Investigation into the circumstances surrounding the death of a man at hospital in December 2010 whilst in the custody of HMP Forest Bank

Report by the Prisons and Probation Ombudsman for England and Wales

January 2012

This is the report of an investigation into the circumstances surrounding the death of a man in December 2010. The man was 35 years old when he died at hospital. He was a serving prisoner at HMP Forest Bank, but had been taken to hospital on 10 November after having a heart attack. He spent four weeks receiving treatment in hospital, but his condition deteriorated. The cause of death was heart failure as a result of infective endocarditis (inflammation of the heart valves affecting the blood supply). I would like to extend my condolences to his family.

The investigation was completed by my investigator. He visited Forest Bank to interview discipline and healthcare staff. One of my Family Liaison Officers contacted the man's family in order to explain my investigation and discuss their concerns. I would like to thank the family for their contribution to the investigation. I have included their response to the draft report on pages 39 – 41.

A clinical review of the treatment that the man received in custody was undertaken by a clinical reviewer, appointed by the local Primary Care Trust. He assessed whether the care that the man received in custody was comparable to that he could have expected in the community. I am grateful for his assistance.

I would like to thank the staff at Forest Bank for their cooperation whilst the investigation was completed. I am particularly grateful to the liaison officer for arranging the interviews.

The clinical reviewer is very critical of the care the man was offered at Forest Bank. He already had a serious heart condition for which he should have been prescribed medication. However, he was not given this drug for over three months. The clinical reviewer thinks that doctors missed opportunities to provide him with the appropriate care. As such, I took the unusual step of recommending a further review to learn lessons from his death.

I also have serious concerns about the day that the man was admitted to hospital. He first complained of chest pains to a nurse at about 7.45am. However, he was not then assessed by a doctor until 2.30pm. After the doctor confirmed that he was having a heart attack, staff called an ambulance. However, after the emergency medical technicians arrived, they were forced to wait an unacceptable 55 minutes before departing whilst staff completed security checks.

I make four recommendations and endorse one recommendation made by the clinical reviewer.

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.

Thea Walton
Acting Deputy Ombudsman **January 2012**

CONTENTS

SUMMARY

1. The man appeared in court on 29 May 2010. He was remanded into custody and taken to HMP Forest Bank. Healthcare staff recorded that he had a leaking heart valve and was due to attend an outpatient hospital appointment in August. They noted that he was taking aspirin. He was released on bail on 15 June, but was rearrested by the police and returned to Forest Bank on 30 June.

2. During the reception process, the man was assessed by a healthcare assistant and a doctor. Although he reported problems with a leaking heart valve and said that he was receiving treatment at the hospital, no further action was taken at the time to contact the hospital or prescribe warfarin (the appropriate medication for his heart condition).

3. Because the man used heroin and crack cocaine in the community, he began a detoxification programme on the Integrated Drug Treatment System (IDTS) wing. He was prescribed methadone.

4. He became unwell in late July. He had a high temperature. Two doctors both assessed him during this period. Both recorded his previous aortic valve replacement but neither prescribed him warfarin. Both doctors planned to review his condition but neither review took place.

5. At the start of September, the man asked a nurse to contact the hospital about his outstanding appointments relating to his heart problems. The nurse asked an administrator to do this. There is no evidence in the clinical record that anybody got in touch with the hospital.

6. A doctor assessed him at the end of September. He ordered tests and prescribed him warfarin for his heart condition from 5 October. About a week later, staff noticed that he had been given the wrong dose of warfarin. The medication was stopped for two days because his blood had become too thin. On 18 October, he received a seven year prison sentence. The doctor admitted him to the healthcare centre for pneumonia on 20 October. He was discharged back to the wing a week later.

7. After his cell door was unlocked for breakfast on 10 November, he told staff that he had been experiencing chest pains. A nurse came to assess him on the wing at about 7.45am. He said that he had been experiencing chest pains that were travelling down his arm. The nurse arranged for him to be examined by a doctor later that morning. However, he was assessed by a doctor during routine surgery hours at about 2.30pm.

8. The doctor ordered an electrocardiogram to check his heart rhythm. The results showed that he was having a heart attack. Staff called an emergency ambulance, but once it arrived, the emergency medical technicians were unable to leave for another 55 minutes whilst discipline staff completed their security and restraint procedures. He was double-handcuffed for the journey to hospital.

9. Later that evening, staff were given permission to handcuff themselves to the man using an escort chain (a length of chain with handcuffs at both ends). He remained seriously unwell as a result of his heart condition. He stayed in hospital for the next few weeks. During this time, he was taken to another hospital for a procedure. He was double handcuffed for the journey to the hospital.

10. The man's condition deteriorated rapidly on 8 December. During the morning, staff were given permission to remove the escort chain. He was moved to the Intensive Care Unit but did not recover and died.

11. The investigation has identified significant problems with the healthcare that the man was offered. The clinical reviewer finds in the clinical review that his long standing heart condition was not treated appropriately for three months. Several doctors assessed him but did not prescribe him the appropriate medication.

12. I am also critical of the care he received on 10 November when he became unwell. Firstly, he was assessed by a doctor nearly seven hours after a nurse first examined him. Secondly, after an ambulance arrived, the crew were made to wait for nearly an hour whilst security checks were completed. In my opinion, this was an unacceptable delay.

13. I was sufficiently concerned about the issues that my investigation highlighted to recommend a further review of healthcare provision at Forest Bank. The review was completed by a doctor.

THE INVESTIGATION PROCESS

14. The investigator was notified of the man's death on 13 December 2010. Notices were issued to staff and prisoners telling them about the investigation process and inviting them to contact the investigator.

15. The investigator liaised with the liaison officer during the investigation. His colleague visited HMP Forest Bank on 15 December to speak to staff and collect paperwork relating to the man's time in custody.

16. The investigator contacted the local Primary Care Trust (PCT) to ask that a clinical review be carried out with regard to the medical treatment which the man received in custody. The purpose of this review is to establish whether the care which he was offered in prison was comparable with that reasonably expected in the community. A clinical reviewer was appointed to complete the review, which is annexed to my report.

17. The investigator visited Forest Bank on 16 and 17 February and 4 April 2011 to interview a total of 11 discipline and healthcare staff. He wrote to the Director on 10 March with the initial findings from the investigation. After the draft version of this report was disclosed to the staff at Forest Bank in advance of the family and the Coroner (because the actions of individual staff were criticised), the prison provided my investigator with additional documentation that he had not originally been given. Some additional facts were then added to the report before it was issued in draft form to other stakeholders.

18. The investigator wrote to the local Coroner's office at the start of my investigation to inform them of its nature and scope. HM Coroner has been provided with a copy of my report.

19. One of my Family Liaison Officers contacted the man's mother in January 2011. She explained the purpose of my investigation and asked her if she had any concerns about the care her son had received.

20. The man's mother expressed concern about the healthcare her son received whilst he was held at Forest Bank. He told his family that he had visited the healthcare centre on numerous occasions with concerns about his health. However, despite his medical history and weight loss, his mother thought that staff had failed to take his concerns seriously. She was also concerned not to have been informed when her son was taken ill with pneumonia. She asked why he apparently missed a number of cardiology appointments.

21. The man's mother also questioned the decisions that were taken by staff on 10 November, when he was admitted to hospital. She thought that there had been a delay in diagnosing her son and also in then taking him to the hospital. I share her concerns about her son's clinical care and admission to hospital and address them in the 'Issues' section of my report.

22. The man's mother also asked about the way in which her son was handcuffed whilst he was treated in hospital. She expressed concern about the conduct of some of the officers escorting him at hospital. She said that some of the officers ate and drank in front of her family 'as if they were at the pictures' whilst they were trying to share private moments with him. She also recalled that one officer had a cold and was sneezing. She was concerned about this because her son was already weak and seriously ill.

23. The man's parents responded to the draft report of the investigation. We have summarised their responses and comments on pages 38, 39 and 40. We are very grateful for their contribution and thoughtful comments.

HMP FOREST BANK

24. HMP Forest Bank is a prison run for the Ministry of Justice by Sodexo Justice Services (a private contractor). 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 retains a member of staff called the Controller in the prison. Discipline staff are referred to as Prison Custody Officers. Sodexo Justice Services have a 25 year contract to run the prison.

Healthcare

25. The Head of Healthcare at Forest Bank does not have a clinical background. He manages three other members of staff (clinical leads) responsible for the Integrated Drug Treatment System (IDTS), mental health treatment and primary (physical) healthcare. The primary care nursing staff are employed by Sodexo Justice Services. General practitioners are provided by a private company, Cimarron. The doctors provide a service from 9.00am until 5.00pm from Monday to Friday and for three hours on Saturday afternoons and Sunday mornings. There is a 20 bed inpatient healthcare centre and 24 hour nursing cover. One nurse and one healthcare assistant work overnight.

Her Majesty's Inspectorate of Prisons

26. Her Majesty's Chief Inspector of Prisons carried out an unannounced full follow-up inspection of Forest Bank from 29 June to 9 July 2010. He commented on the progress made by Sodexo Justice Services in responding to an earlier recommendation regarding the delivery of healthcare:

> 'The prison should put in place a strategy to revise and improve its health care provision.
>
> 'Not achieved.
>
> 'There was no prison health development strategy. We were told that a plan would be developed following the completion of a health needs analysis in October 2010.'

Independent Monitoring Board

27. The most recent annual report published by the Independent Monitoring Board (IMB) at Forest Bank covers the year from December 2009 to December 2010. (The IMB at each prison is made up of members of the public who are both independent and unpaid. They monitor the day-to-day life in their local prison and ensure that proper standards of care and decency are maintained.) The Board did not make any pertinent comments about the provision of healthcare at Forest Bank.

Previous deaths at Forest Bank

28. Since the Prisons and Probation Ombudsman assumed responsibility for investigating deaths in prison custody in 2004, I have investigated six previous deaths at Forest Bank. Of these, one man died of a drug overdose on the day he was released from the prison, one man was murdered, two died of natural causes and two took their own lives.

29. When I investigated the death of a man from natural causes in November 2005, I was critical of the care that he was offered. The clinical review in that instance concluded that the man's death might have been avoided if he had been given appropriate treatment at an earlier stage. I endorsed the recommendations in the clinical review. Whilst the clinical reviewer has not concluded that the man's death might have been avoided if he had been prescribed warfarin and referred to the hospital at the first opportunity, I am greatly concerned that this investigation draws parallels with my earlier findings. Once again, an established health problem was not addressed for some weeks or months, despite evidence being available to healthcare staff.

KEY EVENTS

30. The man had used drugs since his teenage years. He had 15 previous convictions, largely relating to his heroin misuse. He had previously undergone treatment for cardiac problems. A replacement aortic valve had been inserted in his heart. This was made necessary after he contracted infective endocarditis (a bacterial inflammation of the heart) resulting from his intravenous drug use.

31. After his arrest for drug offences, the man was taken from the police station to court on 29 May 2010. He was remanded into custody and transferred to HMP Forest Bank. A Healthcare Assistant (HCA) assessed him in the reception area and recorded that he had previously undergone a heart valve replacement as a result of endocarditis (an inflammation of the heart). She noted that there was 'a leak around [the] stitching of [the] new valve' and that he took aspirin for his condition. She HCA wrote in the clinical record that he was due to attend an appointment with a heart specialist at hospital on 7 August.

32. Another HCA made an entry in the clinical record on behalf of the doctor on the same day and recorded that the man's heart condition had previously been treated with a drug called warfarin but that he was 'now on aspirin'.

33. The man was taken to the magistrates' court again on 3 June and returned to Forest Bank later that day. However, on 15 June, he made another court appearance and was released into the community on bail. His bail conditions required him to attend drug treatment appointments, obey a home detention curfew and live at a permanent address.

34. On 30 June, the man was arrested again and taken back to the police station. He underwent a medical assessment. He said that he had used methadone, heroin and crack cocaine on 28 June. However, because he showed no clinical signs of drug withdrawal, he was not given any detoxification treatment at the police station.

35. The man appeared in court and was remanded into custody again. He was taken back to Forest Bank. Discipline staff completed a cell sharing risk assessment (CSRA) and decided that he presented a low risk of harm to other prisoners. A Prison Custody Officer (PCO) completed a first night assessment and induction checklist. He told the PCO that he had a leaking heart valve.

36. Upon arrival, the man was also assessed by HCA A. During the first night reception health screening, he told her that he thought that he had an appointment at the cardiology department at hospital about his leaking heart valve but did not know when he was supposed to attend.

37. The man also told the HCA that he was withdrawing from drugs. He said that he had been using heroin and crack cocaine. He said that he used to inject drugs but had started smoking them instead. He explained that he had last

smoked crack cocaine and heroin on 28 June. His urine tested positive for both drugs. He said that he was assigned to Bolton Community Drug Team (BCDT) and had a key worker. He told her that he had been prescribed 30ml per day of methadone (a heroin substitute) and had last taken this dose on 28 June.

38. The HCA referred the man to Prison Doctor A, who assessed him the same evening. The doctor arranged for him to receive an initial 15ml dose of methadone until his usual dose could be confirmed with BCDT. He signed a consent form permitting staff to obtain his medical records from his local surgery. The doctor did not take any action with regard to his leaking heart valve.

39. The doctor made an entry in the electronic clinical record under a HCA's name. He told the investigator that it had been one of his first shifts working at Forest Bank and, at the time, he had not yet been provided with a username and password for the electronic clinical record system.

40. The man moved onto house block H1 and was treated as an Integrated Drug Treatment System (IDTS) client. (IDTS is a treatment regime introduced relatively recently into prisons to better help offenders with a substance misuse problem.) He began a detoxification programme and was referred to the Counselling, Assessment, Referral, Advice and Throughcare Services (CARATS). (There is a CARATS team in each prison working with prisoners who misuse substances.) On 1 July, a HCA confirmed with BCDT that he had been prescribed 30ml of methadone each day in the community. He was prescribed 30ml of methadone daily until he was taken to hospital in November.

41. The man transferred to house block G1 on 7 July. He was assessed by a worker from the CARATS team. She recorded that he had used heroin since the age of 18. She also wrote in her notes that he had a leaking heart valve and that he had told healthcare staff about his condition during the reception process.

42. On 20 July, the man told Nurse A that he felt 'generally unwell'. He felt hot and cold and had pains in his arms and legs. She referred him to the doctor. The next day, 21 July, he told a PCO that he was still feeling unwell. He said that he had undergone a heart operation in 2006. Because of the symptoms he described, the PCO asked an IDTS nurse to assess him.

43. Prison Doctor B examined the man later the same day and diagnosed a viral infection. However, he could not rule out subacute bacterial endocarditis. The doctor recorded that he had been an intravenous drug user and that he had previously been given an aortic valve replacement. (However, the doctor did not order further tests or prescribe long term treatment for his heart problems.)

44. The man had a high temperature (39.1 degrees). He was not short of breath but was experiencing discomfort in his chest. He felt tingling in his arms and

legs. The doctor prescribed paracetamol and planned to check him again the next morning. He advised him to ask for a nurse if his condition deteriorated in the meantime. A nurse checked him at 7.00pm that evening and he said that he was feeling a little better.

45. Prison Doctor B did not review the man's health on 22 July as planned. However, Nurse A checked him on 23 July and he told her that he was feeling much better. He was given ibuprofen (a pain killer) and paracetamol.

46. He went to an appointment with Prison Doctor C on 26 July. The doctor recorded that the man had undergone an aortic valve replacement in the past. The doctor noted that he looked well and decided to review his condition in ten days time. There is no evidence in the clinical record that his health was reviewed by a doctor during the following month.

47. On 28 July, the man made another appearance at Magistrates' Court. After he expressed concern that his co-defendant was living on the same wing, he initially moved to house block E1 on 29 July. However, later the same day, he transferred to house block B2. He made further appearances at Magistrates' Court on 11 August and at Crown Court on 18 August, 3 September and 27 September.

48. The man failed to attend two appointments at the triage clinic with a nurse on 27 August and 1 September. Another nurse went to the wing to triage him on 1 September but he was not present. The clinical record does not indicate the nature of these appointments.

49. On 2 September, the man told a nurse that he was feeling generally unwell and that his legs were aching. She made a note of his aortic valve replacement. He asked her to pursue his follow-up appointment with a doctor at the cardiology department at hospital. She asked an administrator to check this for him. There is no evidence of the staff at Forest Bank contacting the hospital.

50. Another nurse checked the man on 5 September. He reported a spasm in his neck and some pain. She gave him a heat pad and told him to ask for a nurse if his symptoms persisted. Another nurse assessed him on 7 September. He was still complaining of pain in his neck and shoulders, which he had experienced for a week. She gave him paracetamol.

51. A nurse assessed the man in the triage clinic on 16 September. He was complaining of pain on his left side under his ribs. He was also sweating a lot. She referred him to the doctor. On 17 September, Prison Doctor C assessed him. He still had pain in his lower ribs. The doctor examined him, ordered blood tests, prescribed ibuprofen and scheduled a review of his condition two weeks later.

52. A nurse assessed the man on 29 September. He had painful swelling in his left knee and calf. She referred him to the doctor in case he was suffering from deep vein thrombosis (DVT). She also thought that the problem could

be a baker's cyst (a benign swelling). She recorded his history of intravenous drug misuse and heart problems.

53. Prison Doctor D assessed the man later that day. He recorded that he had not injected drugs in his groin since June 2010 and that he had suffered from DVT in the past. Although the doctor could not identify any definite sign that he had DVT, he ordered a test to determine if he was suffering from the condition. He also prescribed clexane (a drug used to treat and prevent DVT).

54. On 5 October, because the test for DVT gave a positive result, the doctor decided that the man should be given a daily dose of warfarin. (This is a drug used to thin the blood and prevent clotting. The daily dose varies depending on readings which are taken to check how thin the blood is.) As I go on to discuss in the issues section of the report, the clinical reviewer thinks that he should have been given this drug from the time of his admission to Forest Bank because of his heart condition.

55. On 12 October, Prison Doctor D recorded that the man had been given an incorrect dose of warfarin over the previous few days. The doctor instructed the nursing staff to stop administering warfarin for two days because his blood was now too thin. The nurse checked him on 16 October. He said that he had been vomiting for the last 24 hours. She thought that he was presenting with viral symptoms and advised him to rest and sip water for the next day.

56. He received a sentence totalling seven years in custody at Crown Court on 18 October.

57. A nurse assessed him on 19 October. He had gone to the healthcare centre for warfarin treatment. He reported ongoing abdominal pain on his left side. He said that he had not been eating because if he did it made the pain worse and he started to vomit. She urgently referred him to the doctor. She noted that his weight and body mass index had dropped. She recorded that he looked 'emaciated in the face'.

58. On 20 October, Prison Doctor D assessed him. The doctor recorded that he had pain in his lower left chest and difficulty breathing. He could not get comfortable and looked unwell. The doctor diagnosed pneumonia in his left lung. He ordered tests to check whether he might have tuberculosis (TB) because he had symptoms that suggested the condition. There is no evidence in the clinical record that the tests for TB were carried out.

59. The man moved to the healthcare centre the same day. He was prescribed amoxicillin and flucloxacillin (both antibiotics) and paracetamol for the next week. On 24 October, Prison Doctor E assessed him. He was still complaining of pain in his left lower chest. However, he said that he was generally feeling better and was eating and drinking normally. The doctor thought that his condition was improving but he still had some pain. He prescribed paracetamol again.

60. The same day, a nurse recorded that the man had not been given his scheduled doses of warfarin for several days. She noticed the discrepancy at 7.00pm and tried to contact the out of hours emergency doctor for advice, but did not obtain a reply.

61. On 25 October, Prison Doctor A wrote in the clinical record that the man would need to be prescribed warfarin for the rest of his life. He stressed that warfarin treatment should start again immediately. He completed the prescribed course of medication for pneumonia. A doctor discharged him from the healthcare centre on 26 October because he looked better and was no longer in distress. He moved onto house block E2.

62. A nurse assessed him on 30 October. He reported abdominal and back pain on his right side. He said that he was in a lot of pain and thought that his pneumonia had returned. The nurse thought it unlikely that he had either pneumonia or a chest infection. Prison Doctor E checked him the next day. He was feeling hot and cold and nauseous and was experiencing pain in his groin. The doctor recorded that he did not have a fever but that his groin and abdomen were tender. The doctor thought that he had a urinary tract infection (UTI). He prescribed trimethoprim (an antibiotic used to treat UTIs).

10 November – Admission to hospital

63. At about 7.00am on 10 November, the man was unlocked from his cell to collect his breakfast. A short while later, he went to the wing office and told a PCO that he had been experiencing chest pains since 6.00am that morning. The PCO thought that he looked pale and unwell and telephoned the healthcare centre. She asked Nurse A to come over and assess him. The nurse went to the wing and examined him in his cell shortly before 7.45am.

64. The man told the nurse that, when he woke up, he had experienced chest pains and that the pain was moving down his arm. The nurse's subsequent entry in his clinical record refers to the pain in the present tense, as if it was ongoing when she assessed him. However, when she later spoke to the investigator, the nurse stressed that he told her in his cell that he was not presently experiencing pain. The nurse reassured him and advised him to rest in bed and wait for a doctor to assess him later that morning.

65. The man reported some of the classic symptoms of a heart attack. In November 2010, the Prison and Probation Ombudsman published a survey entitled 'Deaths from circulatory diseases' which made the following remarks:

> 'A common symptom in acute episodes of ischaemic heart diseases is chest pain. It may not always occur, though when it does it is typically described as a crushing pain, which may radiate down the arms (often one arm more than the other, frequently the left arm) and to the jaw and may be accompanied by sweating and clamminess of the skin. The British Heart Foundation advises patients with known ischaemic heart disease that chest pain that lasts more than 15 minutes is probably a heart attack.'

66. A PCO went with Nurse A to the man's cell. She told the investigator that the nurse did not seem overly worried about him. She recalled the nurse reassuring him that he was not having a heart attack.

67. The nurse returned to the healthcare centre and arranged for the man to be assessed by a doctor during the morning as part of the routine daily surgery. When the nurse spoke to a discipline officer later that morning, she got the impression that he was about to see the doctor. As a result, the nurse told the investigator that she was surprised to encounter him in the healthcare centre whilst he waited for the doctor at about 2.30pm. She realised that he had still not yet been assessed, some six and a half hours after she had gone to his cell. He had walked across from the wing for his appointment.

68. Prison Doctor D assessed him at 2.27pm. He said that he had been experiencing chest pains since he woke up that morning. The doctor recorded that he had tight chest pain and pain along the left side of his neck and down the inside of his left arm. The doctor ordered an electrocardiogram or ECG (a test to check the activity of the heart).

69. Nurse B performed three ECG tests just after 3.00pm. They showed that the man was having a heart attack. The doctor decided that he should be taken to hospital immediately because of the ECG results and his history of heart problems. The nurse called an emergency ambulance at about 3.05pm. An ambulance crew set off for the prison at 3.10pm.

70. The nurse notified the SPCO (the orderly officer responsible for the operational management of the prison, answering to the duty governor) that she had asked for an emergency ambulance and that the man would need to leave the prison under escort. Whilst Nurse A sat with him in the treatment room, the doctor wrote a referral letter to the hospital. The letter indicated that he had been experiencing chest pains since 'late last night'. He was given aspirin and provided with an oxygen mask.

71. The emergency ambulance arrived at 3.24pm and two emergency medical technicians reached the healthcare centre a minute or two later. Nurse A wrote in the clinical record that the ambulance could not depart for another 55 minutes because discipline staff were completing paperwork and security checks. She recorded the concern of healthcare staff regarding the delay. During interview, both nurses both remembered that the technicians were frustrated by the delay. Nurse A told the investigator that she continued to sit with him and reassure him.

72. The SPCO oversaw the completion of security checks and a risk assessment. Although two senior managers were in the prison (the duty manager and the security manager), neither went to the healthcare centre after the emergency began to assist the SPCO or talk to the doctor. The duty manager signed off the arrangements when the SPCO took the paperwork to him and the security manager checked the handcuffing arrangements in the ambulance just before it departed.

73. The ambulance carrying the man left Forest Bank at 4.20pm. He was double handcuffed in the ambulance whilst he was taken to hospital (his arms were handcuffed together in front of him and another pair of handcuffs were used to cuff him to the arm of a PCO). He was escorted by three officers. His escape potential was assessed as medium. The reason given for the double cuffing was his recently imposed prison sentence. If he required medical treatment, the escorting staff were advised that they could use an escort chain to restrain him instead. However, the escorting officers needed his permission in order to swap the handcuffs.

74. The man arrived at hospital at 4.28pm and was assessed in the accident and emergency department. The doctors confirmed that he was having a heart attack and would need to stay in hospital. At 7.45pm that evening, the security manager gave the escorting officers permission to swap restraints. The bedwatch log seems to indicate that, from 8.00pm, he was attached to one officer by an escort chain. Following a chest x-ray, he was admitted to the cardiology department at 8.20pm.

75. The next day, the security manager visited the hospital to check the arrangements for the man's escort. The bedwatch log indicates that he was still double handcuffed at this stage. The security manager wrote that the escort chain was to be applied. It is not clear from the documentation if he had been double handcuffed constantly since he arrived in hospital, or if, as seems to be indicated, staff had switched to using the escort chain for a time the previous evening. Although three PCOs had initially accompanied him to hospital, this number was reduced to two.

76. On 12 November, a hospital doctor advised the man that his condition was so serious that he might wish to contact his family. Later that afternoon, one of the PCOs escorting the man telephoned his family to advise them that he was staying in hospital.

77. After she read the draft report, the man's mother told the family liaison officer that she and her husband did receive a telephone call informing them that their son was in hospital. However, she explained that the officer who telephoned would not tell them what hospital their son had been taken to. She said that she and her husband were told that someone would contact them the next day with more information. However, nobody called and in the end she said that they had to contact the prison themselves. She explained that they were put through to the chaplaincy staff, who were eventually able to confirm their son's location.

78. The man remained in the cardiology department. His parents visited him regularly during the next few weeks. Other family members also came to see him. He continued to receive doses of methadone in hospital. The security manager visited the hospital every couple of days to check the security and escort arrangements. He remained attached to one of the PCOs by the escort chain. When he wanted to use the toilet, the chain was attached to a male officer.

79. The man underwent a heart scan on 19 November. On 22 November, he received a blood transfusion. He moved wards later that day. On 23 November, the escort chain was removed and he was double handcuffed again when he was taken from the hospital to another hospital for further tests. Escorting officers were told to contact the duty manager at Forest Bank for authorisation if the handcuffing arrangements needed to change to allow treatment to be given. The duty manager was also required to authorise the reinstatement of the escort chain when he returned to the first hospital.

80. After he transferred to the hospital, staff obtained permission from the Deputy Director for the double handcuffing to be replaced by an escort chain whilst he underwent a non-surgical procedure. He was lightly sedated but was groggy rather than unconscious. When the sedative wore off, staff were told by the Deputy Director to reapply the double handcuffs. Once he was escorted back to the hospital at about 1.00pm, the duty manager gave the staff permission to reinstate the escort chain.

81. On 24 November, a doctor advised the man that he would need to remain in hospital for several more weeks. He remained in a side room off the ward. Staff made hourly entries in the bedwatch log and telephoned the control room at Forest Bank every hour of every day to update them about his situation and level of restraint.

82. The man underwent an ECG and x-ray on 2 December. The next day he was taken for a scan of his heart. Later that day, he was moved to a different ward so that staff could monitor the problems with his heart more closely. He underwent another x-ray and was assessed by a doctor on 5 December.

83. In the early hours of 8 December, the man developed a high temperature of 40.1 degrees. He was prescribed paracetamol and a doctor checked him at 5.30am. At 7.00am he underwent an ECG in bed and a short while later he was taken for an x-ray. At 9.30am, nursing staff told the escorting officers that they were extremely concerned about his health. The hospital staff telephoned his parents and advised them to travel in to be at his bedside.

84. At 10.40am, the man's parents arrived. His father told the escorting officers that he wanted the escort chain to be removed from his son if 'anything happened'. At 11.00am, the security manager arrived with the lead nurse at Forest Bank. He recorded in the bedwatch log that he was awaiting a decision from the doctors about the possibility of the man moving to the Intensive Care Unit (ICU).

85. The man was still secured to an officer using the escort chain, as he had been since arriving in hospital. However, five minutes later, having been told by the doctors that his prognosis was not at all good, the security manager decided to remove restraints on the lead nurse's advice. He sought and received approval for this decision from the Director.

86. The escort chain was removed at 11.10am, but two PCOs remained with the man. His family were at his bedside during the rest of the day and he was moved to the ICU later in the afternoon. He stayed in a side room and attached to a ventilator.

87. The man's health did not improve. On 9 December, hospital staff asked the PCOs not to eat and drink on the ward. (This is something the family subsequently complained about.) The nursing staff telephoned one of the managers at Forest Bank, who gave permission for one PCO at a time to remove themselves and eat in one of the nearby rooms. The nurses also complained to her that the man's parents wanted some privacy with their son and that the officers were getting in the way on the ward. She agreed that only one officer actually needed to be in the room with him from then onwards.

88. The man's parents, brother and niece spent time with him on 9 December. At 8.10pm that evening, the PCOs were given permission by prison managers to remain outside the room from then onwards.

89. At 6.00am on 10 December, a doctor told the PCOs that the man would not recover and that his family were being asked to come to the hospital. His health deteriorated very rapidly in the space of a few hours. At about 7.00am, the doctor talked to the family about turning off his ventilator, as hospital staff thought that it would be inhumane to try to resuscitate him because his heart was severely damaged and could not survive any further treatment.

90. The man died in hospital at 10.35am. His parents and brother were at his bedside. His heart was massively damaged and could not survive any further operations. The cause of death was heart failure as a result of infective endocarditis. The Director wrote to the man's mother expressing his condolences the same day. He also issued notices to staff and prisoners informing them of the man's death.

91. The Roman Catholic chaplain at Forest Bank contacted the man's parents by telephone on Monday 13 December to express condolences on behalf of prison staff. He telephoned them again on 18 January to offer the payment of funeral expenses on behalf of the prison.

ISSUES

Clinical care

92. The clinical reviewer is critical of the healthcare that the man received at Forest Bank before his admission to hospital in November. He writes in his clinical review:

> 'The clinical care that the man received whilst in HMP Forest Bank was not of an acceptable standard. There seems to have been a series of major errors and omissions, primarily on behalf of the medical staff and on occasion by the nursing staff.
>
> 'One gets the impression that medical care centred solely around acute and crisis management for this gentleman rather than addressing ongoing concerns.
>
> 'Clinical knowledge of medical staff appears to have deficiencies.
>
> 'I would have to recommend that medical care provision in particular from doctors was systematically reviewed at Forest Bank in light of this case.'

Reception on 30 June

93. The man's substance misuse resulted in a chaotic lifestyle involving offending. His intravenous drug use caused his heart condition, which necessitated an aortic valve replacement. His offending behaviour may well have meant that he did not regularly attend hospital appointments or look after himself in the community by taking his recommended medication. During his previous admission to Forest Bank between 29 May and 15 June, staff recorded that he had been treated with warfarin for his heart condition in the past but was presently taking aspirin instead. Nonetheless, once he entered custody again on 30 June and told staff about his leaking heart valve, the clinical reviewer stresses that they were under an obligation to take appropriate steps to treat and monitor his condition. There is no further reference to the use of aspirin to treat his condition in the clinical record.

94. Prison Doctor A assessed the man in the reception area on his first night in custody. Although the HCA who initially checked him made a note of his cardiac history and aortic valve replacement, the doctor did not prescribe warfarin (which the clinical reviewer thinks would have been the appropriate treatment).

95. On 25 October, the prison doctor subsequently wrote in the clinical record that the man would need to take warfarin for the rest of his life. The doctor told my investigator that he made an 'inexcusable omission' when he originally assessed him on 30 June. He confirmed that he had access to the HCA's notes on the computer when he assessed him.

96. During interview, the doctor commented that he would not have immediately prescribed warfarin on the man's first night in custody without seeking information from the hospital about his condition. However, he agreed that he should have asked a nurse to contact the hospital the next day to confirm his treatment plan.

97. The doctor was recruited to help run the Integrated Drug Treatment System (IDTS) clinic in the reception area at Forest Bank. The clinic targets drug and alcohol misusers and provides suitable treatment for withdrawal symptoms. The doctor told my investigator that he was working one of his first ever shifts (if not the first) at Forest Bank on 30 June. He did not yet have a username and password to log in to the electronic clinical record. He made his entry about the man under a colleague's name.

98. When he spoke to my investigator, the doctor explained that he had been focussing on adapting to his new role in the IDTS clinic. He had been unsure whether he was principally responsible for general medicine or treating drug and alcohol withdrawal. Although he lacked experience in the IDTS clinic at the time, he told the investigator that he is now comfortable with his role and its parameters. He confirmed that, when he worked his shift in the reception area on 30 June, he was the only doctor present and was responsible for all aspects of prisoner health that were brought to his attention by the HCA. He accepted that HCA A would have referred the man to him not only for his substance misuse but also for the problems with his heart. He conceded that he did not address the latter during their consultation that evening.

99. After the draft report of the investigation was published, the doctor contacted the investigator. He wrote:

> '…the death of the man still bears heavily on my conscience and I am very sorry on my part in not setting his care off in the prison health-care system on the right foot. I would again like to apologise to his family and have, over the past 18 months or so, amended my own clinical practice so that I try to make sure that such an important illness is dealt with properly as soon as the person is admitted to the prison. I do not want such an unfortunate series of events to happen to anybody else.'

Other missed opportunities to treat the man's heart condition

100. Although the doctor accepts that he missed an opportunity to prescribe warfarin, several of his colleagues also missed chances to progress his treatment when he became unwell. After Prison Doctor B assessed him on 21 July, he suspected endocarditis but did not order further tests. He planned to review his condition the following day.

101. The Head of Healthcare explained to the investigator that the planned review did not happen because neither the clinic nurse nor a member of the administration team scheduled a new appointment on the electronic clinical record system for 22 July. He explained that the new system had only just

been introduced at the time and that staff had not yet become sufficiently familiar with it.

102. He also accepted that a review planned by Prison Doctor C after he assessed the man on 26 July did not happen either. He was not then subsequently assessed until September. The clinical reviewer comments in his clinical review:

> 'On 21 July 2010, all the available evidence would strongly indicate that this gentleman had infective endocarditis at this point. The probability of this being the case would have been well in excess of 50 percent given he was a drug user, pyrexial, had a recent history of intravenous drug use, a valve replacement, a heart murmur and previous history of endocarditis.
>
> 'Good medical practice would have dictated that this be urgently addressed. This was far from the case with this gentleman. He should have been admitted at this point to hospital. He could at the very least have had an ECG, blood tests or blood culture. None of these were performed nor was he reviewed in a timely manner.
>
> 'There were multiple opportunities for medical staff to revisit this concern but it did not happen.'

Prescription of warfarin

103. The Head of Healthcare accepted during interview that the clinical record does not clearly document the decisions that different doctors made about the man's ongoing care and warfarin prescription. The clinical reviewer comments:

> '[The man] should have been on warfarin life long. If there were any highly unusual circumstances which could have contraindicated warfarin these should have been explicitly stated and documented.
>
> 'He was warfarinised in an inappropriate manner not according to any recognised protocol and this resulted in him being over-warfarinised. [The staff] also repeatedly forgot to give [the man] the [warfarin].'

104. It was not until 5 October that the man was prescribed warfarin. Prison Doctor D told the investigator that he decided to prescribe the drug after he diagnosed him with DVT. He told the investigator that he would have expected a patient with his medical history to have been prescribed warfarin for the rest of his life.

105. Although the doctor signed the prescription chart, his name is not printed. His reasons for prescribing warfarin are not documented in the electronic clinical record. There is no information recorded on 5 October to explain why the man was being given warfarin or stressing the importance of the drug.

106. There were errors in the way warfarin was subsequently dispensed. The doctor checked on 12 October and stopped the man's prescription for two days because he had been excessively warfarinized and his blood was now too thin.

Lack of referral to hospital

107. My investigator has been provided with evidence showing that staff took some preliminary steps to investigate the man's treatment as an outpatient at hospital when he was initially held in Forest Bank between 29 May and 15 June. It was noted that he was due to attend an appointment with a doctor in the cardiology department on Saturday 7 August and staff recorded that the appointment would need to be rearranged.

108. However, after he returned to Forest Bank, he twice further mentioned outstanding hospital appointments to members of prison healthcare staff (on 30 June and 2 September). On neither occasion is there any evidence in the clinical record to show that staff subsequently got in touch with the hospital and pursued the appointment with the doctor. He was not taken to any hospital appointments prior to the emergency on 10 November. The clinical reviewer considers the failure to liaise with the hospital to be 'of major concern'.

109. The Head of Healthcare explained to the investigator that his staff would normally telephone the hospital in such circumstances and then wait for an appointment letter to arrive in the post. However, they do not normally document their telephone call in the clinical record. In this instance, there is no evidence of a telephone call being made or of a letter being received after the man returned to Forest Bank on 30 June. This is not only unhelpful to my investigation, but also does a disservice to the staff. They may have made telephone calls, but because nothing is recorded, I am forced to conclude that they took no action to investigate the appointments he mentioned.

Lack of a care plan

110. Although the man reported a history of serious heart problems, there was no evidence of a systematic approach to his care. A care plan was not devised and there was no group discussion of his case amongst the medical staff. His ongoing care was not overseen by a lead doctor. Because decisions about his treatment were not clearly documented in the clinical record, it is hard to understand how each doctor assessing him could have a full and clear picture of his ongoing care. The clinical reviewer writes in his review:

> 'Continuity of medical care appears to have been poor…
>
> 'The man was seen by multiple doctors…
>
> '…doctors did not pay appropriate attention to previous clinical entries, they did not read reports, follow advice of other doctors…

'[The clinical records] are very difficult to follow and are unclear at times.'

111. The Head of Healthcare explained that prisoners who are not admitted to the healthcare centre as an inpatient do not normally have care plans. However, he agreed that, because of the serious nature of the man's health problems, he would have expected him to have had a care plan with the benefit of hindsight. He accepted that this was an omission because the man had complex care needs. He said that staff now have access to a care plan template on the electronic patient record system.

112. During interview, Prison Doctor D commented that he would like patients with similar problems to be subject to a care plan in the future. He expressed dissatisfaction that the man was discharged from the inpatient healthcare centre in late October without a care plan, despite needing warfarin, having suffered from pneumonia and having possible tuberculosis.

113. I am surprised there does not appear to be an effective chronic disease management protocol in place at Forest Bank. This would link in with providing appropriate care plans for treatment. For the man, if he had been identified as requiring this at any stage, it would have triggered a more holistic approach to his care.

Tuberculosis test

114. The prison doctor told the investigator that he ordered tests for tuberculosis on 20 October when the man was diagnosed with pneumonia and admitted to the inpatient unit. However, there is no evidence in the clinical record that the tests were carried out. He expressed his frustration during interview that one of his colleagues discharged the man from the healthcare centre on 26 October without the tests having been completed and without tuberculosis having been ruled out.

Conclusion

115. The clinical reviewer is very critical of the care that the man received at Forest Bank. He highlights a number of problems, principally the failure to recognise his pre-existing heart condition and treat it appropriately. The clinical record does not indicate that a methodical approach was taken to his care. It does not demonstrate that the different doctors were communicating with each other or that they had decided on a coherent plan of action. He told staff about his previous health problems and outstanding hospital appointments, but there is no evidence of any action being taken until he had been at Forest Bank for three months. Even then, there is no record of contact being made with the hospital.

116. I agree with the clinical reviewer that the healthcare the man received was 'not of an acceptable standard'. At the end of his clinical review, he makes the following recommendation:

'I would have to recommend that medical care provision in particular from doctors was systematically reviewed at Forest Bank in light of this case.'

117. The local Primary Care Trust do not commission the healthcare at Forest Bank and therefore it is not in their remit to conduct such a review. (The doctors at Forest Bank are employed by a company called Cimarron and the nursing staff are employed by Sodexo Justice Services.) I agree with the clinical reviewer and therefore invite the National Offender Management Service (NOMS) to commission a review. I endorse the recommendation and direct it to the appropriate staff in NOMS:

The Director of Probation and Contracted Services in conjunction with the Director of Offender Health should commission a review of healthcare provision at Forest Bank in light of the treatment the man received.

Informing the man's family about his ill health

118. When the man's parents found out that he had been treated for pneumonia in late October, they asked my Family Liaison Officer why the prison staff had not informed them that he had such a serious condition at the time. The Head of Healthcare told the investigator that it is not usual to contact family members if a prisoner is being treated for a non-life threatening illness. Although the man was admitted to the healthcare inpatient unit, he said that the pneumonia was controlled and he was discharged within a week.

119. Had the man's condition deteriorated and his pneumonia resulted in an admission to hospital, then the Head of Healthcare said that his family would have been informed. One of the reasons that the prison does not tell family members if a relative is admitted to the prison's inpatient unit is that they cannot visit the prisoner at their bedside. (If the prisoner is well enough, a visit can still take place as normal in the visits hall.) Such information might therefore cause relatives unnecessary and undue worry and they would not be able to visit the prisoner in the inpatient unit in order to relieve their anxiety.

120. I also note that prisoners staying in the healthcare centre have the option to use their telephone credit to get in touch with family members.

The emergency on 10 November

121. The man reported chest pains spreading down his arm when he was assessed by Nurse A shortly before 7.45am on 10 November. He did not leave Forest Bank in the ambulance until 4.20pm. A number of factors led to a delay of many hours before a heart attack was diagnosed and he was escorted from the prison.

Nurse A's assessment and referral

122. The prisoners were unlocked from their cells at about 7.00am. The PCO, who started her shift at 6.30am, told the investigator that the man came to the wing office a short while after he was unlocked. He said that he was feeling unwell and that he had a history of heart problems. She thought that he looked pale and ill and checked with a colleague because she did not know him very well. Her colleague confirmed that he did not normally look so pale. She telephoned the healthcare centre and asked Nurse A to come to the wing to assess him.

123. Nurse A also began her day shift at 6.30am. She told the investigator that she received a telephone call from the wing at about 7.30am informing her that the man had complained of experiencing chest pains since 6.00am.

124. During interview, the nurse said that she went to the wing and assessed him. She sat down with him on his bed and asked about the pain he was experiencing. He looked pale but his blood pressure and pulse rate seemed stable and gave the nurse no cause for concern. He did not seem clammy or sweaty.

125. The nurse told my investigator that he said that he was not currently in pain when she assessed him. She used the present tense in her entry in the clinical record, but stressed to the investigator that she had intended to use the past tense. She remembered that he told her that he had experienced central chest pain spreading down his left arm when he woke up. She told him that she would go back to the healthcare centre and put him on the list to be assessed by the doctor later in the morning.

126. The PCO accompanied Nurse A to the cell and remained there whilst she carried out her assessment of the man. She recalled that the nurse was not overly worried about him and told him that he was not having a heart attack. He was lying on the bed throughout the assessment.

127. During interview, the nurse told the investigator that it is not common practice for the doctors at Forest Bank to visit prisoners in their cells unless they are told that there is an emergency. The nurse returned to the healthcare centre and made an entry in the electronic clinical record at 7.46am. She checked the record and read about the man's cardiac history and aortic valve replacement. (This information did not prompt her to further prioritise his assessment because she thought that he did not otherwise appear to be unwell.) She told the investigator that he did not mention his cardiac history to her when they spoke in his cell.

128. She told the administrative assistant organising the morning surgery that the man had had chest pains since he woke up at 6.00am and that he needed to be assessed by a doctor during the morning surgery. She did not make an emergency referral and did not suggest to the administrative assistant that he was having a heart attack.

129. During interview, the nurse remembered that she had met an officer (one of the discipline staff) at about 11.30am, who reassured her that the man was going to be assessed by the doctor. The nurse was therefore surprised to walk into the surgery at 2.30pm and find him sitting in the waiting room waiting for his appointment.

Prison Doctor D's examination

130. Prison Doctor D told my investigator that he regarded the six and a half hour delay before he assessed the man as 'unacceptable'. He thought that he should have been referred to him as soon as he began his surgery at 9.00am. At the time, there was no means available of prioritising a patient at the start of the daily surgery if a nurse thought it important.

131. After the events of 10 November, the doctor suggested to his colleagues that each daily surgery begin with a vacant emergency slot. If a prisoner reports serious symptoms overnight, they can be accommodated in this slot at 9.00am and will not have to wait for an assessment later in the day. I gather that this suggestion has now been implemented.

132. The man went to a routinely scheduled appointment at the general practitioner's daily surgery at 2.30pm. He walked from his cell to the healthcare centre. The doctor told the investigator that he looked remarkably well when he assessed him. However, when he described his symptoms and relevant medical history, he thought that he might be having a heart attack (even though he had none of the usual symptoms such as profuse sweating, fast breathing, vomiting or being cold and clammy to the touch). As a precaution, the doctor ordered an electrocardiogram (ECG). Nurse A and the doctor both recalled how surprised they had been when the ECG results unexpectedly confirmed that he was indeed having a heart attack.

The delay in permitting the ambulance to depart for hospital

133. The doctor diagnosed a heart attack, took ECG readings and instructed that the man needed to be taken to hospital immediately. Nurse B telephoned for an emergency ambulance. Whilst Nurse A sat with him in the treatment room, the doctor wrote a referral to the hospital. He was seated, did not require resuscitation and was ready to be moved. The doctor had given him aspirin and he was provided with an oxygen mask to help him breathe.

134. Because of the man's intravenous drug use, the nurses could not easily find a vein to insert a canula into (this is a tube used to insert fluids). The healthcare staff decided that it would be better if this was done when he arrived at the hospital. There was no clinical reason to keep him at Forest Bank after the emergency medical technicians arrived. Yet they waited 55 minutes before discipline staff allowed them to depart in the ambulance. Nurse A became increasingly agitated as he was forced to wait. The following is an extract from my investigator's interview with the nurse and her colleague, Nurse B:

Investigator: … in terms of technicians doing what they need to do it sounds to me like that would have taken five, ten minutes maximum really from what you're saying because they can't offer a lot of treatment?

Nurse B: Even a paramedic wouldn't offer that much treatment. The aspirin had been given, [the man had] been seen by a GP and the GP was on site, a paramedic wouldn't be doing any more but if a doctor had said this is to happen a paramedic follows [those] rules. The doctor is the lead, the doctor had said he must go to an accident and emergency department. Even a paramedic would not overrule that so even if one of [the ambulance crew was] a paramedic and one was a technician there was no other treatment to be given until he got to [hospital] -

Investigator: No reason to delay really?

Nurse B: No. He'd had three ECGs.

Investigator: So as we said that might have taken five minutes to just assess and say right off we go, what happened to the other 50 [minutes], were you there the whole time?

Nurse A: Yes.

Investigator: What did happen in the other 50 minutes?

Nurse A: We were just waiting.

Investigator: Just waiting?

Nurse A: Waiting for security to come down.

Investigator: Did the technicians say why are we waiting this long?

Nurse A: Yes, yes, and we had to explain we're waiting for security to come and check the cuffs and that was basically –

Nurse B: But they weren't happy were they?

Nurse A: No they weren't happy.

Investigator: And did they express this?

Nurse A: Yes.

135. Some of the discipline staff my investigator interviewed thought that the delay might have been partly caused by the need for the ambulance crew to treat the man on site before moving him. However, the ambulance crew consisted of two emergency medical technicians (rather than paramedics). Technicians are not as highly trained as paramedics and can only deliver a limited form of treatment. The nurses did not remember the technicians providing any additional care other than monitoring him and making sure he remained stable whilst he waited.

136. I do not believe that the delay in the ambulance leaving Forest Bank was caused by the need for either the technicians or healthcare staff to give him additional treatment. Rather, my investigator's interviews with the three senior members of staff responsible for authorising his release to hospital revealed that the delay was caused by the completion of security checks:

The SPCO

137. The SPCO told the investigator that he was acting up in the role of orderly officer on 10 November. (The role would normally be filled by somebody at a grade above SPCO.) This was the fifth or sixth time that he had acted up in the post. He remembered that he had been dealing with an incident in one of the workshops when the call about the man came through on the radio about him. (A prisoner had become violent and needed to be removed.) The incident had just been dealt with when the call came over the radio and did not delay the SPCO's response to the medical emergency.

138. He remembered that he went to the healthcare department and contacted the duty manager to tell him about the emergency. He told the investigator that he had to locate three PCOs to accompany the man to hospital. He recalled that he would normally call upon staff carrying out general duties (rather than those allocated to a specific wing) to avoid unnecessary disruption to the running of the wings. However, he said that there were insufficient 'general duty' PCOs available and he had to use wing staff. During interview, the SPCO said that he secured two of the necessary officers from the wing where he himself normally worked.

139. He told the investigator that he asked a PCO to complete the necessary security and risk assessment documents. He said that various departments needed to complete different parts of the paperwork before it was ultimately given to the duty manager for his approval.

140. Because he was only temporarily promoted into his role and did not have a large amount of experience to draw upon, the SPCO said that he wanted to make sure that every part of the risk assessment process was completed correctly and properly. He said that he would not have been happy for the man to leave the prison without all of the correct documents being completed and authorisations given. He did not seek out the duty manager or the security manager and ask them to use their authority to hurry the process along. He confirmed that the man did not leave until all of the paperwork had been fully completed.

141. The SPCO remembered Nurse A complaining that the risk assessment process was taking too long. He recalled having to wait around for other colleagues to complete their parts of the process. He told the investigator that a manager did not attend the healthcare centre to either assist him or check the man. He told the investigator that it is normal for the duty manager only to appear once all the paperwork and restraints have been prepared. He reflected during his interview and said that, in future, he would seek out the duty manager immediately and ask them to help to expedite the risk assessment process.

The duty manager

142. The duty manager told the investigator that, although he signed off the necessary paperwork and approved the handcuffing arrangements before the ambulance left the prison, he was not otherwise involved in the process of preparing the man for departure. He did not go to see him in the healthcare centre and was not aware of how long it had taken the SPCO to make the arrangements.

143. I think that it would have been better if the duty manager had gone to check the man and speak to the healthcare staff. It would have assisted the SPCO if the duty manager had had oversight of the process and had attended the emergency to expedite the transfer of the man to hospital.

The security manager

144. The Head of Security did not oversee the risk assessment process or involve himself in the unfolding emergency. He checked the handcuffing in the ambulance at the last moment but did not go to visit the man in the healthcare centre. Although the duty manager runs the prison and authorises the level of restraints, it is usual practice for the security manager to deliver final approval of the handcuffing arrangements.

145. The two nurses told the investigator that, even after the man was eventually moved to the ambulance, there was a further period of delay whilst the escorting staff waited for the security manager to come to the vehicle to check the restraints. The nurses said that, although the amount of delay in this instance was atypical, in their experience ambulances always have to wait for paperwork and risk assessments to be completed before leaving Forest Bank.

The possibility of risk aversion

146. The security measures implemented whilst the man was escorted to hospital and during his subsequent stay related to his risk of escape. There was no evidence that he represented a risk of serious harm to the public. He did not have a history of either sexual or violent offending. The risk was judged to be increased by the very recent imposition of a seven year custodial sentence.

147. It would not be completely surprising if a degree of risk aversion influenced the thinking of the SPCO and other discipline staff. There have been two notable escapes from custody in recent years whilst prisoners were being escorted from Forest Bank to hospital. On 2 May 2010, an ambulance was ambushed during its journey, allowing a prisoner to flee. On 2 March 2005, a prisoner escaped from a taxi on the way to hospital. Staff were held at gunpoint during this escape.

148. The Deputy Director assured my investigator that Forest Bank's status as a privately run prison does not affect the way in which security is managed. He said that the contract that Sodexo Justice Services has with the Ministry of Justice makes no difference to the approach that staff take. He stressed that staff follow the same Prison Service Orders as their counterparts in public sector prisons.

149. The security manager acknowledged that the recent escape from an ambulance in 2010 had influenced the decision to routinely send three escorting officers with a prisoner to hospital in an emergency. However, he stressed that the recent escape had not caused staff to prioritise the completion of security checks at the expense of a speedy departure to hospital.

Expediting a transfer to hospital

150. The Head of Healthcare confirmed that the risk assessment process can be overridden if a prisoner is in a serious condition and the completion of security checks might delay the departure of the ambulance.

151. The security manager told the investigator that Oscar 1 (in this instance the SPCO) is supposed to collate the necessary paperwork. He estimated that this should take 15 minutes. In this instance, 20 minutes were available before the ambulance crew even reached the patient from the time the 999 call was made. He confirmed that the risk assessment process can be completed after an ambulance has left if the technicians and healthcare staff think this appropriate.

152. My investigator has seen the forms that need to be completed when a prisoner is taken to hospital. They require multiple signatures from different staff. It would seem sensible for either the duty manager (who normally assists the risk assessment process) or the security manager (who usually checks the physical security of the escort) to be on scene from the beginning of the emergency and to have overall authority to make a decision within a matter of minutes. It seems overly bureaucratic to require the approval of two different managers (albeit with slightly different levels of authority) before an ambulance can depart.

Conclusion

153. The managers my investigator spoke to assured him that healthcare staff and technicians are able to insist that an ambulance leaves immediately and that

paperwork is subsequently completed. However, the investigation has shown that the channels of communication did not operate in this manner on 10 November. (Nurse A expressed her concerns, but this did not prompt a rapid departure.)

154. I consider that a security and risk assessment procedure that takes 55 minutes when a prisoner urgently needs to go to hospital is lamentably deficient. Although the SPCO lacked experience, it seems that he followed the procedure to the letter for fear of not completing the checks to his managers' satisfaction. He spent time waiting for colleagues to provide him with information and sign off their parts of the process. His managers did not go directly to see the man or help to expedite the process.

155. I think that either the current arrangements for preparing an emergency escort to hospital are too complex and laborious, or staff require further training to explain how the risk assessment can be achieved within a reasonable timeframe. At present, the process is not fit for purpose. I make the following recommendations:

The Director should review the risk assessment process which staff have to complete when an emergency ambulance is called to take a prisoner to hospital. Consideration should be given to simplifying the process and reducing the number of people involved. Staff should be trained to complete the process in the most time efficient way.

The Director should instruct duty managers to always go directly to assess the situation when an emergency ambulance is called. They should speak to a member of healthcare staff and expedite any risk assessment procedure accordingly.

Did the delay in getting to hospital affect the man's care and treatment?

156. A consultant cardiologist at the hospital has considered whether the treatment the man received would have been different if he had been sent to hospital as soon as he reported chest pains on 10 November. He wrote to the Coroner with his findings. A consultant forensic pathologist had raised concerns about this issue. The cardiologist treated him after he was admitted to hospital.

157. The cardiologist writes that, because at least ten hours had passed between the man initially reporting chest pains and his arrival at hospital, there was little to be gained from a coronary angiogram (an examination of the arteries) and the insertion of a stent (a tube) after his admission to hospital. The ECG readings showed that it was too late to salvage the muscular tissue in the heart. He considers that 'the hazards [of these interventions] could [have] significantly outweigh[ed] the benefits'. He also thinks that the man's ongoing prescription for warfarin was a reason not to proceed with this sort of procedure.

158. The cardiologist writes:

> ‘When patients present with acute myocardial infarction [heart attack] then of course speed is of the essence…
>
> ‘Ideally, one would wish to offer these treatments within an hour of the onset of symptoms, certainly within six hours…
>
> ‘In the man’s case, the decision to treat with medical therapy rather than interventional therapy … by the time he arrived at hospital does seem entirely appropriate in view of his ECG appearance and the time since the onset of symptoms.’

159. However, he further comments:

> ‘There would… be concern about patients with active infection [the man had endocarditis] undergoing coronary intervention and the possibility of disseminating further infection. Performing coronary intervention in his case could have had the effect of causing further problems…
>
> ‘Therefore it is unlikely that had he [been escorted to hospital] earlier and been taken to an interventional centre that an angioplasty and stent [both surgical procedures] would have gone ahead.’

160. He concludes:

> ‘Therefore my opinion is that even if the man had [been brought to the hospital] much earlier with his myocardial infarction that he would have still been managed with medical therapy rather than interventional therapy and that therefore the outcome would not have been different…’

Restraints

Journey to hospital

161. The man was double handcuffed in the ambulance on 10 November. (This means that both of his hands were placed in front of him in a pair of handcuffs. A PCO then used a second pair of handcuffs, attaching one handcuff to their wrist and the other to the man’s.) The duty manager said that he approved the use of double handcuffing on the basis of assessments made by the SPCO and a nurse. He said that the ambulance crew could have raised objections if they felt that the double handcuffs were going to obstruct treatment.

162. The security manager said that double handcuffing is almost always used when a prisoner is taken to hospital. He said that an escort chain could be considered if the ambulance crew wanted to use a defibrillator, but that they would need to indicate this before they left.

23 November

163. The man was attached to PCOs using an escort chain for the majority of the month he spent at hospital. However, he was escorted to the second hospital for a few hours on 23 November to undergo a medical procedure. He was double-handcuffed for the journey there.

164. He remained in double handcuffs whilst he was away from the first hospital, except when he was undergoing the medical procedure. During the procedure, he was attached to a PCO using an escort chain. When my investigator read the bedwatch log completed by the PCO, it initially seemed to indicate that he may not have been awake for the procedure. My investigator interviewed the PCO to clarify his entries in the log, because prisoners who are fully sedated and undergo a surgical operation are not supposed to be restrained whilst they are unconscious.

165. The PCO indicated that the man had only been lightly sedated rather than being given a general anaesthetic. Therefore the use of restraints was appropriate, because he was only groggy and the procedure was not a surgical operation. He described the procedure as likely to have been an endoscopy (whereby a camera is fed down the patient's throat on the end of a tube). He remembered that the man was awake throughout although he was not very coherent. After the procedure, the nurses gave him medication to bring him around fully, which worked in a matter of minutes. The PCO confirmed that the MRI staff had been content with the use of restraints.

Behaviour of the escorting staff

166. The man's mother made a point of telling my family liaison officer that some of the escorting staff had been sensitive and courteous. However, she also raised concerns about the conduct of some of the PCOs at hospital. She felt that the family were not granted sufficient privacy as her son's condition deteriorated and he lay dying. She was also upset that some of the escorting officers had eaten in front of her son 'as if they were at the pictures'. This behaviour was noticed by the nursing staff, who asked the PCOs to take their food out of the ward on 9 December. She was also distressed that one officer had a cold and was sneezing over her son, who was already extremely fragile and unwell.

167. Although I do not make a formal recommendation, I draw the Director's attention to the man's mother's comments. I acknowledge that it is difficult for staff escorting prisoners to always act as the family might wish because of security concerns. However, I would ask PCOs to bear in mind how their actions can be perceived by others. To be eating sandwiches as distressed relatives say their goodbyes to a loved one could be considered tactless. Similarly, if an officer has a bad cold, the security manager may want to send a different PCO to the hospital to show sensitivity. Although the man was still a serving prisoner and the officers had to stay with him until shortly before he

died, it does seem unfortunate to expose him to further illness in his already weakened condition.

168. I consider that the security manager made an appropriate decision (on the lead nurse's advice) to remove the escort chain when the man's condition deteriorated rapidly on 8 December. Whilst it must have been distressing for his parents to see him still handcuffed when they first arrived at the hospital that morning, I am glad that he took a sensible approach so promptly.

169. Over the next 48 hours, staff were gradually permitted to withdraw, eventually waiting outside the ward. Again, although I do not make a formal recommendation, I would ask the Director to think about how his staff might handle a similar situation in the future. It was clear that the man was highly unlikely to recover, and the withdrawal of the escorting officers at a slightly earlier juncture might have spared the feelings of his parents (and avoided some of the difficulties I have described).

Consideration of release on compassionate grounds

170. The Deputy Director told the investigator that the prison did not begin an application to release the man from custody on compassionate grounds before he died. He said that the staff at Forest Bank realised that he was likely to be in hospital for the foreseeable future, but that it was only in the last couple of days before his death that it suddenly became clear that he was not going to recover. Until that time, the managers at Forest Bank had thought that he was going to return to custody once he had completed his course of treatment and his condition stabilised. The intention was to maintain the bedwatch with the escorting officers for as many weeks or months as was necessary.

171. Release on compassionate grounds is a complex process that involves applications to the Secretary of State. In this instance, although he was very unwell, he was not considered to be terminally ill until his condition deteriorated very rapidly. I am satisfied that the prison took a sensible approach to the ongoing escort at hospital.

Family Liaison

172. The Roman Catholic chaplain in overall charge of the chaplaincy at Forest Bank was asked to liaise with the man's family after he died. He had not received any family liaison training at the time. The only trained family liaison officer (FLO) was absent from Forest Bank and I understand that they are unlikely to return to work in the near future.

173. Three days after the man died the chaplain telephoned his parents to express condolences on behalf of the staff. His mother praised the support that he provided when she spoke to my family liaison officer. However, the chaplain did not mention that the prison would contribute towards funeral expenses (in accordance with the policy of the National Offender Management Service). He did not suggest a face to face visit in order to offer condolences on behalf

of the prison in person. He also did not arrange for the family to receive their son's property.

174. When another of my investigators opened the investigation for the investigator on 15 December, she was told by the Deputy Director that the prison was waiting to see if the family asked for funeral expenses.

175. When one of my family liaison officers spoke to the man's mother on 5 January, she said that the prison had not yet offered to return her son's property. My investigator subsequently raised this issue with prison staff and she was soon after able to collect her son's property from the prison.

176. Another of my investigators was investigating the death of a different prisoner at Forest Bank at the time. She wrote to the Director on 5 January 2011. The investigator pointed out that neither the man's family, nor the family of the other prisoner, had yet been offered funeral expenses, a requirement that is set out in Prison Service Order (PSO) 2710. She reminded the Director of the terms of the PSO.

177. The chaplain telephoned the man's family for a second time on 18 January 2011 to tell them that the prison would like to contribute towards the cost of the funeral. The Director instructed the chaplain to extend this offer to the family.

178. I have sympathy with the chaplain, because he had not received the necessary family liaison training when he was asked to contact the man's family. Although chaplains are often asked to speak to families after a death in custody, this is usually in the company of a trained FLO who is familiar with the requirements set out in the PSO.

179. I consider that a trained FLO should have contacted the family and offered a face to face visit from prison staff after the man died. Funeral expenses should have been offered immediately because he was a serving prisoner. The prison should have offered to take his property to his family, rather than obliging them to collect it. It would also have been helpful if the chaplain had provided the family with information about my investigation. The man's mother was not expecting a telephone call from my FLO and knew nothing about the Ombudsman's investigation. I make the following recommendation:

The Director should ensure that the requirements set out in Prison Service Order 2710 are followed in the event of the death of a serving prisoner.

180. I am pleased to note that the chaplain and an SPCO attended a family liaison training course at the start of March 2011. The prison now has two trained FLOs. In a prison as large as Forest Bank, I consider this to be a necessity.

Hospital visits

181. The man's family have expressed concern that they found it a laborious and upsetting process to gain access to their relative whilst he was treated in hospital for a month. They had to telephone the security department at Forest Bank and prearrange each visit to him. Eventually they became frustrated with the process and spoke to hospital staff, who attempted to make things easier for them.

182. Whilst I understand the need to ensure security when a prisoner is treated at hospital, it might have been helpful if the man's family had been given the name of one particular member of staff who could have assisted in facilitating their visits. For example, one of the chaplains. The chaplain told my investigator that he was not asked to contact the family between 10 November and 10 December, even after his condition deteriorated. I make the following recommendation:

The Director should review the visiting arrangements for family members of prisoners under escort at hospital. Consideration should be given to appointing a member of staff such as the chaplain to liaise with the family and help them with any difficulties they experience.

CONCLUSION

183. It is unusual for the Prisons and Probation Ombudsman to recommend that a prison's healthcare provision be reviewed. However, in this instance the clinical reviewer found the treatment the man received to be wanting. What is perhaps most worrying about his treatment is the lack of any coordination by the doctors. A man with a serious pre-existing heart condition was not offered a long term care plan and no efforts were made to contact the hospital. His potentially life threatening illness was not treated with the appropriate medication for three months. The clinical reviewer rightly comments that the healthcare offered by Forest Bank was 'not of an acceptable standard'.

184. Although the cardiologist has concluded that the man would not have received different treatment if he had been taken to hospital more promptly on 10 November (because of his endocarditis), I have serious concerns about the delays that took place. As the cardiologist notes, the man had sustained serious damage to the muscular tissue in his heart by the time he arrived at hospital. It is very worrying that his description of chest pain spreading down his arm did not prompt an immediate examination by a doctor. That it took over six hours for a doctor to assess him is baffling. That the ambulance crew were obliged to wait 55 minutes whilst a risk assessment process was completed is unacceptable. I hope that the Director and the Head of Healthcare at Forest Bank will think carefully about striking a balance between security and emergency medical treatment, to ensure that in future the former does not take undue precedence to the detriment of the latter.

The man's parents' response to the draft report

185. The man's parents received a copy of the draft report of the investigation. In their response, they said that prior to receiving the draft they had decided to accept that years of substance misuse had taken their toll on their son's health. They had believed that little could have been done to prevent his death.

186. Having read the draft report, they were therefore distressed to learn that the healthcare their son received at Forest Bank for a pre-existing heart condition was not of an acceptable standard and that a series of omissions by healthcare staff had been identified. They think that these omissions may have contributed to their son's death.

187. His parents told the family liaison officer that they recognise that no one individual is responsible for the failure to treat their son appropriately. They read the draft report and consider there to have been a systemic failure in clinical care. They are grateful that the investigation highlighted learning for the benefit of other prisoners and made recommendations to improve practice at Forest Bank. They are concerned that other families should not have to go through a similar experience.

188. They are concerned about the delay in assessing their son on 10 November. They identified a failure to prioritise their son, given the location of his pain and his history of cardiac problems.

189. Although concerned by the delays incurred on the day their son was taken to hospital, they are more worried about the missed opportunities to treat his pre-existing heart problems. Despite him informing healthcare staff of his cardiac history, his family were upset to learn that no apparent efforts were made to contact the hospital where he received treatment. They are also upset that planned reviews of his condition did not take place and that there was a significant delay in prescribing the medication he needed to manage his heart condition. They believe that the healthcare that their son received was inadequate because of his status as a prisoner.

190. They said that it is difficult to live with the knowledge that the outcome might have been different had their son's heart condition been appropriately assessed and monitored from the outset.

191. They were concerned to read about the death of another prisoner at Forest Bank in 2005. They were worried that this earlier investigation concluded that the man's death might have been avoided if he had been given appropriate treatment at an earlier stage. They questioned why serious failures in healthcare were still happening five years later.

192. Responding to the draft report, the man's parents expressed concern at Forest Bank's failure to put in place a prison health development strategy, as highlighted by Her Majesty's Chief Inspector of Prisons in 2010.

193. The man's parents said that, after their son was treated for pneumonia in late October, he told them that he was still in a lot of pain and that the healthcare staff at Forest Bank did not appear to be taking him seriously. His mother explained that she contacted the prison in order to relay her son's concerns. However, she indicated that she could not get past the switchboard operator.

194. The man's mother had assumed that there would be a welfare officer who families could speak to if they have concerns about a relative. She was told she could speak with the chaplain if she wanted. She suggested that there should be a dedicated member of staff or a telephone number which families can call if they have concerns about a prisoner's wellbeing. We draw her suggestion to the Director's attention.

195. The man's mother discussed with the family liaison officer how she and her husband had initially struggled to find out which hospital their son was staying in. She accepts that their son was a prisoner and security must be a priority. However, she felt that the prison staff showed little regard for the distress it would cause a family to be told their loved one was seriously ill but to not inform them immediately where they are and when they can see them. We draw her comments to the Director's attention.

196. The man's mother said that she was surprised to read in the clinical review that her son was recorded as undergoing an alcohol withdrawal regime. She told the family liaison officer that her son was not known to misuse alcohol in the community.

197. References to an 'alcohol withdrawal regime' were made by staff in the electronic clinical record on 2, 3 and 4 July. However, these references were coded entries entered onto the computer without any context or qualification. Upon his arrival on 30 June, staff had recorded that the man was a 'light drinker' who consumed alcohol 'very rarely'.

198. As the clinical reviewer comments in the clinical review, there is no evidence that the man was subsequently prescribed alcohol withdrawal medication. Although he cannot be absolutely certain, he believes that the entries made at the start of July were a data input error, as they were never referred to again.

199. The man's mother also said that she was surprised to read that her son had not complied when attempts were made to treat his hepatitis C. She told the family liaison officer that this did not ring true, because her son would have wanted medical intervention so that he was in less pain and discomfort.

200. When he arrived at Forest Bank on 30 June, the man told staff that he had not yet started treatment for hepatitis C. Prison Doctor A recorded that he had not yet been offered interferon. The doctor 'seriously advised' him to seek treatment for his condition because there was an 80 percent chance of a cure. There is no further reference to the condition in the clinical record. The doctor informed him of the need for treatment, but no further action was taken by clinical staff or requested by him.

201. The clinical reviewer mentioned in the clinical review that some of the man's records were removed by the police. His parents were confused by this remark. Any additional documentation would have been given by the police to the Coroner in preparation for the inquest and will now be held by the Coroner.

RECOMMENDATIONS

To the Director of Forest Bank:

1. The Director should review the risk assessment process which staff have to complete when an emergency ambulance is called to take a prisoner to hospital. Consideration should be given to simplifying the process and reducing the number of people involved. Staff should be trained to complete the process in the most time efficient way.

   The Director accepted the recommendation and provided the following response:

   'A review of the risk assessment is to be undertaken by the Head of Security and Operations. A simplified version of the current risk assessment for emergency escorts will be in use from the implementation date.'

2. The Director should instruct duty managers to always go directly to assess the situation when an emergency ambulance is called. They should speak to a member of healthcare staff and expedite any risk assessment procedure accordingly.

   The Director accepted the recommendation and provided the following response:

   'An operational instruction will be issued as guidance for duty Managers on the appropriate action to take when an emergency ambulance is phoned.'

3. The Director should ensure that the requirements set out in Prison Service Order 2710 are followed in the event of the death of a serving prisoner.

   The Director accepted the recommendation and provided the following response:

   'A checklist of the requirements in the PSO will be developed immediately and will then be incorporated into local contingency plans when they are reviewed. Fully trained FLO Officers give assurance that all aspects of family support is now offered.'

4. The Director should review the visiting arrangements for family members of prisoners under escort at hospital. Consideration should be given to appointing a member of staff such as the chaplain to liaise with the family and help them with any difficulties they experience.

   The Director accepted the recommendation and provided the following response:

   'Visiting arrangements will be reviewed and the Chaplain will form an integral part of liaison with the family members for advice and support.'

To the National Offender Management Service (NOMS):

5. The Director of Probation and Contracted Services in conjunction with the Director of Offender Health should commission a review of healthcare provision at Forest Bank in light of the treatment the man received.

   As a result of the Ombudsman's recommendation, a clinical reviewer was jointly commissioned by NOMS and Offender Health to review the delivery of healthcare at HMP Forest Bank.

   We understand that both the findings and recommendations in the clinical reviewer's report have been fully accepted by the prison and that Forest Bank have put into place an action plan to deal with the recommendations.