Investigation into the circumstances surrounding the death of a man in December 2010, in hospital, while in the custody of HMP & YOI Forest Bank

Report by the Prisons and Probation Ombudsman for England and Wales

July 2011

This is the report of the investigation into the death of a man in hospital in December 2010, while in the custody of HMP & YOI Forest Bank. The man was transferred to hospital as an emergency on 17 December after being taken ill in his cell. He spent two days in the intensive care unit and died at 5.43am on 19 December, with his family at his bedside. The man was 41 years old. I extend my sincere condolences to his wife, family and friends.

Her Majesty's Coroner for Greater Manchester West District undertook a post mortem examination of the man. His death was due to natural causes caused by multi organ failure, neutropaenic sepsis (low white cell blood count that causes infections to the immune system) and an adverse drug reaction to treatment for gout (which I understand was rare and unpredictable).

One of my investigators was appointed to carry out this investigation. A review of the man's healthcare while at Forest Bank was commissioned by Salford Primary Care Trust (PCT). I am grateful to a doctor for carrying out that review which is annexed to my report.

I would like to thank the Director of Forest Bank and his staff for their assistance with this investigation. I am especially grateful to the liaison officer.

I make one recommendation for the attention of the Director. This recommendation is for the immediate training of two family liaison officers. I also note that a prisoner's risk assessment should be reviewed when they are transferred to a hospital's intensive care unit and that entries into wing history sheets are clear and factual.

In this final report, the Director of Forest Bank has accepted my recommendation. Following points raised by solicitors acting on behalf of the man's family paragraphs 27 and 29 have been added to the key events section of this report. A further section has been added to issues section on page 16, in response to those points.

Thea Walton
Acting Deputy Prisons and Probation Ombudsman **July 2011**

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SUMMARY

1. The man arrived at Forest Bank on 7 October 2010. He had arthritis, gout and Crohn's Disease. (Crohn's Disease is an inflammation of the intestine and gout is a severe inflammation of the joints caused through high levels of uric acid in the blood stream.) The man regularly drank large amounts of alcohol, had a family history of heart disease and was overweight.

2. Following an examination by a doctor, the man was prescribed pain relief and blood tests were taken to establish a full blood count. He was seen by a nurse on 20 October, with severe pain in his knee and ankle. The healthcare staff were still waiting for the results of his blood test and the man was advised to continue with his pain relief medication of Diclofenac and Co-codamol in the meantime

3. On 15 November, a doctor undertook a full consultation with the man who told the doctor about his history of gout and arthritis. The doctor noted that the man's foot, knee and low back joints were hot and swollen. He prescribed Allopurinol and Colchicine, to reduce the acid levels in the man's blood.

4. A Prison Custody Officer (PCO) wrote in the wing history sheet, on 17 December, when the evening meal was being served, that the man had not "eaten for four days due to illness and staff to monitor". Around 7.00pm, the PCO visited the man to see how he felt. The PCO found him near to collapse on his bed, with blood in his wash basin, and called for healthcare staff to attend.

5. A nurse and doctor arrived at the man's cell and, following medical observations and an examination, an emergency ambulance was called. The man was escorted to hospital at 7.45pm by three officers and restrained by an escort chain. He was transferred to the intensive care unit (ICU) and placed on a life support machine. Shortly after midnight the following day, the hospital staff advised the officers that his condition was critical and the man's family should be asked to come to his bedside.

6. The man's family arrived at 2.45am and remained with him until he died two days later at 5.43am on 19 December. They did not feel well supported by the prison after the man died and his funeral expenses were not paid until my investigator reminded the prison of their obligation. In March 2011, one of my family liaison officers was told by the man's wife that the expenses had still not been paid, which caused further distress to his family. This was immediately rectified by the prison when my investigator made contact with them again.

7. I make one recommendation for the attention of the Director for the immediate training of two family liaison officers. I make two housekeeping points, firstly for risk assessments when a prisoner is admitted to a hospital intensive care unit. Secondly, that entries into wing history sheets are clear and factual.

THE INVESTIGATION PROCESS

8. The investigation into the man's death was opened on 4 January 2011, when my investigator visited Forest Bank. She was met by the liaison officer and spoke to the Director. My investigator reviewed the man's prison file to select documents to be forwarded to her . Later, she visited house block two and spoke informally to a Prison Custody Officer (PCO) who had known the man and been his personal officer. (A prisoner is allocated a personal officer who is able to directly support the prisoner through regular face to face contact.)

9. Notices of this investigation and terms of reference had been sent to the prison in advance of my investigator's visit but, to date, there has been no response. Members of the Independent Monitoring Board (IMB) did not ask to meet with my investigator and her contact details were made available. (The IMB are volunteers drawn from the community who monitor the day to day life of the prison, its staff and prisoners.)

10. On 5 January, my investigator spoke to a PCO by telephone. She asked him to send her a statement outlining his contact with the man on 17 December.

11. One of my family liaison officers (FLO) spoke to the man's wife. She did not have any specific points to raise in relation to the investigation. However, she said she wanted to know about the events that led up to his admission to hospital and the time taken to inform her of her husband's illness. She asked about her husband's health before he was taken to hospital and about the delay before she was told that he had been admitted. The 'Key Events' section of this report includes an account of the circumstances that led to The man being taken to hospital and I trust that her questions are adequately addressed.

12. A clinical review of the man's healthcare was undertaken by a doctor on behalf of Salford PCT. On 17 February 2011, one of my investigators interviewed a PCO at Forest Bank on behalf of my investigator.

13. A feedback letter was sent to the Director on 5 January 2011, reminding him of the prison's obligation to offer funeral expenses to the man's family. On 17 March, my investigator wrote to the Director to inform him that the initial findings of this investigation indicate there were no serious issues, other than the lack of support to the man's family.

14. The report was issued in draft for consultation with the prison, PCT and the man's family. Solicitors acting on behalf of the man's family provided details of a telephone conversation The man had with his mother in December and also letters he wrote to his wife. I have dealt with this new information in the key events section of the report paragraph 27 and 29, and summarised those points on page 15.

HMP & YOI FOREST BANK

15. HMP & YOI Forest Bank is a prison run for the Ministry of Justice by a private contractor, Sodexo Justice Services. It is located in Salford just outside Manchester. The prison has a maximum population of 1,424 men. Instead of a Governor (as would be the case in a public sector prison), the prison is run by a Director. The Ministry of Justice employs a Controller to ensure that the contract is being delivered. Officers are referred to as prison custody officers.

16. Five doctors run the daily surgeries with at least one doctor working in the prison from 9.00am until 9.00pm from Monday to Friday. The doctors service is run by a private provider, Cimarron. At weekends, a doctor runs a surgery from 1.00pm until 5.00pm on Saturdays and from 9.00am until 12.00pm on Sundays. Overnight, one nurse and one healthcare assistant work in the prison. The prison has a 20 bed inpatient unit.

17. Her Majesty's former Inspector of Prisons, carried out a full unannounced inspection of Forest Bank in June 2010. Two extracts from the summary of that report said :

> "Forest Bank is a good local prison and a number of improvements were evident since our last inspection. For a local prison, prisoners spend a good amount of time out of their cells. The quality of education, training, employment and other activities was generally good – work in the kitchens and the employer-led employment initiatives were particularly impressive – but there was simply not enough available. Most prisoners could access an activity place but many were only part time. So although 88% of prisoners could access some form of activity our roll check found about half the prison population locked in their cells during the working day."

The report further noted that "The standard of health care has improved."

18. The Independent Monitoring Board published their recent Annual Report in 2009 and the report executive summary said:

> "This is the tenth anniversary of the opening of Forest Bank and is a significant milestone in the history of the establishment and represents a huge achievement by the staff and management team."

19. This was the third natural cause death to occur at Forest Bank in 2010. Whilst the man's death was not similar to the others, training family liaison officers was raised in the report of the death of a man in July of the same year.

KEY EVENTS

20. The man was an Australian national. He lived with his wife and family in Manchester and was a window cleaner. In October 2010, he was remanded to Forest Bank by a magistrates' court, charged with serious offences. The man had previous convictions and this was his second time in custody.

21. On arrival at Forest Bank, The man was seen in reception by a healthcare assistant (HCA). The HCA noted that his blood pressure was high at 162/94, (an average reading is 130/80), with a pulse rate of 94 beats per minute (bpm), (an average is 60-100bpm). He was overweight at 20 stone and regularly drank large amounts of alcohol, although he was assessed as not alcohol dependent. The man told the nurse that he suffered from Crohns Disease, gout and arthritis. He told the HCA that he did not take any medication other than Diclofenac and Co-codamol for pain relief. The HCA referred the man to see the doctor.

22. A doctor examined the man later that day. The doctor noted the man's gout and arthritis and confirmed the prescription of Diclofenac and Codeine, plus an antibiotic for an ingrown toe nail. Furthermore, the doctor noted the family history of heart problems and that the man's brother had died at 35 years from a heart attack. He arranged for blood tests to be taken.

23. On 12 October, the man's blood sample was taken. Three days later, a doctor reviewed the results and asked for the man's community doctor to be contacted by Forest Bank healthcare unit, to obtain his community medical records. A doctor saw the man on 18 October, and had details of his previous medical history. The doctor noted that the man had gout and arthritis and he was advised to continue with the prescribed pain relief medication. Omeprazole, for excess stomach acid, was not prescribed although the man had been prescribed this medication by his community doctor.

24. A nurse saw the man two days later, when he was complaining of extreme pain in his left knee and ankle. The nurse recorded that the doctor was still waiting for the full results of the man's acid blood levels and he should continue to take his prescribed pain relief in the mean time.

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25. According to his medical notes, the man was sent four doctor's appointment letters between 22 October and 11 November but did not attend any of the appointments. On 12 November, he was sent another letter and finally attended an appointment with a doctor three days later on 15 November.

26. The doctor undertook a comprehensive consultation with the man. He told the doctor he had suffered with gout for many years and, on examination, the doctor found that the man's foot, knee and low back joints were hot and swollen which affected his mobility. The doctor renewed the pain relief prescription and also prescribed Allopurinol and Colchicine to treat the symptoms of gout and to reduce the acidity in his blood respectively.

27. The man wrote three letters to his wife between 6 and 12 December. In the letters he refers to feeling unwell, retaining fluid and said his feet were causing him problems. On 10 December, the man wrote that he had made a request to see the doctor, however, there is nothing noted in his medical record that he had asked for an appointment. Two days later, he wrote that he had bad gout in his elbows and right knee. Furthermore, he said that the bottom of his back "felt like it was on fire", and his throat burned whilst swallowing.

28. On 12 December, the man's personal officer, PCO recorded that he was a quiet prisoner who did not readily associate with other prisoners on the wing or interact with wing staff, preferring to spend time in his cell during association periods. (Association period is the time a prisoner sends out of his cell to mix with other prisoners, make telephone calls and have showers.) He went to classes in the education department in the afternoons.

29. The man's mother received a telephone call from her son at around 7pm on 14 December. He told his mother that he had not eaten for four days because he was ill, and prison staff had told him that if he did not start eating the next day, they would get someone to see him. The wing history sheet did not have any written note for staff to monitor the man's ill health. His mother said her son had to finish the telephone call because he needed to go to the toilet as he had been suffering from vomiting and diarrhoea.

17 December

30. Two Prison Custody Officers (PCO) were on duty in the man's house block on 17 December. At 5.30pm, the prisoners were called to collect their evening meal. When he noticed that the man did not collect his meal, PCO Jones made an entry in the wing history sheet to the effect that the man had "… not eaten for four days due to illness and staff to monitor".

31. At interview one of the PCOs said that whilst he wrote 'four days' in the wing history that he was generalising and could not be certain of the time. The officer said:

> "It's just a sort of, that's just a bit of a reminder to the staff that you know he [The man] may have collected his breakfast the day before because it's not uncommon he hasn't or he may have collected his dinner. But he's obviously started to miss a couple of meals. So to myself who's documented that I just thought staff to monitor just in case that obviously he doesn't collect the following day he don't collect breakfast, dinner or tea then obviously it's a case for me to look at."

32. The officer told my investigator that, when he previously spoke to the man sometime earlier, he explained that he did not always feel like eating and often felt unwell. During interview, the officer was clear that the man was not refusing food, for example as a protest, but was exercising his right not to eat.

He had not told any staff he was unwell during the day until he said that he did not want his evening meal. Furthermore the PCO said;

> "Occasionally he'd say I don't want something tonight but he'd still collect a sandwich so it's different you know. But he'd still eat hot meals but I wouldn't say because obviously we do separate shifts, I wouldn't say that he eats that many hot meals but he would tend to order a sandwich instead."

33. A nurse made a retrospective entry in the man's medical notes at 7.57pm. (Nurses record their clinical contacts on an electronic medical record that can only be accessed from certain terminals in the prison. Therefore their entries are often made some time after their contact with the prisoner.) She said that a wing officer had spoken to her at medication time, which is around the same time that prisoners collect their evening meal. She had been told that the man had not eaten for four days and was becoming "lethargic". The nurse wrote that she would arrange an appointment for him to see the doctor that evening.

34. Around 7.00pm, a PCO visited the man to check how he was, having noted that the man had also not collected his lunch. The PCO went to the cell to see why he was not eating. On entering the cell, the PCO found the man sitting on his bed with his back against the wall. The PCO saw that the man's lips and tongue were dark in colour and there was blood splashes in the sink. The PCO spoke to the man who was disoriented, but able to hold a conversation. The officer left the cell to telephone the healthcare unit to ask the staff to come to see the man.

35. A nurse responded to the request together with a colleague and a doctor. On examination the doctor noted that there was evidence that the man had vomited blood, was confused and may have had a fit. A low blood pressure reading of 117/75, with a high pulse rate of 125 bpm was recorded. The man's abdomen was tender. An emergency ambulance was called.

36. In her medical entry at 7.57pm, the nurse recorded that she remained with the man until the ambulance arrived to continue taking his clinical observations (that is his pulse, blood pressure and breathing). The man became agitated and three PCOs had to ensure that he remained safe as he would not keep his oxygen mask on, which was needed to assist his breathing.

37. The ambulance arrived at 7.45pm and the man was escorted to hospital with three officers. He was restrained by an escort chain and the risk assessment noted that the man was still agitated. (An escort chain is a six foot length of chain with one cuff attached to an officer and the other cuff to the prisoner. A risk assessment is completed when a prisoner is escorted away from the prison to ensure public safety.)

38. Following a medical assessment in the hospital accident and emergency unit, the hospital staff advised the officers that the man's family should be contacted and allowed to remain at his bedside as his condition was serious. At 10.25pm, the officers telephoned the prison night orderly officer at Forest

Bank to ask for the man's family to be informed. The night orderly officer spoke to the bed watch officers at 11.15pm, to tell them that the man's wife had been contacted and they should expect her to visit. The escort chain was removed and the man was transferred to the intensive care unit (ICU) at 00.25am, the following day, 18 December.

39. Hospital staff in the ICU would not allow the three bedwatch officers on to the ward. The man was now heavily sedated, unconscious and on a ventilator. The nurse thought that the presence of three officers was intrusive to other patients. Following a discussion with the duty prison manager and hospital staff, it was agreed that one officer would stay at the man's bedside and the remaining officers would position themselves outside ICU next to the entrance door.

40. The man's wife visited her husband at 2.45am, along with his mother. A record was made in the bed watch notes that his wife and the family were allowed to visit the man in the ICU whenever they wished. The man was on a life support machine and he remained heavily sedated. At 6.30pm on 18 December the escort was reduced to two officers, one at the bedside and the other outside the ICU. Other members of the man's family visited and remained with him as his medical condition continued to be critical.

41. Healthcare staff at Forest Bank stayed in touch with the ICU staff at the hospital to obtain regular updates on the man's condition. He was visited by a nurse from the prison's healthcare unit. The man died at 5.43am on 19 December, with his family by his bedside.

Family liaison

42. A member of the chaplaincy spoke to the man's wife shortly after his death. She did not ask for any support from the prison and the funeral expenses were not offered, as the prison are required to do by Prison Service Order 2710. My investigator wrote to the Director and advised him that in accordance with the PSO, the funeral expenses should be offered to families of every prisoner who is in custody at the time of their death regardless of whether the death occurs in prison or elsewhere. The Director made arrangements for the funeral expenses to be paid.

43. On 1 March, my FLO was told by the man's wife, that the funeral expenses were still outstanding, and the funeral director had threatened to take legal action. My investigator made contact with the liaison officer and asked for the payment to be made immediately. I note that the finance office at Forest Bank then acted promptly and the funeral expenses have now been paid directly to the funeral director.

ISSUES

Clinical care

44. A review of the man's medical care while at Forest Bank was carried out by a clinical director at Salford PCT. He visited Forest Bank to speak to healthcare staff and assessed the man's medical record.

The man's medical history

45. On the man's arrival at Forest Bank, he told healthcare staff about his health problems. He suffered from arthritis due to gout in his ankle and foot and Crohn's Disease. He drank heavily but was not assessed as alcohol dependent. There was a family history of heart disease. The man was overweight, at 20 stone. He had a full blood test, including a cholesterol check, and his community doctor provided his medical record. The clinical reviewer noted that both these interventions were good practice.

46. His community records showed that prior to his arrival at Forest Bank, the man was prescribed Diclofenac and Co-codamol for pain relief and Omeprazole for excess stomach acid. However, the clinical reviewer noted that he was not prescribed Omeprazole at Forest Bank and this was described by the clinical reviewer as a "serious omission". He was prescribed Colchicine and Allopurinol for his gout and arthritis. The clinical reviewer concludes, "this was appropriate for his needs".

47. The man told healthcare staff that he had Crohn's Disease, a serious bowel condition, when he arrived at Forest Bank. The clinical reviewer comments, "This was not addressed in anyway throughout his time at HMP Forest Bank. This was a serious omission."

48. Upon receipt of the clinical review for this investigation, my investigator asked the doctor to clarify what he meant by the "serious omissions" he referred to in his report and the impact that they might have had on the man's care. Unfortunately, the clinical reviewer did not elaborate any further on these points. From a lay person's perspective, I am concerned that the man's prescription of Omeprazole and treatment of Crohn's disease were allowed to lapse while he was in prison. I cannot comment further without clinical qualification, but trust that the Head of Healthcare will evaluate whether appropriate steps were taken to meet all of the man's healthcare needs.

The man's appetite

49. The PCO made an entry on the wing history sheet on 17 December that The man had not eaten for four days and felt unwell. At interview the PCO said that he was not certain of the length of time and he was being approximate. Furthermore, he said that the man had told the officer previously that he often did not eat as a result of feeling unwell. He suffered from Crohn's Disease

and his appetite might have been affected by the nature of this disease and intermittent abdominal pain.

50. Additionally, the man spent most of his time in his cell. He did not readily mix with other prisoners or interact with officers, preferring to keep his own company. It is not possible to say and neither was a record made as to whether he told anyone about his health, including wing staff, before 17 December. As well there is no record of how often he did not collect or eat his meals. No complaint applications were made by the man in relation to healthcare or wing based issues.

51. The PCO was certain that the man did not refuse food for any reason other than a seemingly poor appetite because he was unwell. His weight on arrival at Forest Bank was 20 stone. From the post mortem examination his weight had fallen to 19 and half stone. I do not think that a weight loss of seven pounds over a three month period would be seen as dramatic, and it could well have gone unnoticed by officers and healthcare staff.

52. The clinical reviewer comments that wing staff could have sought medical attention before the 17 December if the man previously reported that he had not eaten for four days and felt unwell. However, the PCO told my investigator that his entry in the wing history sheet was not accurate and was a reminder to others to see how he was the next day. As far as I am aware, this is the only example of an inaccurate record and so I do not make a recommendation. However, the Director will want to remind the PCO that records should be correct and consider whether there are any more general training needs.

Response on 17 December

53. The man was found disorientated in his cell around 7.00pm and healthcare staff were called to see him. His observations showed that his oxygen levels were 97 percent, his blood pressure was low but his pulse rate was fast. A physical examination showed that he had abdominal tenderness, was confused and disoriented. The clinical reviewer says, “A presumed diagnosis of a gastrointestinal bleed was made. This was all appropriate.”

Escort at hospital

54. Following a manager’s risk assessment three officers escorted the man to a hospital on an escort chain. Restraints were removed appropriately following a medical assessment and the man’s impending transfer to the ICU.

55. On arrival at the ICU, discussion took place between hospital staff and the prison duty manager. The ICU staff felt the presence of three officers at the man’s bedside was unacceptable. Following those discussions, one officer remained at his bedside whilst two officers positioned themselves outside the unit door. The following day, after another risk assessment, only one officer was required to wait outside the door.

56. In my view, the risk assessment should have been reviewed when it was known that the man was very ill and being transferred to ICU. I agree with the hospital nurse that the presence of three officers in an ICU is inappropriate. As well as being obtrusive for the family, it carries the risk of infection. I appreciate that the prison did reduce the number of staff in the ICU and so do not make a formal recommendation. However, I suggest that the Director considers whether the risk assessment is always reviewed when a prisoner is taken to a hospital intensive care unit.

Cause of death

57. On 4 April 2011, four months after the man's death, my investigator received the post mortem examination report. The report states that the cause of his death was multi organ failure, neutropaenic sepsis and an idiosyncratic (rare) adverse drug reaction to treatment for gout.

58. The clinical reviewer considered the findings of the post mortem and says:

> "In lay person terms, this means he developed very low white blood cells as a result of a drug called Colchicine given for his gout. This reaction was highly unusual and could not have been predicted by the medical team at Forest Bank prison. This subsequently made him very vulnerable to infection. Thus he developed a severe pneumonia and a fungal infection of his gut which laid directly to his demise."

59. As noted by the clinical reviewer, this was a rare reaction to the man's treatment for gout, which caused a sudden deterioration in his physical condition. The clinical reviewer said the man's death was therefore "unforeseeable".

Family issues

60. One of my family liaison officers spoke to the man's wife and asked if there were any points she would like to be considered as part of the investigation. His wife asked for two points to be discussed in the report.

- The condition of her husband's health before he was admitted to hospital.
- The delay in being told that her husband had been admitted to hospital.

61. The first point has already been explained in the main body of the report that describes the man's health from his reception into Forest Bank, until his emergency admission to hospital.

62. When the man arrived at the hospital he was very unwell. Hospital staff assessed him and he was then moved to the ICU. It was only at this stage that hospital staff advised the bed watch officers that the man's family should be notified of his serious medical condition. On receipt of this information the bed watch officers made contact with the night prison manager who then

agreed that the man's wife should be told. Four hours after he was admitted to hospital the man's family were told.

63. For security reasons, it is the prison's responsibility to inform families of a prisoner being admitted to hospital when their medical condition is so serious that the family are requested to attend the hospital.

64. The prison acted on advice of hospital staff as, until that time, they were unaware of how critical his condition was. I am satisfied that the prison acted promptly once they were made aware that the man's condition was serious and that this was an appropriate time for them to be told that he was in hospital.

Family liaison

65. During my investigator's visit to Forest Bank on 4 January, she spoke to the Director. My investigator was told that the prison had not offered funeral expenses because the man had died outside of the prison. My investigator then spoke to a member of the chaplaincy who told her that he had little contact with the man's wife and did not know whether the funeral expenses had been offered. A family liaison log was not completed as required.

66. The following day, my investigator wrote to the Director to explain that it was expected that the man's wife should be offered financial assistance towards her husband's funeral as he was still in custody at the time of his death. On 19 January, my investigator was advised by the liaison officer that the funeral expenses had been offered to the man's family.

67. However, my family liaison officer was told by the man's wife, six weeks later on 1 March, that the funeral bill had still not been paid. The funeral director was considering taking legal action against her for non payment which was obviously distressing for her. My investigator made enquiries with the liaison officer and was told that the prison's finance department did not have the funeral director's bank details, and so the bill had not been paid. It is unfortunate that the finance department had not been more pro-active and made enquiries about how to pay the expenses. After the second reminder by my office, the finance department eventually raised a cheque and forwarded it to the funeral directors that day. The liaison officer apologised for the distress this caused the man's family.

68. In my report of a death at Forest Bank in July 2010, I was concerned that there was no trained family liaison officer at Forest Bank and that a chaplain, had taken on the role. The report noted that the Director should consider training family liaison officers. In the light of the lack of support for the man's family and the mismanagement of the payment of funeral expenses, I make the following recommendation to the Director.

As a matter of urgency the Director should ensure that a minimum of two staff are trained to carry out the role of family liaison officers following a death in custody.

Family response to draft report

69. The letters written by the man to his wife indicate that he was unwell, his gout was painful, with problems of fluid retention and swelling. The man told his wife he had made an appointment to see the doctor. My investigator found no evidence of a medical appointment for the man in December, or that he requested one. Furthermore, there is nothing noted in the wing observation sheet that he had reported any medical problems to wing staff.

70. The man's mother informed her solicitor that she spoke to her son on 14 December. He told her he had not eaten for four days and that he was suffering from vomiting and diarrhoea. It was noted on 17 December that staff were aware of a comment that the man had not eaten for four days. However, my investigator did not find any evidence that the man had reported to staff that he had not eaten for four days on 14 December. Nothing was noted in his medical record or wing observation sheet that he was having problems with diarrhoea or vomiting.

CONCLUSION

71. The man was prescribed pain relief for his illness when he arrived at Forest Bank. However, his medication for excess stomach acid was not prescribed and his Crohn's Disease was not addressed. The clinical reviewer suggests that failure to address these two issues was a "serious omission".

72. A misleading entry in the wing history sheet made on evening of 17 December 2010, recorded that the man had not eaten for four days. It later transpired that this entry was not accurate. Nevertheless, as a result of this entry, an officer checked The man, found him to be extremely unwell and he was subsequently escorted to hospital. Sadly, the man died two days later.

73. I note the findings of the post mortem and the clinical reviewer's opinion that the man's death was due to multi organ failure as a result of a reaction to medication. This was highly unusual and the clinical reviewer commented that his death could not have been foreseen.

74. I am disappointed with the prison's liaison with the man's family in this case. Funeral expenses were not offered until the intervention of my investigator. Those expenses were not paid until March 2011, when his family told my family liaison officer that the funeral director was considering taking legal action. It is the responsibility of the Director to ensure effective family liaison following a death in custody. I therefore trust that this matter will be addressed with urgency.

75. My office has investigated deaths in prison since April 2004 and improvements in prison family liaison have been a notable improvement since that time. The National Offender Management Service (NOMS) has invested in training family liaison officers and, as a consequence, I rarely find gaps such as I have in this investigation. I trust that Sodexo Justice Services will now ensure that suitable family liaison is provided. I am confident that the provision of family liaison is part of the contract between NOMS and Sodexo. I will arrange for my report to be sent to the NOMS Director responsible for overseeing contracted prisons such as Forest Bank.

RECOMMENDATIONS

For the Director

As a matter of urgency the Director should ensure that a minimum of two staff are trained to carry out the role of family liaison officers following a death in custody.

Accepted – “Two members of staff have received training to carry out the role of family liaison officers following a death in custody.