a focus on using the opportunity to offer health promotion advice to enable individuals to make informed health choices. Part of the review includes the clinical management and care for those prisoners with substance misuse from the point of reception and throughout custody and release.

19. There is a dedicated inpatient team who are developing structured intervention programmes for the management of patients in the unit. Every inpatient has a nursing care plan and there is a regime for medical ward rounds when every patient is assessed and reviewed by the lead nurse and doctor. There is provision of a Clinical IT System at HMP and an implementation plan has been agreed between HMP Forest Bank and Salford PCT to ‘go live’ in early 2007. This forms part of the Npfit programme which will ensure that prisons have access to appropriate NHS links.

KEY EVENTS

15 September to 3 November 2005

20. On arrival at Forest Bank on 15 September 2005, the man told staff that he had no next of kin. During the reception health screening, the man said that he had abused alcohol for a number of years, but stopped when he began suffering from vomiting and severe stomach pain. Consequently, he had not had an alcoholic drink for four months. Question 11 of the assessment asks the assessor to record their impression of the prisoner's behaviour and mental state. This section of the form was not completed.

21. The man then completed the first night induction, where his immediate needs were discussed, including an explanation of how to access the Listeners (prisoners trained to offer support to others) and Samaritans. There is and was no personal officer scheme in operation at Forest Bank, so the man was told to contact the nearest member of staff should he have a problem. He was then located in E-wing.

22. On 16 September, the man was seen during morning surgery by a doctor, a locum medical officer. The doctor noted that the man had a history of abdominal pain, was vomiting blood once or twice a day and lost weight, but had a regular bowel habit. The physical examination at this time revealed an enlarged liver. The man weighed 56 kilograms. The doctor ordered blood tests, and said that the man would require an upper gastrointestinal tract endoscopy. The doctor said that he would review the man the following week. The blood tests were taken on 19 September and returned to the prison the following day.

23. Another locum medical officer, reviewed the bloods results on 1 October. They showed that the man was anaemic. This was eleven days after the receipt of the results and I have been unable to establish a reason for the delay.

24. The man eventually saw the locum medical officer on 10 October. This was nine days after the results had been assessed by him. Again, I have been unable to establish a reason for this delay. The doctor described the man as being very thin, and with an enlarged liver. The doctor prescribed Ferrous Sulphate and referred the man to the Gastroenterology Department at Hope Hospital.

25. On 31 October, a Prison Custody Officer (PCO) referred the man to the community mental health in-reach team. The PCO's referral said that the man had lost a significant amount of weight, which was thought to be due to his physical problems. The PCO said that the man appeared to be responding to hallucinations, grinning and his behaviour was described as bizarre.

26. The deputy team leader of the community mental health in-reach team assessed the man's mental health on 1 November. Her impression was that the man was paranoid, that he was suffering from a psychotic illness and lacked insight. The man was admitted to the Healthcare Centre and located in a four-bed ward, although he was the only patient there.

27. On 3 November, an RMN noted that the man's weight had fallen to 54 kilograms. She wrote in the clinical record that she would discuss with the doctor whether fortified drinks should be prescribed to the man.

28. At about 7.45pm, a prisoner orderly served hot water to prisoners in the Healthcare Centre. He said that the man was acting as normal, going about his regular routine and appearing to be fine.

29. At about 8.00pm on 3 November, a nurse and PCO commenced night duty. They received a verbal handover from the day staff, counted the prisoners and relieved the day staff. No specific information about the man was passed on to the night staff.

30. This was the first night that the PCO had worked in the Healthcare Centre. The Nurse was the Hotel 2, emergency response. Both staff said that the man was alone in Ward One, sitting in a bedside chair watching television. At 10.00pm, the PCO conducted a further roll count and the man was still watching television in the chair. At midnight, the PCO noticed that the man was by then in bed, apparently asleep.

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31. At 5.00am, the PCO conducted another roll count and the man was still in bed. At 6.00am, the PCO noticed that the man had sat up in bed.

32. At 6.15am, a nurse reported for day duty and began to receive a handover from the night nurse, including the role of Hotel 2. At this time, the man pressed the emergency call button, which was on the wall next to his bed. The PCO was not sure how to identify the correct ward on the activation system, so called for the nurses to assist him.

33. They went to the ward and could clearly see the man. He was lying on his side and raised his head and made eye contact with the day nurse, but did not give her the impression that he wanted to attract her attention. The staff did not consider that there was anything to be concerned about, and went about their duties.

34. The night nurse went home shortly afterwards, as she had been replaced by the day nurse. A day PCO arrived for duty in the Healthcare Centre, at 6.30am and, after a handover, the night PCO went home. The man's health was not discussed at the handover meeting.

35. The prisoner orderly was unlocked at 6.30am to help serve breakfast to prisoners. Shortly after 7.00am, he placed a tray of breakfast on the flap of the inspection hatch of Ward One. He placed the meal on the flap, as he could not see the man in the ward, and assumed he was in the toilet.

36. After completing the deliveries, the prisoner orderly returned to the man's ward to offer him some toast. He found that the breakfast had not moved, he thought it unusual, so looked further into the ward. He noticed that the man was lying on the floor in the toilet, not moving. The orderly immediately shouted for the day PCO who entered the ward.

37. The PCO saw that the man was ashen in colour, lying on his back, with congealed blood around his mouth and on the floor. He was in a position which looked as though he had rolled sideways on to his back, after being hunched over the toilet bowl. It appeared as if he was supporting himself with his arms hooked over the edge of the bowl. The PCO used his radio to alert other staff that there was a "Code Yellow 2" in the ward. (This told staff that there was an emergency and that a prisoner was unconscious.) The emergency response was immediate. However, as it was obvious to the medical professionals who attended that the man had died, resuscitation was not attempted.

38. Despite determined efforts, including searching the records of other agencies and advertising in local and national newspapers, the prison has been unable to identify any of the man's family or friends.

FINDINGS AND CONCLUSIONS

39. The man had a history of alcohol abuse. He had stopped drinking alcohol for four months, as he was being treated by his GP for stomach pains and vomiting. However, the pains and vomiting had not stopped when the man was taken to Forest Bank.

40. Following a mental health assessment, the man was located in the Healthcare Centre. It is surprising that he was not admitted to the Healthcare Centre at an earlier stage for his physical condition, which had caused concern from the day of his reception into prison.

Clinical Review

41. The Operations Manager of the Salford PCT, co-ordinated the clinical review. In order to examine relevant health issues and assess the clinical care, the Salford Primary Care Trust serious untoward incident policy was followed. The Operations Manager and the PCT Clinical Lead reviewed the documentation and carried out interviews with the healthcare managers. The clinical review is based on this and evidence gained from interviewing nursing staff, prison custody staff and the GPs involved.

42. The clinical reviewer was asked to specifically comment on the timeliness of the prison in referring the man and the attempts to gather information from the man's doctor. The reviewers were also asked to assess the appropriateness of the staff failing to enter the ward on the morning of the man's death when he pressed his emergency call bell. On initial assessment of the case, it appeared to the investigator that staff might have been working on the assumption that the man's problems were related to his history of alcohol abuse, and the reviewer was asked to establish whether this lessened the interventions that were offered.

43. When asked, the locum medical officer was not aware of the National "Standard '2 week wait' referral for suspected cancer". It is clearly evident that earlier intervention could have prevented this man's death from this condition. It is unclear if the processes were in place for cancer 2-week wait referrals at HMP Forest Bank. This not withstanding locum medical officer showed a clear lack of knowledge of a widely well-publicised system and guidelines that have been in place for a number of years. This deficiency and other issues that became evident during the interview raises concerns around his overall performance as a clinician and a doctor at the PCT is of the opinion that at this point the Primary Care Trust on whose performers list locum medical officer appears, should be informed, for them to assess his skills and competencies and if necessary take any further action following this assessment.

44. The investigation team has discovered from the locum agency that locum medical officer was working within HMP Forest Bank between 1 and 10 October and could have viewed the man's records with the blood results in that time.

Clinical Care

45. The clinical review concluded that the reception screening offered to the man was insufficient and there were gaps in the documentation especially Question 11. This is unfortunate, as it would have provided a benchmark for future assessments.

46. The man was seen during morning surgery on 16 September, but there was a three day delay between the ordering of the blood tests to their drawing and submission to hospital on 19 September. The clinical reviewer has discovered that there was enough time to have the blood tests drawn and sent to the laboratory at the hospital on the same day they were ordered. This time delay is unexplained.

47. The first blood test results were returned to Forest Bank within 24 hours of reporting, as is normal procedure within pathology at the hospital. However, the man's medical record shows no evidence of:

    - the date the results were received at Forest Bank,
    - the results being brought to the attention of the GP,
    - an appointment being made for the man to be notified of these results.

48. There are two further unexplained time lapses. The first was for 11 days between the blood test results being received at the prison and the doctor reviewing them. The second delay of nine days was between the doctor reviewing the blood test results and seeing the man. Both these delays are unexplained and are unacceptable.

49. The first blood results, combined with the patient history of weight loss, abdominal pain, haematemesis and hepatomegaly, indicates that there was sufficient evidence for the GP to make an urgent referral to the hospital.

50. The referrals to hospital were made to "departments", rather than named consultants. There is no documented evidence of these referrals being followed up.

The timeliness of referral to the National Health Service

51. In the opinion of Salford PCT's Clinical Lead, the man's symptoms and history of vomiting blood should have resulted in an urgent and immediate referral to the hospital. The man fitted the criteria for the "two week wait" for suspected cancers, as detailed in national guidance. The medical records for the man are sufficiently detailed to

suggest that doctors would have acted in a timely fashion to prevent the man's condition from worsening.

Attempts to gather information from the man's doctor

52. No attempt was made by Forest Bank to gather information from the man's own doctor, as he denied having one. However, the Salford PCT investigator, identified the man's doctor using the National Tracking database. The prison would benefit from having a link to the database, to allow them to trace doctors, when this information is not available from a prisoner.

Emergency Call Bell

53. On the morning of his death, the man pressed his emergency call bell. Staff checked him through the window of the ward, but as he responded by raising his head they did not check him more closely. My investigator asked the clinical reviewer to comment on the appropriateness of this.

54. The alert light accompanying the bell illuminates by every bed within the ward. Lockers or chairs beside the beds obscure these lights in two of the four beds in the Ward One. There was a slight delay in the response to the emergency bell, as the PCO on duty that night had never worked within Healthcare Centre and needed the assistance of other staff to identify who was calling for help.

55. The emergency call bell is activated by patients needing assistance. When staff responded to the man's call for help, he raised his head, but he should have been spoken to in order to ascertain the reason why he called for assistance. The man was the only patient in that ward and with three members of staff present, I see no reason why they did not enter the ward and speak to him.

Medical History

56. When my investigator made an initial assessment of this case, it appeared to him that staff might have been working on the assumption that the man's problems were related to his history of alcohol abuse. During the PCT interview process, all staff denied being influenced by this assumption. Following the investigation, I am happy that the man's history of alcohol abuse did not lessen the interventions that were offered to him.

Analysis of the Post Mortem Report

57. The post mortem report concluded that the man died from gastrointestinal haemorrhage, due to a gastric ulcer.

58. The report recommended that a doctor with post graduate experience in primary care should comment as the pathologist expressed concerns that, despite a clear history of vomiting blood, and confirmation of significant anaemia, the man was not referred for urgent investigation of his upper gastrointestinal tract. The clinical reviewer asked a doctor from the PCT to comment on this.

59. The doctor from the PCT is of the opinion that sufficient information was available from the initial history and examination of the man to have initiated a referral to a gastroenterology unit urgently. The doctor from the PCT considers that this may not have been done, because of the restrictions of the prison environment and the difficulties the prison system encounters when sending prisoners to hospital.

60. When the blood test results were returned, they revealed a significant degree of anaemia that would have warranted blood transfusion to correct and further urgent investigation. The man was prescribed iron therapy and had further blood tests ordered as a routine. This was a failing on the doctor's behalf to correctly identify the appropriate treatment to manage the patient's clinical condition.

61. The clinical review concludes that the man's death was avoidable, at that time, from a condition that is easily treated, if the correct action had been taken when he was seen by a doctor.

RECOMMENDATIONS

1. I recommend that the Forest Bank management team continues to work with Salford PCT to develop robust, consistent services. Medical professionals need to be assessed and developed to ensure the highest quality of services are available to prisoners.

2. I recommend that computer systems are developed to ensure that the prison has access to appropriate links with the local hospital and wider National Health Service are available.

3. All medical investigations and letters of referral must be logged and documented within the Medical Record, and must provide comprehensive details.

4. The Healthcare Centre managers must ensure that prisoner care plans are up-to-date, and entries in the Medical Record are made contemporaneously. The entries must be concise and legible.

5. I recommend that all staff should be made aware of the different alerts within the Healthcare Centre, when the emergency call bells are activated. All lights associated with the emergency call bells should be visible from the observation windows at all times.

6. I recommend that the Director reminds his staff that, if a prisoner activates the emergency call bell, it is imperative to investigate the reason for that call and not rely on eye contact.

7. I recommend that locum prison doctor is interviewed by the PCT to complete the clinical investigation. Depending upon the outcome of this interview, an assessment and decision needs to be taken locally as to any further action if required regarding locum prison doctor's professional registration.

8. I recommend that the host PCT on whose performer's list locum prison doctor appears, to be informed, for them to assess his skills and competencies and depending upon the outcome of this assessment instigate further action.