PRISONS AND PROBATION OMBUDSMAN for England and Wales

Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP & YOI Forest Bank in August 2012

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is the report of an investigation into the death of a man, a prisoner at HMP Forest Bank. He was 73 years old when he died of heart disease in August 2012. I offer my condolences to his family and friends.

The investigation was carried out by an investigator. The local PCT appointed a clinical reviewer to review the healthcare the man received at Forest Bank.

The man had significant health problems when he arrived at Forest Bank. He used a wheelchair; he was blind and suffered from heart disease, diabetes and skin cancer. He was accommodated in the prison's healthcare centre where he was mostly able to look after himself independently. Staff helped him measure his blood sugar and issue insulin at meal times. At the beginning of August, he was found collapsed in his cell. Despite a prompt response from healthcare staff an ambulance was not called. Resuscitation attempts were unsuccessful and it appears that he was dead when he was found.

I am concerned that escort risk assessments did not take into account the man's poor physical health and did not justify the use of restraints when he was taken to and stayed in hospital. While it would not have altered the outcome in his case, there is also a need to ensure that an ambulance is called as soon as an emergency is identified. Although the clinical reviewer identifies a need for some improvement in chronic disease management at the prison, overall he is satisfied, and I agree, that the care the man received while at Forest Bank was equivalent to that he could have expected 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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **February 2013**

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SUMMARY

1. On 23 September 2011, the man was convicted of serious offences and was sentenced to 11 years and six months imprisonment. He was sent to HMP Preston. On 28 October, he transferred to HMP Forest Bank.

2. He was a frail older man, with many health issues, so he was placed in the healthcare centre. He was registered blind, used a wheelchair and had severe diabetes, for which he was insulin dependent. He also had heart disease and a rare form of skin cancer that was not able to be treated with surgery, because of his poor health.

3. On 16 January 2012, he had a heart attack and was taken to hospital. He was double handcuffed and escorted by two prison officers. Double handcuffing means his hands were handcuffed together in front of him and he was then handcuffed to an officer using another set of cuffs. Once he arrived at the hospital and was admitted, the double cuffs were removed and replaced with an escort chain[1]. He remained restrained for the rest of his stay in hospital till 10 April when he was discharged to the prison's healthcare centre. He was reviewed regularly in the cardiology clinic. He was too poorly for surgery, so was treated conservatively, using medication to control his symptoms.

4. At around 10.50am at the beginning of August, a chaplain on his Sunday morning healthcare visit found the man unresponsive on the floor of his cell and alerted staff. A code blue was called and healthcare staff attended, but an ambulance was not called. Although there were signs that this was too late, resuscitation was attempted. He was pronounced dead by the doctor who attended at 11.08am.

5. We agree with the findings of the clinical review that the care the man received while at Forest Bank was equivalent to that he might have expected in the community. His diabetes and heart disease were appropriately managed using medication, despite there being no formal arrangements for chronic disease management. Unfortunately, his heart condition was such that he was likely to die suddenly at any time.

6. The use of restraints for the man's hospital admission was not justified by the escort risk assessment. Although the internal emergency response was prompt, an ambulance was not called at any time despite a life threatening emergency code being used, contrary to national guidance.

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[1] A single handcuff is attached to the prisoner and a length of chain connects this to another worn by an officer. The escort chain allows more freedom of movement for the prisoner and makes it easier for nursing staff to administer treatment.

THE INVESTIGATION PROCESS

7. The Ombudsman's office was notified of the man's death on 5 August 2012. An investigator issued notices informing staff and prisoners at Forest Bank of the investigation and asking anyone who had relevant information to contact her. No responses were received.

8. The investigator was given copies of the man's medical records and relevant aspects of his prison records. The local PCT appointed a clinical reviewer to conduct a clinical review the man care in custody. The clinical review was received on 8 November 2012.

9. The investigator visited Forest Bank on 8 August 2012. She met the Head of Operations, the prison family liaison officer (FLO), a member of the Independent Monitoring Board (IMB) and staff that had been involved in the man's care. She was shown where he lived and the facilities that were available to him.

10. Both the investigator and clinical reviewer interviewed three healthcare staff on 27 September. They returned to interview the man's personal officer and another member of healthcare staff on 10 October. The investigator liaised with the Director of Forest Bank throughout the course of the investigation.

11. HM Coroner for Greater Manchester West District was informed of the investigation and provided the results of the post-mortem examination. The Coroner will be provided with a copy of this report to assist with her enquiries.

12. One of the Ombudsman's family liaison officers contacted the man's wife shortly after his death. He explained the investigation process and invited her to raise concerns about her husband's care. She wanted to know if he had been taking his insulin regularly.

13. The man's wife received a copy of the draft version of the report as part of the consultation period. Having considered the investigation findings, she said that she had found the report informative and helpful and had no further comments to make.

14. The report was issued for consultation with the Prison Service. Two paragraphs have been amended. All recommendations were accepted and the responses to the recommendations have been added to the recommendations page.

HMP FOREST BANK

15. Forest Bank is a local prison in Salford, holding more than 1,364 prisoners. It holds remand and sentenced male adults and remand young offenders from courts in the North West. The prison is run under contract by a private company.

16. Primary care services are provided by a private healthcare provider. There is a 20 bed inpatients unit with 24 hour nursing cover. Prison doctors are provided by a GP agency. Doctors are available from 9.00am to 9.00pm Monday to Friday, 1.00pm to 5.00pm Saturday and 9.00am to 12.00pm Sunday. There is out of hours cover at other times.

HM Inspectorate of Prisons

17. The most recent inspection of Forest Bank was an unannounced full follow-up inspection in June to July 2010. The Inspectorate described Forest Bank as a good local prison that had made a number of recent improvements, including in their healthcare provision. The Inspectorate reported that cells in the inpatient unit were basic, although there were good relationships between healthcare staff and prisoners.

Independent Monitoring Board

18. All prisons have an Independent Monitoring Board (IMB) made up of volunteers from the local community who monitor standards to help ensure prisoners are treated fairly and decently. In its most recent report (2011), the IMB commented on the caring and professional manner in which staff involved in recent deaths in custody had acted. More broadly, the IMB commented that prisoners had good access to nurses and doctors and, overall, there was a lot of excellent work done at the prison.

Previous deaths at Forest Bank

19. In the two years before the man died, there were five natural cause deaths at Forest Bank. This investigation has identified some recurring issues from previous investigations. Following a death in 2010, we had concerns about the lack of chronic disease management which are repeated here. The quality of escort risk assessments has also been criticised in a previous investigation.

KEY EVENTS

20. On 25 March 2010, the man was charged with serious sexual offences committed some years previously and remanded to custody. While he was in court, he had a heart attack and was taken to hospital. He was discharged on 27 March and taken to HMP Preston. He was blind and used a walking stick and a wheelchair. During his first reception health screen, he said that he was diabetic and insulin dependent.

21. On 12 July, the man was granted bail and released from Preston. On 23 September 2011, he was convicted and returned to HMP Preston. During a routine health screen, he said he had been diagnosed with skin cancer while he was on bail, and had a check up outstanding.

22. The man's past medical history was requested from his community GP. The GP wrote that he was diagnosed with angina in 2003, confirmed that he had a heart attack and his skin cancer was being monitored. He had been offered surgery to the lesion on his right wrist, but he had decided not to have it, as he was unlikely to survive the anaesthetic. The GP recommended that he should have regular reviews for diabetes, and chiropody, as well as annual eye screening. The GP was concerned that his imprisonment might affect the regularity of his reviews, which could in turn affect his health.

23. On 28 October, the man was sentenced to 11 years and six months and went to HMP Forest Bank. Due to his poor health and mobility, he was given accommodation in the healthcare centre. He was able to look after his own basic needs such as washing and dressing. Officers in the healthcare centre helped him clean his cell and took his meals to him.

24. He had difficulty getting in and out of bed, and was given a lower bed on 30 October. On 17 November, a Healthcare Assistant spent time with him to make sure that he was able to guide himself around his cell and find the things that he needed.

25. The man complained of chest pain on 23 December and was advised to use his glyceryl trinitrate (GTN)[2] spray to alleviate it. During the early hours of 24 December, he had two electrocardiograms (ECG)[3] which showed some fluctuations in his heart rate, so he was taken to hospital. He was discharged later that day. The discharge letter advised that an outpatient review was to be arranged. He had further ECGs in hospital, which showed that he was suffering from an abnormal heart rhythm.

26. On 16 January 2012, the man had a heart attack and was taken to hospital. When a prisoner goes out of the prison, a risk assessment is completed to determine whether handcuffs or other restraints should be used. The risk assessment should consider factors such as the risk of escape and the risk of harm to the public and hospital staff. It should be based on an assessment of the prisoner's actual risk at the time, taking into account his health and physical condition. The medical contribution to the escort risk assessment said that

[2] A medication sprayed onto the tongue to alleviate angina symptoms.
[3] A simple test that records the rhythm and electrical activity of the heart. The test takes a few minutes and is painless. The test helps doctors to tell if there are problems with the heart and if the patient is having a heart attack.

restraints should not be used because of his limited mobility and judged that he was not a risk to escorting staff or the public. Nevertheless, he was taken to hospital double handcuffed and accompanied by two officers. Once he was admitted, the double cuffs were removed and replaced with an escort chain, which stayed in place until he was discharged on 10 April.

27. He was reviewed in the cardiology clinic on 28 March. It was noted in a summary of the consultation that the risk of anaesthetic and heart surgery outweighed the benefits because of his poor health.

28. During his weeks in hospital prison healthcare staff kept in touch with the hospital about his condition. Hospital staff wanted to make sure that he was pain free before he was discharged from hospital. He was eventually discharged from hospital to the healthcare centre at Forest Bank on 10 April. His discharge letter shows that he was diagnosed with ischaemic heart disease[4] and untreatable skin cancer.

29. During the early hours of 12 April, the man was taken to hospital with chest pain. He had an ECG and a chest X-ray while at hospital, which showed he was suffering from angina and a chest infection. He was prescribed antibiotics and discharged back to the healthcare centre at Forest Bank. Forest Bank has not provided the Person Escort Record (PER), so we do not know if he was restrained for this hospital appointment.

30. The man had a dermatology review on 8 May. The lesions on his hand and arm appeared to be getting better with treatment. He was advised to use moisturiser on the lesions.

31. During the early hours of 11 May, he said that he was feeling unwell. A nurse found him slumped over his bed. The nurse helped him onto his bed and he then became unresponsive. A code blue emergency was called and three other nurses attended. He was put into the recovery position and given oxygen. After the oxygen was applied and he had recovered, he explained that he had felt dizzy and faint. An ECG did not show anything concerning. A doctor advised him to rest and he was to be reviewed if there were any other concerns.

32. The man attended a review in the cardiology clinic on 19 June, and his background history of significant artery disease and severe aortic stenosis[5] was noted. He was not suitable for any form of intervention and his symptoms were to be managed using medication. He was to be reviewed in six months time. If his symptoms became worse, he was to be referred for palliative care[6]. (Again, Forest Bank has not provided the PER, so we do not know the level of restraint used.) Two further code blues were called for him on 8 and 10 July. On both occasions, he said he felt unwell. He was assisted to by healthcare staff and given oxygen, but did not need hospital treatment. There were no changes in his

[4] A condition where blood supply to the heart is reduced, damaging the heart muscle.

[5] Narrowing of aortic valve in the heart, which makes it harder for blood to be pumped into the aorta. Severe narrowing can cause heart failure.

[6] Palliative care focuses on the relief of pain and other symptoms and problems experienced in serious illness. The goal of palliative care is to improve quality of life, by increasing comfort, promoting dignity and providing a support system to the person who is ill and those close to them.

medication and he was able to continue with his daily activities as he had before. He recovered and was not referred for palliative care.

Day of the man's death

33. A PCO said that at about 10.20am on 5 August, the man asked for a razor. The PCO gave him his razor and got his shaving foam for him from his shelf. He told him he was feeling fine. The PCO told him to let him know when he had finished. He explained that the man was able to shave without assistance and, as it was the daytime, his cell door was left open. The PCO then went to the dayroom to supervise prisoners there.

34. A prison chaplain was in healthcare doing his Sunday morning rounds. At about 10.50am, he went to the dayroom and told the PCO and Nurse A that he had found the man unresponsive on the floor of his cell. The PCO and nurse immediately went to the cell. It took them about a minute to get there from the dayroom, which is at the other end of the corridor from the cell. The cell door was ajar and he tried to push it open, but he could only get it open slightly and could not see if the man was breathing. The PCO called a code blue over the radio. The communications log shows that a code blue was called at 10.55am.

35. Nurse B was assigned to respond to emergency calls that day and heard the code blue. She went to the cell with another nurse, who had picked up the emergency response bag (a bag with basic life saving equipment in). On her way, she passed the doctor's consulting room and told the doctor that there was a medical emergency. The nurses and doctor arrived at the cell about two minutes later, 10.57am. The investigator was told that as she was small, Nurse B could get through the gap in the cell door and moved the man out of the way so the other staff could get in the cell.

36. Nurse B saw that the man was not breathing and asked for a defibrillator and oxygen to be brought to the cell, which two nurses went to get. The doctor helped to turn him over onto his back as he was laying on his front. He said that he still had shaving foam on his face, but there was no blood. He was apparently cold to the touch, waxy in appearance and had some pooling of blood on the underside of his arms, a sign of livor mortis, one of the indicators of death, the presence of which is usually an indication that it would be futile to begin cardiopulmonary resuscitation.

37. Despite the signs, Nurse B and the doctor tried to resuscitate the man. The defibrillator advised that resuscitation should continue, which it did for about ten minutes, before the doctor and the nurses agreed that there were no signs of life and stopped the attempt. The doctor pronounced him dead at 11.08am. At no point during the incident was an ambulance called.

Support for prisoners

38. Notices were displayed around the prison to let prisoners know of the man's death and the support that was available to them. All prisoners on suicide prevention monitoring procedures were reviewed and offered additional support.

Support for staff

39. A debrief was held by the Residential Manager the same day for staff to discuss any issues or concerns they had regarding the death of the man. All staff involved in the man's care were invited to the debrief and were offered additional support from the staff care team, if they felt they needed it.

Support for family

40. A chaplain acted as the prison's family liaison officer (FLO). The FLO and another chaplain visited the man's wife's home that afternoon and broke the news. The FLO suggested the family could visit the prison and arranged for his property to be returned, and funeral expenses to be paid. At the request of his family the FLO arranged the funeral, which was held on 20 August 2012.

ISSUES

Clinical care

41. The man had significant health problems when he arrived at HMP Forest Bank. He was an insulin-dependent diabetic, and had heart disease and skin cancer. His GP wrote of the importance of regular clinical reviews when he arrived at Forest Bank. His clinical record shows that although there is no system in place to ensure that regular diabetes reviews take place, staff helped him to measure his blood sugar before every meal and ensured that he took his insulin daily, as prescribed. His heart condition was managed using medication, as advised by the cardiologist.

42. The clinical reviewer says that the nature of the man's heart condition meant that he was likely to die suddenly. He has some concerns about the lack of a structured approach to chronic disease management, but does not feel that this contributed his death. However, the clinical reviewer considers that general lack of a structured support to management of chronic disease to be a concern.

    The Head of Healthcare should ensure that systems for chronic disease management are developed which include a clear review programme for each condition.

Emergency response

Calling an ambulance

43. The Director of Offender Health and the Chief Executive Officer, National Offender Management Service, wrote to all prison Governors and Directors and prison healthcare managers on 17 February 2011 to reiterate previous guidance about the importance of calling an ambulance as soon as possible in an emergency. Any delays can have a significant impact on the patient's chances of survival, so staff should not wait for healthcare to attend.

44. A code blue emergency was called for the man at 10.55am. A code blue signifies a life threatening emergency that requires immediate medical assistance. An ambulance should have been requested at this point. Although medical staff responded promptly, an ambulance was not called. The doctor told the investigator that he did not know why an ambulance was not called, but he felt he had sufficient knowledge of the man and his medical conditions to be able to make an informed decision to stop resuscitation and that calling an ambulance would not have benefited him. We consider that as soon as he was discovered unconscious on the floor an ambulance should have been called. We accept the healthcare staff were able to make a decision that he was dead, but the fact that they first attempted resuscitation suggests that an ambulance should have been called, at least as soon as the code blue went out over the radio net to the communications room. There should be no need to wait for healthcare staff to attend.

45. Forest Bank's policy for medical emergencies requiring an ambulance, dated June 2011, says "In the event of a medical emergency any member of the Healthcare team has the authority to call for an ambulance". The policy does not follow the requirements of the February 2011 letter from the Chief Executive of

NOMS and the Director of Offender Health which made it clear that where there are concerns about the immediate health of a prisoner an ambulance should be called without waiting for healthcare staff to attend. Any member of staff should be able to request an ambulance and we consider one should be requested as soon as a code blue emergency is called. The extent of the prisoner's condition is not always known immediately, but a request for an ambulance can always be stood down if it is found that one is not needed. Although calling an ambulance in this case would not have made any difference to the outcome in his case, in other circumstances if staff were able to revive a patient, they would then have to wait longer for an ambulance to arrive to provide further medical assistance.

The Director should ensure all staff understand the need to call an ambulance immediately in a medical emergency and that local policies reflect this.

Escort risk assessments

46. Prisons have a duty to protect the public when escorting prisoners to hospital, and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes into account factors such as the prisoner's health and mobility. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that medical opinion regarding the prisoner's ability to escape must be considered as part of the assessment process. It deemed that restraining by handcuffs of a prisoner receiving chemotherapy (and, by implication, other life saving treatment) was degrading and that such restraint would be likely also to be regarded as inhumane unless justified by other relevant considerations.

47. The man was taken to hospital on 16 January after he had had a heart attack. During the escort to hospital he was restrained using double cuffs which are usually used for prisoners who are regarded as a high risk of escape and a high risk to the public. The medical report in the risk assessment says that there were medical reasons (due to his limited mobility) why he could not be placed in restraints to and from hospital, but did not stipulate if his medical conditions affected his level of risk. He was not considered as a risk to escorting staff or the public, however he was considered as a risk of escape if the cuffs were removed. It is difficult to understand how that conclusion was reached when he was frail, suffering from a heart attack, in very poor physical condition, with limited mobility and was registered blind.

48. When the man was admitted to hospital the double cuffs were removed and an escort chain was applied. He continued to be restrained for some weeks throughout his stay in hospital. His ill health and the consequent low level of risk he presented did not justify the need for him to be restrained using double cuffs or an escort chain and it is hard to see why the presence of two escorting officers would not be sufficient to provide adequate security. There could have been other occasions where inappropriate restraints were used, but Forest Bank could not provide the relevant paperwork. It is apparent that his condition and

how this impacted on his risk was not given sufficient weight during the risk assessment process.

The Director should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances, including their health and mobility, and are based on the actual risk the prisoner presents at the time.

CONCLUSION

49. The man was a frail man, with many health problems, most significantly diabetes and heart disease. Although the clinical review found some improvements were needed in the management of chronic diseases, this did not impact on his treatment. The care that he received was equivalent to that he might expect in the community.

50. When he was taken to hospital restraints were used which were not justified by justified by a full and proper assessment of his risk. Although it would not have affected the outcome for him, there is a need for the prison to revise it emergency procedures so that an ambulance is called whenever there are grave concerns about the immediate health of a prisoner.

RECOMENDATIONS

1. The Head of Healthcare should ensure that systems for chronic disease management are developed which include a clear review programme for each condition.

   Accepted – The system for chronic disease management is to be reviewed in line with Prison Health Performance Quality Indicators (PHPQI's) / clinical review recommendation. There is a lead nurse for chronic disease management. They have received the appropriate training and updates are facilitated.

2. The Director should ensure all staff understand the need to call an ambulance immediately in a medical emergency and that local policies reflect this.

   Accepted – The operational instruction was re-issued to all staff on 16 November 2012.

3. The Director should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances, including their health and mobility, and are based on the actual risk the prisoner presents at the time.

   Accepted – All risk assessments are undertaken on an individual needs basis and include mobility.