



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in October 2014
at HMP Forest Bank**

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 who died of chronic obstructive pulmonary disease (COPD) on the 10 October 2014, at HMP Forest Bank. I offer my condolences to his family and friends.

One of my investigators carried out the investigation. A clinical reviewer reviewed the man's clinical care at the prison. Forest Bank cooperated fully with the investigation.

The man was sentenced to three and a half years in prison in June 2013. Doctors had diagnosed him with COPD in 1993. He repeatedly experienced periods when the symptoms of his COPD were severe. As result, he spent time as an inpatient in the prison's healthcare unit and at outside hospital. Clinicians monitored and treated the man as necessary, but his condition deteriorated over time.

On 8 October 2014, healthcare staff decided that the man could no longer cope with living on his residential wing and admitted him to the healthcare unit for more intensive nursing to meet his need. He died in the unit two days later.

I agree with the clinical reviewer that the man received an appropriate standard of healthcare at HMP Forest Bank, although the investigation identified a need for more structured end of life care planning. I am also concerned that staff restrained the man without justification, when he went to hospital for an appointment just two days before he died. I have raised the matter of unjustified use of restraints with the prison before and the Director needs to ensure that staff responsible for risk assessments understand the legal position.

The 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

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SUMMARY

1. The man was sentenced to three and a half years in prison on 14 June 2013, and sent to HMP Forest Bank.
2. The man had poor health and suffered from a number of medical conditions including chronic obstructive pulmonary disease (COPD - a term used to describe a range of serious lung conditions). The man had mobility problems and needed a wheelchair for long distances. He also suffered from heart failure, glaucoma, urinary tract problems and stomach ulcers.
3. Healthcare staff frequently reviewed the man's health conditions. He spent some time as an inpatient in the prison's healthcare unit and in hospital because of exacerbations of his COPD (periods when the symptoms of COPD become very severe). He attended frequent hospital appointments to manage and treat his COPD and other conditions.
4. The man's COPD deteriorated over time and clinicians reviewed and treated him as necessary. On 8 October, he moved from his wing to the healthcare unit as he needed more intense nursing and was no longer able to manage daily living tasks on the wing.
5. On the morning of 10 October, two healthcare assistants went to the man's cell to help him get up, but the man was not responsive. A nurse came to check him but could find no signs of life. The Healthcare Inpatient Manager attended and verified that the man had died.
6. We agree with the clinical reviewer that the standard of healthcare the man received Forest Bank was equivalent to that he could have expected to receive in the community. The care and treatment of his COPD and other conditions were in line with general NHS practice but the investigation identified a need for more structured end of life care planning. We are concerned that when officers took him to hospital, just two days before he died, they used restraints, despite healthcare input into the risk assessment which said he was very poorly, in a wheelchair and could not escape without assistance. We make two recommendations.

THE INVESTIGATION PROCESS

7. The investigator issued notices informing staff and prisoners at HMP Forest Bank of the investigation and asking anyone with relevant information to contact him. No one responded.
8. NHS England appointed a clinical reviewer to review the man's clinical care at the prison.
9. The investigator obtained copies of the man's prison medical record and relevant extracts from his prison record. He interviewed four members of staff at Forest Bank on 2 December 2014 and one member of staff by telephone on 12 December.
10. We informed HM Coroner for Bolton of the investigation, who provided a copy of the post-mortem report. We have sent the coroner a copy of this investigation report.
11. One of the Ombudsman's family liaison officers contacted the man's sister, his next of kin, to explain the purpose of the investigation. The man's sister did not have any specific issues for the investigation to address and commented that she had been able to visit the man regularly and had found the prison's family liaison officer very helpful.
12. The man's sister received a copy of the draft report. She did not make any comments. The prison also received a copy of the draft and their response to our recommendations and action plan is added at the end of this report.

HMP FOREST BANK

13. Sodexo Justice Services manage HMP Forest Bank, a local prison in Salford, serving courts in the North West. It holds around 1460 prisoners.
14. Sodexo provides primary health care services. There is a 20-bed inpatient unit with 24 hour nursing cover. An agency provides GP services with doctors on duty 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.

Her Majesty's Inspectorate of Prisons

15. The most recent inspection of Forest Bank was in October 2012. Inspectors found that a large team of staff worked well together to provide a high level of health services. Prisoners had access to a well-trained and professional team who delivered a wide range of clinics with minimal waiting times. Pharmacy services were generally well organised and dental care was good. Inspectors reported that there had been significant investment in palliative care services.

Independent Monitoring Board

16. 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 recently published report for the year to October 2013, the IMB reported positively about healthcare services, the wide range of clinics provided and end of life care.

Previous deaths at Forest Bank

17. Since the beginning of 2012, there have been four deaths from natural causes at Forest Bank. We have made previous recommendations about the unjustified use of restraints.

KEY EVENTS

18. On 14 June 2013, the man was sentenced to three and a half years in prison and sent to HMP Forest Bank.
19. At a reception health screen a nurse noted that doctors had diagnosed the man with COPD in 1993. The man had been in hospital between 13 May and 10 June with pneumonia. When he was sentenced, he was in an intermediate care centre in the community. The nurse noted that the man had given up smoking. He needed a walking stick and used a wheelchair for long distances. He had a hearing aid in his left ear and had multiple health issues including, heart failure, glaucoma, urinary track problems, psoriasis, and stomach ulcers. Initially, he stayed in the prison's healthcare unit for assessment, but, after a few days, he moved to a standard residential wing.
20. Prison doctors and nurses saw the man often to monitor and treat his health conditions and he had frequent hospital appointments. Over the next six months, the man's COPD deteriorated and the prison's healthcare unit or the hospital admitted him as an inpatient several times, with exacerbation of his COPD. In October 2013, hospital doctors also confirmed heart failure.
21. On 20 December, a prison GP, A, examined the man after he had complained of shortness of breath. Dr B reviewed him again on 27 December. The doctor said the man's COPD was advanced and recommended he should go to hospital. However, the man refused to go and said he was happy to stay at the prison.
22. On 5 February 2014, Nurse A, saw the man after officers reported he had breathing difficulties. The man said he had a chest infection with flu-like symptoms. The nurse noted that the man was breathing without difficulty, but referred him for an urgent appointment with the GP. Dr C saw him the next day and prescribed an antibiotic.
23. On 24 February, a prison GP, Dr D, examined the man and noted that he had swollen feet. He considered the man was most likely developing right-sided heart failure and was at end stage COPD. The doctor asked healthcare staff to keep the man under review. Records show that nurses saw him daily.
24. On 15 April, Nurse D responded to an emergency call and found that the man was having difficulty breathing. She checked his vital signs, gave him oxygen and called an ambulance. Paramedics took him to hospital where he remained until 30 April. When he came back to the prison, Nurse C admitted the man to the healthcare unit.
25. On 6 May, Dr D discussed with the man his views about resuscitation. The man said he did not want anyone to try to resuscitate him if his heart or breathing stopped. He signed an order to record his decision and staff reviewed the decision with the man frequently.

26. On 8 August, Nurse D took the man's clinical observations and noted his blood pressure was low. She referred the man to the GP. Dr E carried out an ECG test, which showed the man had ischemia (a restriction in blood supply to tissues) possibly caused by a heart attack. The doctor advised the man that he needed urgent admission to hospital but the man refused to go and signed a disclaimer. He went back to his wing and healthcare staff continued to monitor him.
27. The man had a long standing catheter which healthcare staff at the prison managed. On 7 September, Nurse C and a GP had difficulty replacing the catheter and sent the man to hospital. He came back to the prison later that day. Nurse E noted he had a complicated kidney infection for which doctors had prescribed an antibiotic.
28. Over the next month, records show that the man's health deteriorated further and he became unable to carry out day to day tasks for himself. Nurses noted he was eating less, was short of breath and was frailer.
29. On 8 October, the man went to hospital for an outpatient's appointment, and two officers escorted him. Information on a risk assessment for the escort indicated that his unit considered he was polite and compliant and not very mobile. The medical report said he did not have the ability to escape unaided. However, the security contribution indicated he was a medium risk of escape. There is some confusion about what level of restraint was used.
30. An untimed duty manager assessment from duty manager A said he was to be "Single cuffed at all times. Escort chain used for treatment if required." A note at the bottom of the assessment said, "Cuffing arrangements altered to [what looks like] 'escort'. Prisoner is wheelchair bound." At 10.10am, the orderly officer briefed the escort staff in reception that he was to "remain double cuffed at all times." He left the prison at 10.45am. There is no indication in the documents that the escorting officers were informed that there was any change in arrangements, but the orderly officer told the investigator that the duty manager had reassessed this in reception and only an escort chain was used.
31. One of the escorting officers, Officer A, said that the standard protocol for an escort is that prisoners are always double-cuffed. She said that she had never been on an escort when the prisoner had not been double-cuffed. Double-cuffing usually means that the prisoners has his hands cuffed in front of him and then has one wrist attached to a prison officer by an additional set of handcuffs. An escort chain is a long chain with a light handcuff at each end, one attached to the prisoner and the other to an officer. In this case, the Officer said that they used standard handcuffs for the man's hands and they attached an escort chain to his wrist.
32. When he got back from hospital, the healthcare manager, Nurse E, admitted the man to the healthcare unit because she did not consider he could cope with day to day living tasks and needed additional nursing. Nurses implemented a care plan for him. On 9 October, Nurse F recorded that the

man had eaten a small amount of food during the day and had moved from the bed to a chair. He noted that the man had settled before night time lock-up. Nurses did not record any concerns during the night.

33. At 8.10am on 10 October, two healthcare assistants went to the man's cell to help him get up. They could not get any response from him. Nurse G attended and could find no signs of life and noted the man felt rigid and was pale. The Healthcare Inpatient Manager, Nurse E, attended and verified that the man had died.

Family Liaison

34. A prison chaplain acted as the prison's family liaison officer. At 9.40am, he visited the man's sister, his nominated next of kin, at her home and informed her and her husband that the man had died. He offered condolences and support. The Director of Forest Bank wrote to the man's sister on 17 October to add his condolences.
35. The man's funeral was on 22 October 2014. The prison did not contribute to funeral expenses as the man had a pre-paid funeral plan.

Support for staff and prisoners

36. A Director's notice informed staff and prisoners of the man's death and the support available. A senior manager debriefed the staff involved in the emergency response and offered appropriate support. The prison reviewed prisoners identified as at risk of suicide and self-harm, in case the news of the man's death had adversely affected them.

Post-mortem report

37. A post-mortem examination established that the cause of the man's death was bronchopneumonia and chronic obstructive airways disease.

ISSUES

Clinical care

38. The clinical reviewer found that the clinical care the man received at HMP Forest Bank was equivalent with that he could have expected to receive in the community. The care and treatment of his conditions was in line with mainstream NHS practice. However, he found that end of life planning was not in line with national guidelines.
39. Nurse E told us that the man did not fully recover from an exacerbation of his COPD in late 2013, when he also went into an acute heart failure. The nurse could not recollect the exact date when the healthcare team started to plan for the man's end of life care but told us that the team had frequent meetings to discuss his care because they noticed that he was becoming weaker. The deputy director responsible for healthcare, told us the healthcare team were expecting the man's death anytime from August 2014. On 13 August, he chaired an end of life meeting with the healthcare team, the chaplaincy and the head of residence, to discuss the man's case. There are no clear records of these meetings or a clearly set out plan, but there was some evidence of good care, including contact with the man's family.
40. Once it becomes evident that a serious medical condition will not be responsive to active treatment, it is appropriate that an end of life care plan is put into place. The NHS document 'The route to success in end of life care – achieving quality in prisons and for prisoners' sets out how an end of life care pathway might be implemented in prisons. Among the benefits of an end of life pathway are that it helps carers plan when and how care will be delivered and helps patients make choices about how they are cared for towards the end of their lives.
41. We understand that it is often difficult to identify the stage at which a person with COPD is likely to die, and therefore difficult to predict when to begin to offer supportive and palliative care, but once this stage was reached with The man it would have been appropriate to begin formal planning. We are satisfied that healthcare staff at Forest Bank reviewed and treated the man's conditions well and there is evidence of some discussions about end of life care, but we consider this could have been improved by a more coordinated approach. We make the following recommendation:

The Healthcare Manager should ensure that formal end of life pathways are considered and implemented for prisoners nearing the end of their lives, in line with national guidance.

Restraints, security and escorts

42. The Prison Service has a duty to protect the public when escorting prisoners outside prison and a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of

escape, the risk to the public and which take into account factors such as the prisoner's health and mobility. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between a prisoner's risk of escape (and the risk to the public in the event of an escape) when fit and his risks when suffering from a serious medical condition.

43. While at Forest Bank, the man attended hospital appointments on at least 29 occasions. For each of these appointments the prison completed an escort risk assessment which included a medical report completed by a healthcare staff. Records show that a single handcuff was used on most occasions, although an escort chain was used occasionally.
44. On 8 October 2014, two days before the man died, he was taken to hospital for an outpatient's appointment. The medical report in his escort risk assessment clearly stated that the man could not escape unaided; he was in poor health, not very mobile and needed a wheelchair. The head of operations and security assessed the man as low to medium risk and recorded that a single handcuff should be used. An annotation on the form suggested that the cuffing arrangements had been altered as the "prisoner is wheelchair bound." It is not clear when this decision was made, but it looks as if the use of an escort chain was intended.
45. Shortly before the man left the prison, the duty orderly officer clearly recorded that she had briefed staff to keep the man doubled-cuffed at all times, although that was not what the original risk assessment had concluded. It appears from the account of one of the escort officers that the man had his hands cuffed in front of him and officers used an escort chain in addition – a form of double cuffing. However, she said that the duty manager changed this in reception, before the man left and only an escort chain was used. We have been unable to reconcile the different accounts, but consider that, in any event, the use of an escort chain was not justified.
46. There is need for all those involved in making decisions and escorting prisoners to hospital appointments to ensure that they take a prisoner's health and mobility fully into account in risk assessments in line with the requirements of the 2007 High Court judgment. Healthcare staff clearly indicated that the man was in poor health with limited mobility and unable to escape unaided. One of the escort officers described him as very weak at the time and too weak to walk. The use of any restraint in the circumstances seems hard to justify. Security is paramount but it appears that staff at Forest Bank take a very risk averse approach, inconsistent with the legal guidance. We make the following recommendation:

The Director should ensure that staff authorising the use of restraints for prisoners taken to hospital understand the legal position, and that risk assessments are completed which fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

RECOMMENDATIONS

1. The Healthcare Manager should ensure that formal end of life pathways are considered and implemented for prisoners nearing the end of their lives, in line with national guidance.
2. The Director should ensure that staff authorising the use of restraints for prisoners taken to hospital understand the legal position, and that risk assessments are completed which fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

ACTION PLAN: Mr The man – HMP Forest Bank

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and Function Responsible
1	The Healthcare Manager should ensure that formal end of life pathways are considered and implemented for prisoners nearing the end of their lives, in line with national guidance.	Accepted	The individual care plan template for those prisoners who are identified as approaching end of life care will include the clinical consideration for implementing end of life care needs in line with national guidance.	30 April 2015 Healthcare manager
2	The Director should ensure that staff authorising the use of restraints for prisoners taken to hospital understand the legal position, and that risk assessments are completed which fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.	Accepted	Escort documentation reviewed to take into account the health/age and mobility of the prisoner when making a decision on the use of restraints, based on the actual risk the prisoner presents at the time.	30 April 2015 Head of Operations and Security