PRISONS AND PROBATION OMBUDSMAN for England and Wales

Independent Investigations

Investigation into the circumstances surrounding the death of a man at HMP Forest Bank in May 2011

Report by the Prisons and Probation Ombudsman for England and Wales

December 2012

This is the report of an investigation into the death of a man. He was found in his cell at HMP Forest Bank on the morning of 3 May 2011. The post mortem established that he died of heart disease. He was 37 years of age. I extend my condolences to his family. I hope the report goes some way to answering any questions they may have.

The investigation into the man's death was undertaken by an investigator. A clinical review of his medical care in custody was commissioned by the local PCT and undertaken by a clinical reviewer. I am grateful to him and the Director and staff of Forest Bank for their co-operation with the investigation. I apologise for the delay in issuing this report.

The man was remanded into prison on 18 October 2010 and was waiting to be sentenced. He was assessed by healthcare staff on reception and reviewed at various times throughout his stay at Forest Bank. He had been diagnosed with slightly raised blood pressure and had possible symptoms of high cholesterol but these were not investigated further. He had episodes of dizziness and loss of consciousness and had been referred to a neurologist. He was also prescribed medication for psychosis but a formal diagnosis had never been given.

This investigation found that the man had reported a number of symptoms of ill health that were not fully investigated, nor were National Institute for Health and Clinical Excellence (NICE) guidelines followed. A psychiatrist rejected a referral for him without seeing him and staff failed to challenge this despite their misgivings. His prescription chart was poorly completed and information was either missing or conflicted with other records. In addition, procedures for suicide and self-harm were not followed when he reported thoughts of harming himself and the actions taken after his death were not fully documented.

The clinical reviewer concluded that the care given to the man at Forest Bank was below a desirable standards and I agree. I acknowledge that staff would not necessarily have suspected severe heart disease in someone of his relatively young age nor that his death could have been prevented. Nevertheless, it is clear that there were serious failings in his care. I would expect Forest Bank to act on the eight recommendations in this report to ensure there is no replication of these deficiencies.

After the draft report was issued, solicitor's acting on behalf of the man's family raised the point that the prison did not request his medical records from his General Practitioner (GP). I have added discussion of this matter and one further recommendation to the report.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **December 2012**

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SUMMARY

1. The man was remanded into Forest Bank on 18 October 2010. He died in May from acute left ventricular failure as a consequence of ischaemic heart disease (an inadequate supply of blood to the heart due to narrowing of the arteries).

2. He was seen by healthcare staff at Forest Bank on numerous occasions. There is no evidence that staff requested his medical records from his GP in the community. He twice had slightly raised blood pressure but this was not investigated further as should have happened according to the prison's healthcare guidelines. He had also been diagnosed with Xanthelasma (deposits of cholesterol in the skin) and although a test was recommended this did not occur.

3. While in custody, the man had episodes of dizziness and loss of consciousness. It was suspected that epilepsy could be the cause although no thorough tests were completed to ascertain this. However, he was referred to a neurologist after repeated episodes. He was prescribed medication for psychosis but there is no evidence that a formal mental health assessment was conducted. He was referred to a psychiatrist who read his medical records but did not have a consultation with him. He was also prescribed opiate substitution medication as he had tested positive for opiates.

4. At the beginning of May the man was found in his cell. Healthcare staff responded immediately to the emergency code called by a colleague but there was no attempt to resuscitate him as he showed no signs of life. He was pronounced dead at 8.30am by paramedics.

5. Some, but not all, aspects of the Death in Custody contingency plans were completed and there is little evidence of what support staff received and how the man's next of kin were informed.

6. We conclude that there were shortcomings in the management of the man's healthcare, although there is no suggestion that these led to his death. It is important that these weaknesses are remedied. We make eight (seven from the draft report and one new) recommendations. These relate to healthcare staff following the national guidelines on managing hypertension and episodes of loss of consciousness, ensuring healthcare colleagues challenge decisions of their peers when necessary, how prescriptions are recorded in the prison, requesting GP records, implementation of suicide and self-harm procedures and completion of documents after a death in custody.

THE INVESTIGATION PROCESS

7. The investigation was carried out by an investigator, who visited HMP Forest Bank on 6 May 2011. She met the Director, members of the Independent Monitoring Board (unpaid, independent volunteers who visit the prison to ensure proper standards of care and decency are maintained) and the Prison Officers' Association. She was also briefed by the prison's two family liaison officers. She returned to the prison on 8 and 14 July, to interview staff alongside the clinical reviewer.

8. Notices announcing the investigation and its terms of reference were issued to both staff and prisoners at Forest Bank. The notices were displayed around the prison and invited staff and prisoners to contact the investigator should they wish to do so. However, no one contacted the investigator.

9. The investigator was shown the cell in which the man lived. She reviewed his prison and health records and other documentation relating to the time that he spent at Forest Bank. She also had access to a summary of telephone calls made by him.

10. A clinical review was commissioned from the local PCT and was undertaken by a clinical reviewer.

11. The investigator has also been in contact with the Coroner's office. A copy of this report will be sent to HM Coroner for Greater Manchester West to assist with her enquiries. The delay in issuing this report was due to workload pressures in this office.

12. One of the Ombudsman's family liaison officers contacted the man's partner to discuss the purpose and scope of the investigation and give the family the opportunity to raise any concerns they had about his death. His partner asked how his withdrawal from valium had been managed, as she was concerned about his inability to sleep. The clinical reviewer was asked this question and although he did not answer it specifically, his report discusses how the medication was being managed. She also asked if the head injury he sustained prior to custody could have been linked to his death as he had never previously experienced seizures. The post mortem report concludes that he died from ischaemic heart disease, so does not link the head injury to his death.

HMP FOREST BANK

13. HMP Forest Bank is run by Sodexo Justice Services and it opened in 2000. It is a category B local prison for adult and young adult male prisoners and has the capacity to house up to 1,424 prisoners. (Prisoners are risk assessed when they go into prison and given a category based on their offence and the risk that they pose to the public should they escape.) Category B are prisoners for whom the highest security conditions are not necessary but for whom escape must be made very difficult.

14. The last full unannounced inspection of Forest Bank by HM Inspectorate of Prisons was in 2010. The resulting report said Forest Bank was a good local prison having made a number of improvements since the last inspection. The Chief Inspector said as the prison serves the local area it had “engaged energetically with a range of community partners to assist prisoners to resettle successfully on release”. The report said there was no prison health development strategy; although the plan was to develop one following the completion of a health needs analysis that year.

15. In its report for the year 2009 to 2010, the Independent Monitoring Board said it had an “excellent professional working relationship” with staff and the senior management team who, “are dedicated, caring and diligent in carrying out their respective roles within the prison”. The report raises concern about the cuts to the budget but that staff should be “congratulated for the amount of thought and effort which has gone into the planning…to maintain the regimes”. The report also said that one of the main complaints related to the “transfer of information and money for prisoners arriving at Forest Bank from public sector prisons”.

16. The man’s death is the fourth from natural causes in Forest Bank since the Ombudsman was given the responsibility for investigating deaths in custody in April 2004. All deaths in custody are subject to investigation by this office and there were no similarities between the circumstances of his death and those previously at Forest Bank.

KEY EVENTS

17. The man appeared at Magistrates' Court on 18 October 2010 and was remanded into HMP Forest Bank. A Cell Sharing Risk Assessment (CSRA) was completed on his arrival which said he was a low risk of harm to others. (The CSRA is a document to assess the risk a prisoner poses to others sharing a cell.) A first night assessment was also completed which noted he had "anxiety disorder" and it was recorded in his healthcare record that he had used cannabis in the month prior to custody.

18. The same day, the man was referred to the doctor due to physical injuries, including pain in his ribs and a possible fractured nose as well as his mental health. He told healthcare staff he was beaten up a few days prior to coming into custody but discharged himself from hospital. The notes show he was receiving medication for mental health problems, namely agoraphobia (an intense fear of being in a public place) and anxiety disorder. He was receiving disability living allowance for this. The record states that he had no self-harm or suicidal thoughts but had tried to harm himself two weeks before coming into prison by burning himself with a cigarette. That evening, a doctor reviewed him and prescribed prochloperazine (used for anxiety, mania, schizophrenia, dizziness and nausea), diazepam (for anxiety), and duloxetine (an antidepressant). He also prescribed him paracetemol and ibruprofen for pain relief.

19. The following day, healthcare staff contacted the man's GP to ask what medication he had been prescribed in the community. The surgery staff faxed through a copy of his prescription form, showing that he was prescribed duloxetine, diazepam and prochlorperazine (for anxiety). Only the medication information was requested and there is no evidence that the full medical record was requested at that or any other time.

20. On 29 October, the man was seen by a mental health triage nurse at his request. However, he said he did not want any further involvement with the mental health team because the doctor had now prescribed him medication.

21. On 8 November, at the man's request, the doctor asked for him to be located in a single cell due to his low mood and his snoring. His prisoner personal record notes he was moved into a single cell on 11 November, due to his mental health issues. A week later, again at his request, he was moved to a different cell to share with another prisoner. Staff noted this arrangement worked well and he appeared more settled.

22. It was recorded in the man's prison record, on 6 December, that he told staff he had burnt himself with a cigarette because he had not received his medication. Staff wrote that he was due to get his medication that evening. Two days later, he was seen by a doctor, who noted there were no signs of mental illness so he stopped the prochloperazine and prescribed medication for agitation.

23. The man was seen by a nurse on 19 and 23 December. He had reported a cough and then a sore throat. He also asked to have a review with a mental health nurse. His prison records show that on 19 December he was polite and compliant on the wing but could get angry and frustrated, although wing staff did not know the cause of this.

24. On 4 January 2011, the man appeared at Magistrates' Court for the start of his trial. He then returned to Forest Bank.

25. Two days later, he was seen by a nurse as he was complaining of insomnia, dizzy spells and felt depressed. He again asked to see the mental health team and she referred him to the doctor and the mental health nurse. Later that evening, healthcare staff responded to an emergency call from the wing as he had collapsed and had an abrasion on his head. The nurse referred him to the pharmacist for a review of his medication which took place the following day. The pharmacist made recommendations for certain changes to be made to his medication, although he noted that he did not have a full understanding of the rationale for why a certain drug, duloxetine, had been prescribed as it had not been recorded on the prison healthcare system.

26. A doctor saw the man again on 10 January, as he was having problems with his sleep. He noted that he had a history of auditory hallucinations and delusional behaviour but did not believe him to be psychotic. He prescribed olanzapine (to treat schizophrenia and mania) and asked for him to be seen by the mental health team.

27. The man was seen on 14 January by a mental health nurse "regarding his symptoms of anxiety, insomnia, panic attacks, depression and self harm - along with his history of suicidal behaviours". She wrote in his medical record he was "desperate for help in relation to the above symptoms" and she was going to refer him to the doctor.

28. On 20 January, during an appointment with a doctor, the man asked the doctor to increase his dosage of olanzapine or give him sleeping tablets. The doctor suggested a review with the mental health nurse instead. However, the man declined the review as he thought he was waiting to see the mental health in-reach team (the team are the second stage once a prisoner has seen the mental health nurse). He became abusive to the doctor and was given a warning for his behaviour. There is a written request, dated 21 January, on his file for him to see the Independent Monitoring Board as he was unhappy with the decision made by the doctor. There is no record as to whether this request was granted.

29. That same day, a nurse entry in the man's medical record said "asked to see IDTS re: review of his medication. He stated he had been using Subutex on the wing and was asking for substitute medication ie methadone". (the Integrated Drug Treatment Service, IDTS, is a multi disciplinary team in the prison working to ensure effective treatment is available for prisoners with drug misuse issues. Subutex is an opiate substitution medication. The team comprises prescribers, drug workers, prison officers, education staff and others.) This is the first reference to IDTS in his file. The nurse referred him to see a doctor.

30. An entry in the man's personal record says, on 22 January, he "fell down the stairs and started fitting Oscar 1 and Hotel called and attended" (Oscar 1 is the officer in charge and Hotel 2 is the call sign for the emergency nurse on duty). Healthcare staff saw him on the wing and the medical record entry says he had a seizure but "No medical intervention required following recovery … communicating well, orientated to time and place, advised to rest in pad". The following day, he was then seen by a healthcare assistant, who wrote in his medical record:

> "Seizure…likely first episode seizure yest, few weeks ago had collapse, thought to be postural hypotension [fall in blood pressure] due to meds interacting. Recalls feeling dizzy, held railing then LOC [loss of consciousness], felt nauseous afterwards, no incont, no tongue biting, says feels dizzy all the time".

The record also says:

> "headbutting+punching walls, cig burns on forearm; form of DSH to help him deal with stress, fed up nothing being done, says on w/l [waiting list] for mental health team for past 3w, threaten to self medicate, chat re abuse of subutex".

He had a urine test that day which was positive for subutex and methadone.

31. The following day, a doctor wrote in the man's medical notes, "Discussed reluctance to keep prescribing methadone. Stabilise, then reduce from 20mls daily". The doctor also noted he had "Xanthalasm R eyelid-suggest cholesterol and profile, strong family history of heart disease". There is no record of a cholesterol test having been done. (Xanthelasma is yellow cholesterol deposits under the skin around the eyes.)

32. The mental health nurse saw him again on 26 January and they discussed his recent seizures and current medication. She did not think there was any evidence of psychosis. He asked to see a psychiatrist and she said the mental health in-reach team had booked him an appointment for 31 January, to see a psychiatrist. Our investigation team had access to a letter in relation to him, written by the psychiatrist, dated 4 February, to the prison medical officer. The psychiatrist did not see him but had read his medical record and said:

> "he seems to be demanding sleeping pills, a variety of benzodiazepines, any antipsychotic and Olanzapine. The entries don't suggest any mental illness/psychotic disorder other than drug dependence. If you think he has a psychotic illness I am happy to see him but if he just demanding medication…..I am happy to trust your judgement in declining the offer".

33. This was not progressed any further by the healthcare department. At interview, the doctor was asked if he felt able to challenge that decision. He said no, as the psychiatrist was an experienced prison psychiatrist.

34. The man had an appointment at the hypertension clinic on 8 February and was seen by a nurse. She told the investigator that he had been asked to attend the clinic as he had had slightly raised blood pressure on his reception to the prison. His blood pressure was also slightly raised on this occasion so she gave him dietary advice, referred him to the smoking cessation adviser and arranged for him to be reviewed in three months. She asked him about family history of heart disease but said he told her it was not in his immediate family. She explained to the investigator that the hypertension policy at Forest Bank is to only investigate further if there are three readings of raised blood pressure.

35. On 17 February, healthcare staff were called to the wing after the man told wing staff he had "fitted" in his cell. A nurse examined him and her entry in the medical record notes "He claims to have blacked out; he has a very small

lump to the side of his head. OBS taken BP 140/70, SATS [oxygen in the blood] 98%, PEARL, ice pack given, no further intervention needed".

36. A doctor reviewed the man on 22 February and he noted he "has a long history of head trauma and substance misuse: he has allegedly had 8 or so episodes where he blacks out". The doctor referred him to an outside hospital neurology department for further investigation and there is a letter in his file with an appointment for 10 May. The clinical reviewer asked the doctor why no fuller examination was done to see what might have been causing the loss of consciousness. This would have involved asking if anyone had witnessed the episodes. Although the doctor had been told that other prisoners had been present when he had some of the episodes, he said "I never wanted to talk to them because of confidentiality reasons really ".

37. The next entry on the man's medical record was on 8 March, when he said he was struggling with his methadone reduction programme and a nurse agreed he could remain on the same dosage. He was seen the following day by another nurse, who said he complained of "feeling anxious, having panic attacks, feeling low in mood". She informed the mental health nurse and she saw him again on 11 March. She noted in his medical records he:

> "appeared both angry and anxious. He states he has not self medicated for the past 6 weeks and feels that he doesn't get the help and support he needs. He stated he received a copy of a letter saying that he was declined for an appointment with the psychiatrist within the prison".

His prisoner record entry on that day states he had employment in one of the workshops, was getting on well with other prisoners and there were no issues at that time. On 18 March, it was noted that he had not attended for his methadone since 13 March.

38. On 20 March, his prisoner personal record says "He fell whilst fitting in his cell. Hotel 2 [one of the healthcare staff] attended". Healthcare staff spoke with the man, who said "he woke on the floor after banging his head". He told a nurse that he did not feel dizzy or sick but had a headache for which she gave him paracetamol. Two days later, another nurse was called to his wing as he had a "funny turn" and fell over. He told her he had a few episodes like this and was waiting to see the neurologist. The same day, another nurse was asked to see him on the wing. She said he was "sweating profusely….disorientated and confused, slurred speech". She told the investigator that she did the necessary checks and asked a doctor to see him as he "looked unwell". She was worried he had taken other "substances" as well as his prescribed medication. He was then seen by a doctor, who planned to "reduce duloxetine and stop [increased risk of seizures]". The doctor also noted he was "presently completing a lofexidine detox" and he "advised stop lofexidine". (Lofexidine is used for the management of withdrawal symptoms in those undergoing opiate detoxification.) This is the first mention of lofexidine in his medical notes and the investigator and clinical reviewer could see no reference to this in his prescription charts.

39. A doctor reviewed the man on 28 March and prescribed him anti-epileptic medication while he waited to see the neurologist. The doctor said he told him he was "acquiring meds on the wing! Seriously advised to stop this".

40. The man was convicted at Crown Court on 11 April and was further remanded into Forest Bank for the preparation of a pre-sentence report (this is a report asked for by the court which assesses levels of risk in relation to offending, harm and victim empathy).

41. Records show that on 22 April, the man went to see a doctor, reporting low back pain and side effects from Epilim, which included low back pain and thoughts of deliberate self-harm. He reported taking Subutex to help him sleep. Although he was treated for his physical complaints, there is no indication in the records that action was taken in relation to his thoughts of self-harm.

42. On 23 April, a doctor entered in the man's medical record "History: see last consultation and positive urine for subutex <been having 8 mls daily> plan, to start on 10ml methadone and titrate". The entry appears to conflict with prescription charts which suggest he was already being prescribed methadone. This was the last contact he had with healthcare as he failed to attend an appointment with the pain clinic on 2 May.

43. The investigator was given access to three letters written by the man to his partner on 29 and 30 April and 2 May in which he was hopeful about the future. The investigator also read the summary of a telephone conversation with his partner on 1 May and one to his aunt on 2 May.

Day of the incident

44. A Prison Custody Officer (PCO) unlocked the man's cell at 8.05am as he was due to go to work. He was lying in his bed unresponsive and the PCO called a "code yellow". (Code yellow was the call code used for urgent healthcare assistance at that time. Forest Bank has since changed to using red and blue codes.)

45. A nurse told the investigation team she was in healthcare when she heard the code yellow so she collected the emergency bag from the pharmacy and went to the cell with another nurse. She checked for signs of life but cardiopulmonary resuscitation (CPR) was not attempted as rigor mortis had set in and she had the impression that the man had been dead for some time. She asked Oscar 1 to telephone for an ambulance. Her manager then came to the cell and asked her to return to the healthcare unit.

46. The incident report in the man's file said the paramedics attended the prison and his time of death was recorded as 8.30am.

After the man's death

47. The deputy Director held a hot debrief at 12.30pm. (This is a meeting for staff to discuss issues and any lessons learned following serious events.) The care team was briefed and were on hand to provide support to staff. Arrangements were also made for the safer custody team to review all prisoners subject to suicide and self-harm prevention monitoring. Later that day, the Director of Forest Bank issued two notices for staff and prisoners informing them of the man's death. The notice to prisoners said they could contact staff if they wished to speak to a member of the chaplaincy or a Listener (prisoners trained by the Samaritans to offer a confidential listening service for their peers). An incident form was also completed which noted which internal and external agencies were informed of his death.

48. In interview, the response nurse told the investigation team that after the man's death she received support from her healthcare colleagues and had spoken with a member of the care team who offered her counselling. One of the prison chaplains was later asked to speak to two members of staff, which he did. There was minimal information on his file as to whether all aspects of the death in custody plans were followed and additional information was subsequently obtained during the investigation.

49. The prison's family liaison officer, accompanied by a senior prison custody officer, went to the home of the man's next of kin, his aunt, to break the news of his death and offer support. As there was no response, they went to see his other named next of kin, his partner. A few days later, several family members visited the prison. They spoke to the Director and visited the cell and the chapel. One of the family liaison officers was asked by the family to attend the funeral. The family accepted the prison's offer of payment of the funeral costs.

Post mortem report

50. A post mortem and toxicology report was provided by the Coroner's office giving the cause of death as ischaemic heart disease. The pathologist considered whether the man's death was caused by epilepsy and thought it unlikely, although he acknowledged that the possibility could not be entirely excluded.

51. The toxicology report showed that the antipsychotic, antidepressant and epilepsy drugs the man was taking were present in his blood. His blood and urine contained methadone which had also been prescribed. The post mortem considered if methadone could have contributed to his death and said:

> "there is an overlap between therapeutic and potentially toxic methadone levels depending on the subjects pattern of use and tolerance … the levels in this case were not unduly high. No other drugs or alcohol were detected".

52. Taking account of the above and the severity of the heart disease found during the examination, the pathologist concluded the cause of death to be ischaemic heart disease and the degree to which the man had it could have caused his death at any time.

53. **ISSUES**

Clinical care

54. The clinical review concludes that the healthcare the man received at Forest Bank was "suboptimal", ie below expected standards. The clinical reviewer recognises it is unusual for someone of the man's age to die from cardiovascular disease and considers it is understandable this may not have been considered as a possibility. Despite his view that aspects of his care were substandard, he also believes it would be comparable to the care received in a significant proportion of community based general practices. Nevertheless, he raises concern about particular aspects of his treatment.

Requesting GP records

55. PSO 3050 Continuity of healthcare for prisoners, says that every effort should be made to retrieve any information required from the prisoner's general practitioner (GP) or other relevant service with which they have had recent contact. The investigator asked the clinical reviewer if this would have been useful in the man's treatment. His reply was that the records might have been useful, although, in his opinion, it should have been possible to diagnose his problem without them.

56. However, the GP records was a source of additional information that could have been available to the prison doctors, had they been requested. Staff could have asked for them when the man arrived at Forest Bank or in January 2011, when he had the first of the "fits" and was noted to have Xanthalasma on his lid, when he told the doctor he had a family history of heart disease.

The Head of Healthcare should ensure that when a prisoner is first received into prison, staff request and review past medical history from their community GP.

Blood pressure and Xanthelasma

57. The man had Xanthelasma in his eyelid and a doctor also noted a strong family history of heart disease. He also had frequent episodes of dizziness but no further tests were completed. The clinical reviewer draws attention to the fact that in spite of these facts, no further investigations were conducted. He said that, although the outcome of such investigations might have been normal, there was a possibility that tests might have revealed abnormalities which might have been treatable.

58. The clinical report also states that the man's blood pressure was noted to be borderline on two occasions and, again, no further investigation was carried out. Staff followed Forest Bank's hypertension protocol. However, the clinical reviewer refers to the National Institute for Health and Clinical Excellence (NICE) guidelines. These are nationally agreed standards of care which all medical practitioners in England and Wales should follow current at that time. The NICE guidelines suggest a formal cardiovascular risk assessment should have been completed. This would also have included checking his cholesterol levels; performing and electrocardiograph (ECG); exploring his smoking and recording the exact nature of any family history of heart disease. We concur with the clinical reviewer's view that the protocol for the management of hypertension should be revised and implemented and make the following recommendations:

The Head of Healthcare should revise the protocol for the management of hypertension ensuring it is compliant with NICE guidelines and that all healthcare staff understand and implement the protocol.

The Head of Healthcare should ensure that healthcare staff take full account of family history when arranging clinical investigations for prisoners who report, or are observed to have possible signs of high cholesterol or hypertension.

Exploration of the man's episodes of loss of consciousness

59. The man's loss of consciousness was never fully explored. The clinical report states that:

> "the commonest causes of episodes of loss of consciousness or dizziness would either be epilepsy or cardiac arrhythmia (irregularity); making a diagnosis is difficult but it first involves obtaining an accurate history from a person who has witnessed one of the events the performing examination of a person's cardiovascular system and central nervous system."

The symptoms should be investigated by way of blood and liver function tests as well as consideration of an electrocardiograph. A doctor did refer the man to a neurologist on 9 March, but none of the above tests were performed by the prison healthcare staff. We concur with the clinical reviewer that a protocol, reflecting NICE guidelines, should be developed for investigating the cause of episodes of loss of consciousness. It is disappointing that staff chose not to investigate such obvious signs of ill health. Accordingly, we endorse his recommendation, slightly recast:

The Head of Healthcare should develop a protocol that is NICE compliant for investigating episodes of loss of consciousness and should ensure that staff conduct clinical investigations of prisoners who experience such episodes.

Mental Health

60. The clinical reviewer comments on the lack of provision of mental health and psychiatric assessments. He states:

> "it is disappointing that the man never received a formal mental health assessment or if one was performed it does not appear in his record" … despite "the absence of a firm diagnosis he received a wide range of psychotropic medication".

61. A mental health nurse did see the man, although it is not recorded if this was a formal mental health assessment. He was also referred to a psychiatrist who chose not to see him once he had read his medical records. At no point was this decision challenged. The clinical reviewer considers that an assessment should have been performed in view of the history of possible psychosis and hallucinations. We note a doctor's views that he would have benefited from a mental health assessment but that he did not consider it appropriate to challenge the decision of the psychiatrist. In these circumstances, we would expect a doctor to advocate in the best interests of

the patient. Therefore, we agree with the clinical reviewer's opinion and make the following recommendation:

The Head of Healthcare should ensure that medical staff challenge the clinical decisions of others if they consider the decision might impair the care of the individual or is not in their best interests. If they are unable to secure treatment from a particular clinician, alternatives should be sought.

Prescription charts

62. The clinical reviewer raised concerns as to the clarity of the prescription charts. He had difficulty in ascertaining when and what medications had been prescribed as there were two different systems for recording. The investigation has found potentially serious discrepancies in the completion of prescription charts. For example, there was reference to the man being on lofexidine detoxification but no indication as to when this was implemented and prescribed. Also, a doctor specified a plan to start prescribing methadone when he was, in fact, already in receipt of that medication. One of the entries also makes reference to him not attending for methadone for five days in March, with no indication as to why or whether this was followed up. The clinical reviewer says there should be one robust system in place. We concur and make the following recommendation.

The Head of Healthcare should ensure that staff record all medication prescribed to a prisoner on a single prescription chart and that it is fully and systematically updated. A single, robust recording system should be put in place and adhered to for recording all prescription medication.

Suicide and self-harm prevention measures

63. The records show that the man reported instances of low mood and, on at least one occasion, thoughts of self-harm. The doctor to whom he reported this mainly attributed it to the side effects of a particular medication, Epilim. At this point, his medical needs were addressed, but no action taken in respect of his remarks about self-harm. Although this had no bearing on his death, it is essential that thoughts of self-harm, even if mentioned in a medical setting, are addressed in accordance with the suicide and self-harm provisions. It might well be decided subsequently that formal support is not required, but implementation of the measures enables the decision to be taken on the basis of a risk assessment. We therefore make the following recommendation:

The Director and Head of Healthcare should ensure that prisoners who express thoughts of self-harm, to either medical and discipline staff, are managed under the suicide prevention and self-harm management procedures.

Emergency response

64. The man was found in the morning when staff unlocked his cell. A code yellow call was made. Although healthcare staff attended with equipment, they decided not to attempt cardio pulmonary resuscitation as it appeared that he had been dead for some time and rigor mortis had set in. In order to preserve the dignity of the deceased, prison guidelines advise staff against resuscitation in these circumstances. The clinical reviewer agrees that the decision by the nurses was correct as he showed no signs of life. We agree with this judgement.

Death in custody contingency plans

65. All prisons should have in place contingency plans for dealing with follow up action after a death in custody. This is outlined in Prison Service Order 2710 “Follow up to deaths in custody”. The investigator found minimal information in the man’s file regarding the process after his death. In particular, there was no evidence of what arrangements were in place to support staff. There is also an expectation that debrief meetings should take place after a death in custody to discuss any issues arising from an emergency and consider support for staff. Feedback after a death assists the prison to explore the lessons learnt and minimise future risk. The response nurse said she did not attend a hot or critical debrief and, although one of the care team visited her, there was no information as to whether any other staff were offered support. Much of this information was obtained at an advance stage of the investigation, but it is of concern the actions taken were not fully documented at the outset.

    The Director should ensure staff fully document the actions taken after a death in custody and that those records are made available to the PPO investigator.

CONCLUSION

66. The man arrived at Forest Bank on 18 October. On reception it was noted he had slightly raised blood pressure and he was seen again for a review of this some time later. He was diagnosed with Xanthelasma and a cholesterol test was recommended but never done. No further tests were completed in relation to his blood pressure or cholesterol. He also said he had used cannabis in the month prior to coming into custody and he told healthcare staff he had started using subutex whilst in prison. He was given opiate substitution medication but it is unclear in his medical records as to when this started.

67. While at Forest Bank, the man had episodes of dizziness and loss of consciousness. Although he was referred to an outside hospital neurology department, further investigative tests were not done by prison healthcare staff.

68. He was prescribed psychotropic medication but there is no record of a formal mental health assessment on his records. He was referred to a psychiatrist who read his notes and decided not to see him unless staff thought it necessary. This decision was never challenged.

69. From his prison records, it would appear he had periods of being settled in the prison but also times when he was unhappy, which seemed to coincide with how he thought his healthcare was being handled. He received a warning for his behaviour towards healthcare staff on one occasion.

70. The post mortem said the man could have died from his condition at any time and therefore this could not have been predicted. However, the overall healthcare he received was not always to a satisfactory standard. We believe further investigation of the symptoms he presented should have been done by prison healthcare staff as this may have resulted in an earlier diagnosis of the heart disease.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that when a prisoner is first received into prison, staff request and review past medical history from their community GP.

2. The Head of Healthcare should revise the protocol for the management of hypertension ensuring it is compliant with NICE guidelines and that all staff understand and implement the protocol.

   This recommendation was accepted. The prison response was,

   > "Protocol to be revised to include compliance with NICE guidelines. Protocol to be implemented and cascaded to staff."

3. The Head of Healthcare should ensure that healthcare staff take full account of family history when arranging clinical investigations for prisoners who report, or are observed to have possible signs of high cholesterol or hypertension.

   This recommendation was accepted. The prison response was,

   > "All prisoners undertake the reception screening process, any prisoner with identified and or signs of hypertension are referred to hypertension clinic.
   >
   > Full account of family history taken on hypertension clinic."

4. The Head of Healthcare should develop a protocol that is NICE compliant for investigating episodes of loss of consciousness and should ensure that staff conduct clinical investigations of prisoners who experience such episodes.

   This recommendation was accepted. The prison response was,

   > "Protocol to be developed in line with NICE guidelines for the investigation of episodes of loss of consciousness to include clinical investigations on reported incidents of such episodes."

5. The Head of Healthcare should ensure that medical staff challenge the clinical decisions of others, if they consider the decision might impair the care of the individual or is not in their best interests. If they are unable to secure treatment from a particular clinician, alternatives should be sought.

   This recommendation was partially accepted. The prison response was,

   > "Whilst HMP Forest Bank accepts this initiative and will drive it forward, it is difficult to monitor the personal medical opinions of the medical staff. The Head of Healthcare will encourage this in future circumstances."

6. The Head of Healthcare should ensure that staff record all medication prescribed to a prisoner on a single prescription chart and that it is fully and systematically updated. A single, robust recording system should be put in place and adhered to for recording all prescription medication.

   This recommendation was partially accepted. The prison response was,

   > "This is subject to SystmOne review for development to facilitate prescription to be recorded onto system."

7. The Director and Head of Healthcare should ensure that prisoners who express thoughts of self-harm to either medical and discipline staff, are managed under the suicide prevention and self-harm management procedures.

   This recommendation was accepted. The prison response was,

   > "All medical and discipline staff have undertaken ACCT foundation training in accordance with Prison Service Instruction 64/2011 Risk of Harm to Self to Others and from Others (Safer Custody)."

8. The Director should ensure staff fully document the actions taken after a death in custody and that those records are made available to the PPO investigator.

   This recommendation was accepted. The prison response was,

   > "Contingency plans to be updated to ensure this is in place. Also after each death, PDU to check documents and make sure all relevant information is shared appropriately."