A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Forest Bank in April 2013

Our Vision

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

This is the investigation report into the death of a man in April 2013, at HMP Forest Bank. He was 42 years old and died as a result of ischaemic heart disease. I offer my condolences to his family and friends.

A clinical review was commissioned to investigate the man's clinical care. Forest Bank cooperated fully with the investigation.

The man had a longstanding heart condition but he had been discharged by his cardiologist in 2006 and had no outstanding medical appointments. Shortly after he arrived at Forest Bank in January 2013, he reported chest pain which was initially thought to be the result of a gastric problem. The symptoms persisted despite medication. In March, a doctor referred him for an endoscopy to help establish the cause of the pain but the hospital does not appear to have received the referral. Late in the morning on 30 April, he was found collapsed in his cell. The emergency response was swift and prison staff and paramedics attempted to resuscitate him. He was taken to hospital but pronounced dead soon after arrival.

It is not clearly documented why prison doctors ruled out cardiac problems when the man presented with chest pains and an opportunity was missed to investigate this as healthcare staff did not review or follow up an abnormal electrocardiogram. The clinical reviewer has identified a need, and I agree, for healthcare staff to follow the guidelines of the National Institute of Clinical Excellence for dealing with recent onset chest pain. Sadly, we cannot know whether earlier intervention would have saved him.

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 **April 2014**

CONTENTS

Summary

The investigation process

HMP Forest Bank

Key events

Issues

Recommendations

Action Plan

SUMMARY

1. When the man arrived at Forest Bank on 19 January 2013, he told healthcare staff that he had received treatment for a long-term defect in his heart several years before. He had been discharged from the care of a cardiologist in 2006 and, until 2008, had been prescribed medication for his heart condition.

2. On 22 January, the man reported that he had been experiencing back and chest pain but he had no symptoms when a nurse examined him. The nurse took his blood pressure, which was slightly raised and carried out an electrocardiogram (ECG). The results of the ECG were not documented and during the course of this investigation, the clinical reviewer discovered that it showed abnormalities. The prison doctor saw him the next day and suspected silent reflux. The doctor prescribed medication to reduce his stomach acid. Three weeks later, on 11 February, another prison doctor changed his medication as it had not improved his condition. At a review a month later, he was no better and the doctor who made the provisional diagnosis referred him to the local hospital for an endoscopy to establish the cause of his symptoms.

3. After returning from an education class one morning in April, the man's cell mate found him collapsed and unresponsive and called for help. The first prison officer to arrive made an emergency call for assistance and began cardiopulmonary resuscitation (CPR). Nurses followed quickly and took over. An ambulance had been called immediately the emergency call was made. Paramedics arrived at 11.32am and continued the resuscitation attempts. He was then taken to hospital, with three escort officers.

4. When they arrived at the hospital, the man was taken immediately to the resuscitation room. Hospital staff tried to resuscitate him but his death was confirmed at 12.15pm.

5. A few minutes after the man left the prison, the duty manager telephoned his partner to tell her what had happened. She and another family member went to the hospital, where hospital staff broke the news of his death. The prison's family liaison officer, a prison manager and members of the escort team all spoke to the partner at the hospital.

6. We agree with the clinical reviewer's view that healthcare staff at Forest Bank provided timely care and handled the emergency procedures professionally. However, the nurse who assessed the man when he first reported chest pain did not complete his full medical history and an abnormal ECG taken that day was not documented, reviewed or followed up. We consider that the ECG result should have caused staff to investigate fully the possibility of a cardiac condition as well as gastric problems.

THE INVESTIGATION PROCESS

7. Notices announcing the investigation were issued to staff and prisoners, inviting anyone who might have information about the man's death to contact the investigator. No one responded.

8. The investigator visited Forest Bank on 14 May 2013. The Deputy Director outlined the circumstances of the man's death and the investigator visited different areas of the prison, including the man's cell. He met two members of the Independent Monitoring Board and the Head of Healthcare. He interviewed the man's cellmate who had raised the alarm on the morning of 30 April. On 9 and 30 July, the investigator and the clinical reviewer interviewed ten members of staff at Forest Bank.

9. The investigator obtained copies of the man's prison and medical records from Forest Bank. A clinical reviewer was carried out.

10. One of the Ombudsman's family liaison officers and the investigator visited the man's partner to tell her about the investigation and invited her to identify relevant issues that she wished the investigation to consider. She raised the following:

    - The appropriateness and timeliness of assessments made by healthcare staff at Forest bank and the medication subsequently prescribed.
    - Clarity about the sequence of events on 30 April and the checks that were made before he was found unresponsive in his cell.
    - Whether he was alive when he left the prison and when he died.
    - Inappropriate comments by a member of prison staff when she arrived at the hospital.

11. The man's family received a copy of the draft report. They did not make any comment. The prison considered our draft report and recommendations, which they have accepted. The prison has also submitted an action plan detailing what they have done to address the issues we raised and this is included at the end of the report.

HMP FOREST BANK

15. Forest Bank is a local prison in Salford, serving courts in the North West. It holds around 1,364 remanded and sentenced men. The prison is privately managed by Sodexo Justice Services.

16. Primary care services are provided by Sodexo. There is a 20-bed inpatient unit with 24 hour nursing cover. An agency provides GP services. Doctors are available from 9.00am to 9.00pm Monday to Friday, 1.00pm to 5.00pm Saturday and 9.00am to 12.00pm Sunday. There is out of hours cover at other times.

HM Inspectorate of Prisons

17. The Inspectorate conducted an unannounced inspection of Forest Bank in October 2012. Inspectors found that the prison had invested in the professional development of a large team of healthcare staff and provided a wide range of appropriate clinics, with minimal waiting times, delivered by appropriately trained specialists.

Independent Monitoring Board

18. Each prison has an Independent Monitoring Board (IMB) of volunteers from the local community who oversee all aspects of prison life to help ensure prisoners are treated fairly and decently. In its most recent annual report for 2012, the IMB reported positively about healthcare services and the wide range of clinics provided and speed of obtaining appointments.

Previous deaths at Forest Bank

19. Since the beginning of 2012, there have been three deaths from natural causes at Forest Bank. We have made previous recommendations to Forest Bank about chronic disease management and calling ambulances.

KEY EVENTS

20. The man was remanded to HMP Forest Bank on 19 January 2013, charged with offences of arson and burglary. He was 42 years old and this was not his first time in prison.

21. During a reception health screen (given to all prisoners when they arrive in prison), the man told the Healthcare Assistant that he had been born with a heart valve defect but did not currently take medication for it. He had not seen a cardiologist for many years and had not seen his community doctor for several months. He declined an appointment with the prison doctor but signed a consent form for staff to request his medical notes from his community doctor.

22. On 22 January, the man told a nurse that he had back pain and intermittent mild central chest pain which became worse on exertion. The nurse examined him and noted he was not distressed or in pain at that time, his colour was normal, he had no shortness of breath but his blood pressure was slightly raised. He told him that he had seen a cardiologist in the past and had been prescribed beta blockers (which are used to treat various heart conditions). The nurse recorded his vital signs and carried out an electrocardiogram (ECG), a test to measure the electrical activity of the heart. An entry in his medical record indicates that the ECG result would be reviewed by a doctor the next day. There is no entry in his medical record to show that this was done. The clinical reviewer, asked the community doctor and a medical advisor at NHS England to review the ECG, and she confirmed that the results indicated abnormalities.

23. The nurse assessed the man using the Manchester Triage System (MTS) template, a widely used, standardised method to assess and prioritise patients, which advised that he should be seen by a doctor. The MTS template was only partially completed. The history and nature of his pain was not fully recorded as the nurse had concluded by that stage that he should be referred to the doctor.

24. Prisoners with raised blood pressure are usually referred to the cardiovascular nurse, who uses a cardiovascular risk assessment tool integrated into the SystmOne electronic medical record, to assess cardiovascular risk factors. As the nurse had booked an appointment for the man to see the doctor the next morning, he considered it was not necessary for the cardiovascular nurse to review him.

25. The man told a doctor on 23 January, that he had a bicuspid heart valve (a malformation of a blood vessel) and had been treated by cardiologists at hospital. The doctor noted that he had a heart murmur. His chest was clear and he found no lymphadenopathy (diseased or swollen lymph glands). He concluded that he possibly had a silent reflux (heartburn or the regurgitation of acid from the stomach to the gullet) and prescribed a trial of omeprazole (to reduce acid in the stomach) for four weeks. He did not consider that an urgent referral to hospital was necessary. On the same day, healthcare staff

requested his medical records from his community doctor. The doctor told the investigator that he did not think he was suffering from cardiac pain and he could not remember whether he saw the ECG result.

26. On 25 January, the man had a secondary health screen with a nurse, in which he mentioned his heart condition but said he had no health concerns. On the same day, the healthcare department received a faxed letter from his community doctor stating that his only prescribed medication was zopiclone (for insomnia), he had no outstanding referrals or hospital appointments and that he was normally fit. The doctor sent copies of two old hospital letters. The first, dated October 2006, was from his cardiologist and contained the result of an exercise tolerance test report after a complaint of chest pain. The letter noted no significant past medical history and that an ECG had been normal, apart from a trivial mitral regurgitation (a heart disorder in which the mitral valve does not close properly). He had advised him to reduce his blood cholesterol and discharged him to the care of his community doctor. The second letter, dated October 2007, was a notification that he had not attended an appointment for an ECG.

27. A doctor noted, on 11 February, that omeprazole had not helped the man's chest pain. He replaced the omeprazole with metaclopramide (used to relieve nausea and sickness) and lansoprazole (another medication to reduce stomach acid). On 11 March, he saw a doctor, who noted that he still had chest pain. He did not re-prescribe the medication and referred him to hospital for an endoscopy. After his death, healthcare staff discovered that the hospital had not received the referral letter.

28. Between 5 February and 2 April, the man did not attend six healthcare appointments. Most related to completing a course of vaccinations and none related to his chest pain.

29. Towards the end of April a Prison Custody Officer (PCO) unlocked the man's cell at around 7.00am. She said she spoke to him several times during the next hour. She described him as quite normal and chatty. He did not say that he felt unwell and he did not look ill.

30. The man's cellmate attended an education class that morning and left their cell at around 8.00am. He said the man appeared well and did not complain that he felt unwell. At around 9.20am, during cell checks, a PCO said he had a conversation with him and noticed nothing remarkable.

31. Just after 11.15am, the cellmate returned to his cell. The cell was locked, and he looked through the observation flap and saw the man sitting on the top bunk, leaning against the rear wall with his head leaning to his right. He did not reply when his cellmate called out, so he thought he was asleep. A Senior PCO then opened the door for him and locked it after the cellmate went in. The cellmate began to prepare to roll a cigarette then realised something was wrong with the man. He looked blue and he got no response when he shook his shoulder. He touched his face and his skin felt cold. He immediately pressed the cell call bell, kicked the door and shouted to get help. A few

seconds later, the Senior PCO returned and opened the cell door. The cellmate came out immediately looking very distressed and told him that something was wrong.

32. An officer moved the cellmate temporarily to a friend's cell before he was taken to the healthcare centre where he remained until the police interviewed him. He was then relocated permanently with his friend on D wing.

33. The Senior PCO went into the cell and found the man in the same position described by his cellmate. He was concerned by the man's mottled appearance and immediately sent an emergency code blue radio message (timed at 11.19am) to indicate a prisoner with breathing difficulties. He shook his shoulder, called to him and tried to find a pulse in his wrist and neck. He then began cardiopulmonary resuscitation (CPR), with the man lying on the bed. A short while later the Head of Residence, a wing manager and another Senior PCO, arrived at the cell followed closely by two nurses.

34. Both nurses arrived at the cell with an oxygen cylinder and emergency bag around 20 to 30 seconds after hearing the code blue message. Nurse A asked the officers to place the man on the floor so that she could begin CPR. Three officers lifted him from his bed and then left the cell to allow the nurses more room. Simultaneously, she asked someone to call the doctor and the Senior PCO radioed the communications room. She requested that another emergency bag and a defibrillator be brought from the prison hub. (An automated external defibrillator analyses heart rhythm and delivers electric shocks to victims of cardiac arrest when it determines there is a rhythm that is likely to respond.)

35. Nurse A performed chest compressions and Nurse B used a mask to support his breathing. When the Senior PCO brought the defibrillator to the cell, the wing manager took over chest compressions while Nurse A attached defibrillator pads to the man's chest and inserted an airway. The defibrillator assessed him and gave an electric shock three times. Another nurse and a prison doctor arrived and assisted the resuscitation attempts. The first two nurses and the doctor continued CPR after the fourth cycle as the defibrillator had advised that a shock should not be delivered.

36. According to an officer's handwritten log, ambulance staff arrived at D wing at 11.32am and were in the cell at 11.34am. They replaced the prison defibrillator with their own but it did not advise to administer a shock. At 11.36am, the man was transferred to the ambulance. The nurses continued administering CPR throughout while the paramedics tried unsuccessfully to intubate him. (Intubation involves placing a plastic tube into the windpipe to maintain an open airway.) The equipment used to intubate him was faulty, so they inserted a laryngeal mask airway and started mechanical ventilation.

37. The ambulance crew continued treating the man and they left the prison at 11.58am with three prison custody officers as escorts. No restraints were used.

38. At 12.04pm, the duty manager at Forest Bank telephoned the man’s partner and asked her to go to the hospital where he had been taken. At 12.10pm, a prison chaplain, who is also the prison’s family liaison officer, was asked to go to the hospital.

39. During the five-minute journey to the hospital, one of the ambulance crew continued CPR and administered adrenalin injections. When they arrived, the man was taken immediately to the resuscitation area where CPR continued. The efforts were unsuccessful and he was pronounced dead at 12.15pm.

40. When the man’s family arrived a short time later, hospital staff broke the news to his partner and her brother. Afterwards, the man’s partner asked the escort officers what had happened. They were unable to tell her much as they had only seen him during the journey to hospital. She later told the Ombudsman’s family liaison officer and investigator that one of the officers had said, words to the effect that her partner “had been taken ill and we threw him in the ambulance and got down here”. His choice of words had distressed her.

41. The prison chaplain arrived at the hospital at about 1.00pm. He offered his condolences and explained the process after the death of a prisoner. The Operations Manager at Forest Bank arrived at about 1.55pm and spoke to the family.

42. The prison Director held a debrief at 1.15pm for the staff involved with the emergency. They were offered support by the prison’s post incident care team. The escort officers and the Operations Manager returned to the prison at around 3.30pm. They completed statements and were also debriefed and offered support by the post incident care team. The prison chaplain spoke with the man’s cellmate about his death, and subsequently arranged for him to see a counsellor.

43. A post-mortem examination took place on 1 May 2013 and found the cause of death was ischaemic heart disease and valvular heart disease.

44. The prison chaplain arranged for the man’s family to visit the prison on 2 May. They met the Director and spoke at length to his cellmate. His property was returned to his family and the prison contributed to the cost of his funeral. The Head of Healthcare and deputy family liaison officer represented Forest Bank at the funeral.

ISSUES

Clinical care

The man's chest pain

45. At his health screen at Forest Bank on 19 January 2013, the man disclosed that he had a heart valve defect but had not seen a cardiologist for many years since his discharge in 2006. He declined to see the prison doctor. Within three days, on 22 January, he reported back and chest pain, although he had no symptoms during an examination by the nurse. The nurse assessed him and took an ECG, in line with the National Institute for Clinical Excellence (NICE) guidelines for the assessment of recent onset chest pain. The ECG results were not recorded in the medical record as they should have been and there is no indication that they were reviewed by any of the medical staff. The clinical reviewer established that the ECG results had shown abnormalities. Due to this oversight by healthcare staff, no follow up action was taken on the abnormal ECG result. We therefore make the following recommendation:

    The Healthcare Manager should ensure that healthcare staff review and document all ECG results and take appropriate action on those that show abnormalities.

46. The nurse partially completed the Manchester Triage System template which indicated that the man should be seen by a doctor. As the assessment was that he should be referred to the doctor, the nurse did not fully complete the template to include the history and nature of his pain. It is highly unlikely that the missing information from the MTS and SystmOne impacted on the manner and timing of his death, but it is important that full histories are taken. In some cases this might lead to an early referral to a specialist. We therefore make the following recommendation:

    The Healthcare Manager should ensure that healthcare staff keep records in line with the General Medical Council and Nursing and Midwifery Council's guidance on record keeping and fully complete all medical documents to support effective clinical judgments and decisions.

47. The nurse found that the man's blood pressure was slightly raised. Although this would normally lead to a cardiovascular nurse review and assessment for cardiovascular risk factors, this was unnecessary as an appointment had already been arranged for him to see the doctor. The next day, 23 January, a doctor examined him. In spite of his history, the doctor did not think the pain was cardiac in origin or required a referral to hospital for assessment and treated him for silent reflux. The doctor did not see the ECG results as they had not been entered in the record.

48. The man had a secondary health screen on 25 January, in which he reported no health concerns. On 11 February, a doctor reviewed him and continued

treatment for a gastric condition. On 11 March, the doctor referred him for an endoscopy to establish the cause of his discomfort. The hospital did not arrange an appointment as they did not receive the referral letter, although it appears to have been sent from the prison. Forest Bank has since implemented a system for healthcare staff to follow up referrals when appointments are not received within the expected time.

49. NICE Clinical Guideline 95 provides information on recent onset chest pain. It advises clinicians to assess patients for signs of and risk factors for cardiovascular disease and indicates that a person with chest pain of suspected cardiac origin should be referred to hospital for same day or urgent assessment and treatment. Although the man had a longstanding heart defect, his cardiologist had discharged him in 2006 and had not prescribed any ongoing medication. It is evident that neither doctors considered his pain to be cardiac in origin. One doctor said at interview that he did not consider he was suffering from cardiac pain but his rationale for excluding cardiac pain was not documented. Neither doctors were aware of the ECG of 22 January or requested one.

50. The clinical reviewer notes that the man had timely access to healthcare but he was not referred to hospital for further assessment when he reported chest pain. She was unable to determine whether such a referral would have prevented his death. We consider that given his longstanding heart condition and the nature of his symptoms, it should have been referred for further investigation, in line with NICE guidelines.

The Healthcare Manager should ensure all medical and nursing staff are aware of and follow current clinical guidance for assessing cardiovascular disease risk and the management of patients with acute chest pain.

Emergency response

51. A Senior PCO radioed a code blue emergency at 11.19am and prison and healthcare staff reached his cell very quickly and began to attempt resuscitation immediately.

52. Prison Service Instruction PSI 03/2013 Medical Emergency Response Codes instructs that on receipt of a code blue message, staff in the communication room should immediately call an emergency ambulance. The code blue broadcast was logged by the control room, healthcare and others at 11.19am. The contingency plan action list shows that the ambulance was not called until 11.25am, some six minutes later, but the communication room log gives the timing as 11.22am which is more likely to be accurate and accords with ambulance service records. The ambulance arrived promptly at 11.32am and the paramedics were at the cell within two minutes.

53. The clinical reviewer concludes that the staff involved in the resuscitation attempts provided prompt, professional and appropriate emergency treatment,

with good partnership between the prison and healthcare staff and we agree.

54. At interview, one doctor said he was impressed with the professionalism of the nurses during the emergency procedures and thought it would be beneficial if he and other doctors undertook joint resuscitation training with the other healthcare staff as part of their normal training programme. The clinical reviewer has made a recommendation about this which seems a sensible suggestion.

Family liaison

55. Prison staff contacted the man's partner a few minutes after the ambulance had left the prison and advised her to go to the hospital. She later said that one of the prison escort staff at the hospital had made an inappropriate and insensitive remark when she asked about events at the prison. The investigator interviewed staff who attended the hospital and specifically asked about this incident. They all said they did not hear this remark and denied making it personally. Unfortunately, we have been unable to resolve this issue but the Director may wish to remind staff of the need to deal sensitively with the prisoners' families in emotional and difficult circumstances.

RECOMMENDATIONS

1. The Healthcare Manager should ensure that healthcare staff review and document all ECG results and take appropriate action on those that show abnormalities.

2. The Healthcare Manager should ensure that healthcare staff keep records in line with the General Medical Council and Nursing and Midwifery Council's guidance on record keeping and fully complete all medical documents to support effective clinical judgements and decisions,

3. The Healthcare Manager should ensure all medical and nursing staff are aware of and follow current clinical guidance for assessing cardiovascular disease risk and the management of patients with acute chest pain.

ACTION PLAN: The Man – HMP Forest Bank

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and Function Responsible	Progress (to be updated after 6 months)
1	The Healthcare Manager should ensure that healthcare staff review and document all ECG results and take appropriate action on those that show abnormalities.	Accepted	The process for documenting ECG results will be reviewed to include the scanning of ECGs onto SystmOne and making them available to a GP for review. Appropriate clinical assessments and findings will then be recorded, with management checks being built into this process. (Although Healthcare staff can document the results of ECGs, they are not qualified to review them. Only a GP can review ECG results and identify any abnormalities. All ECG results obtained will therefore be provided to a GP for review with the results being recorded by healthcare staff as described above.)	April 2014 Healthcare Manager	
2	The Healthcare Manager should ensure that healthcare staff keep records in line with the General Medical Council and Nursing and Midwifery Council's guidance on record keeping and fully complete all medical documents to support effective clinical judgements	Accepted	Healthcare staff have been made aware of the General Medical Council and Midwifery Council's guidance on record keeping and the expected standards of record keeping required when recording clinical data. All nursing team have been re-issued GMC & Midwifery Council's guidelines which has been recorded and signed for. This has been communicated via three team meetings in healthcare and discussed at the Clinical Governance Meeting in November and	Completed Healthcare Manager	

	and decisions.		then again at the Meds Management meeting in December, both of which were minuted and minutes distributed to all healthcare staff. The information has also being added to all Personal Development Record's as an audit check of record keeping in line with the recommended guidelines and included in the 2013/2014 objective for Clinical Leads. There are also quarterly Management checks conducted by the Healthcare manager to check compliance and where non compliance is found for individuals performance will be raised and monitoring and / or further action will be put into place.		
3	The Healthcare Manager should ensure all medical and nursing staff are aware of and follow current clinical guidance for assessing cardiovascular disease risk and the management of patients with acute chest pain.	Accepted	All medical and nursing staff are aware and have been reminded of following current clinical guidance for assessing cardiovascular disease risk and the management of patients with acute chest pain. NICE guidance is now an additional agenda item on team huddles and is discussed at Clinical Governance and Medicines Management which are will minuted and minutes distributed to all healthcare staff.	Completed Healthcare Manager	