PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in January 2015 while a prisoner 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 liver disease in January 2015, while a prisoner at HMP Forest Bank. He was 51 years old. I offer my condolences to the man's family and friends.

The investigator carried out the investigation. A clinical reviewer reviewed the man's clinical care at Forest Bank. The prison cooperated fully with the investigation.

The man was released on licence from a prison sentence in August 2012. During his time in prison, he had received treatment for hepatitis C, which was unsuccessful. In May 2014, he was recalled to prison after breaching his licence conditions and subsequently received a two-year prison sentence.

An ultrasound examination of the man's liver in August 2014 confirmed he had cirrhosis of the liver. Healthcare staff monitored the man's condition and he had some hospital treatment for his liver disease. Over the next months, his health deteriorated and he suffered from a brain condition, caused by advanced liver disease.

On 12 January 2015, an officer found the man very unwell in his cell. Healthcare staff attended and called an ambulance. The man was taken to hospital, where he died ten days later.

I consider that the man received a satisfactory standard of care at the prison. The clinical reviewer found that much of the man's care at the prison was good, but identified some areas for improvement, including that healthcare staff needed to be more alert to early warning signs when a seriously ill prisoner's condition begins to decline. Better communication with the local hospital is also needed to ensure care plans adequately reflect a patient's condition at all times.

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 **July 2015**

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SUMMARY

1. The man served a sentence at HMP Preston from 9 August 2010 until 3 August 2012, when he was released on licence. Records show he had unsuccessful treatment for hepatitis C. A consultant said he needed another round of treatment.

2. While on licence, the man committed another offence. On 17 May 2014, he was recalled to prison and sent to HMP Forest Bank. Subsequently, he was sentenced to a further two years in prison.

3. At an initial health screen on 19 May, a nurse recorded that the man was waiting for further hepatitis C treatment. On 21 May, the man did not attend an appointment for a second health screen, but a nurse saw him on his wing and was concerned his hepatitis C was unstable. Blood tests showed abnormal blood coagulation and liver function. However, there is no record that anyone reviewed the results.

4. An ultrasound scan on 27 August 2014 confirmed that the man had liver cirrhosis. Over the following months, the man had hospital treatment for symptoms and complications of advanced liver cirrhosis and active viral hepatitis C. His health continued to deteriorate.

5. On 12 January 2015, an officer found the man very unwell in his cell and asked healthcare staff to attend urgently. Nurses attended and requested an ambulance and the prison doctor to attend.

6. The man was taken to hospital and his condition continued to deteriorate. He died in hospital on 22 January. His family were with him at the time.

7. The clinical reviewer found that much of the man's care was good, but identified some areas for improvement, including that healthcare staff should have monitored the man's declining condition more closely and that communication between the prison and hospital about his treatment should have been better. We make two recommendations.

THE INVESTIGATION PROCESS

8. The investigator issued notices to staff and prisoners at HMP Forest Bank informing them of the investigation and inviting anyone with relevant information to contact her. No one responded.

9. NHS England commissioned a clinical reviewer to review the man's clinical care in prison.

10. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison record. She and the clinical reviewer interviewed five members of staff at Forest Bank.

11. We informed HM Coroner for Greater Manchester West District of the investigation, who provided the cause of death. We have sent the coroner a copy of this report.

12. The man's mother received a copy of the draft report. She did not make any comments.

HMP FOREST BANK

13. HMP 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. 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 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.

Her Majesty's Inspectorate of Prisons

14. 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

15. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its latest annual report for the year to 31 October 2014, the IMB noted that the healthcare department had a specialist hepatitis clinic.

Previous deaths at Forest Bank

16. The man was the third prisoner to die from natural causes at Forest Bank since the start of 2013. There were no significant similarities with the circumstances of the other cases.

KEY EVENTS

17. Between 9 August 2010 and 3 August 2012, the man was a prisoner at HMP Preston. At his reception healthscreen, a nurse had noted he had hepatitis C (a virus that is carried in the blood and can damage the liver.) He had regular blood tests to monitor the condition, and a course of treatment that was unsuccessful. In December 2011, a consultant at Liverpool Royal Hospital indicated that the man should have further treatment for hepatitis C. There is no record that he had this before he was released from prison at the beginning of August 2012.

18. While on licence, the man committed a further offence. On 17 May 2014, he was recalled to prison and sent to HMP Forest Bank.

19. At an initial health screen, a nurse noted the man had active hepatitis C and was waiting for further treatment. She noted he was taking medication for stomach ulcers and had a history of cannabis and heroin use. The nurse booked an appointment for him to see a doctor. On 20 May, a prison GP saw the man and re-prescribed lansoprazole to reduce stomach acid.

20. The man did not attend an appointment for a second health screen on 21 May, but another nurse saw the man on his wing that day and noted that he appeared unsteady on his feet. She arranged for an electrocardiogram (an ECG, which records the electrical activity of the heart) and blood tests. The ECG was normal but blood tests showed abnormal coagulation (blood clotting) and liver function. There is nothing in the records to show that anyone reviewed or followed up these test results.

21. At 10.51pm on 22 May, a nurse saw the man as he had passed out twice and fallen. The nurse recorded that his blood pressure was low and that his speech was not clear. She admitted him to the healthcare unit for staff to monitor him. At 3.42pm, a prison GP recorded that the man was feeling better. However, there is no record that she examined him in person.

22. On 23 May, a prison GP saw the man and was concerned about his fall. The doctor noted that he still looked and felt unwell and arranged for him to be admitted to North Manchester General Hospital for assessment. While the man was in hospital, a nurse contacted the escort officers for information. They said the man might have a clot and that doctors were treating him with clexane injections (anticoagulant medication). This was the first of a number of times when prison healthcare staff liaised with escort officer to get information about the man's clinical condition, rather than with hospital staff.

23. The man was discharged from hospital on 26 May. The hospital discharge letter contained only a prescription and no clinical information about his treatment. A doctor noted that the hospital 'presumably did not find a clot' and that the man was happy to return to a standard wing. Healthcare staff did not request any further information from the hospital.

24. On 4 June, a nurse noted that the man looked yellow and frail. He had complained of pain the night before and said he had been doubly incontinent, but he was not in pain at the time. The nurse referred the man to the GP and staff moved him to a single cell to provide more privacy.

25. On 5 June, a locum GP examined the man who complained of diarrhoea and shortness of breath. The GP noted the man was weak and poorly nourished and hydrated. He prescribed medication and noted that the man should have an abdominal scan if his symptoms persisted.

26. On 6 June, the man collapsed and went to hospital as an emergency. The hospital discharged him the same day. The GP noted that the man had been discharged without a summary of his treatment and, when he had phoned the hospital to get information, he had been disconnected. Healthcare staff made no further attempts to get discharge information from the hospital.

27. The next day, 7 June, the man collapsed again. The nurse found him lying on his side. He had been incontinent of urine and, although he was conscious, he was very confused. The nurse arranged for the man to go to hospital as an emergency. The hospital admitted him and he had an ultrasound scan and blood tests, which confirmed he had encephalopathy (a brain disorder, which is a common complication of liver disease). Again, the prison nurses spoke to escort officers for updates on the man's condition rather than hospital staff.

28. The hospital discharged the man on 11 June. The nurse assessed him when he got back to the prison and noted he was alert and orientated and preferred to return to his own cell, rather than be admitted to the healthcare unit. The GP saw the man the next day and prescribed lactulose (which is used to help prevent encephalopathy in people with liver disease).

29. Healthcare staff saw the man daily and recorded that he was generally unwell. He continued to complain of abdominal pain and healthcare staff gave him dietary advice and medication.

30. On 23 June, a specialist nurse for blood borne diseases arranged blood tests to assess the man's condition and referred him to his hospital specialist. The blood test results showed he had an abnormal liver function and active hepatitis C infection.

31. On 25 July 2014, the man was sentenced to two years in prison for burglary. He remained at Forest Bank.

32. On 28 July, a consultant in infectious diseases examined the man and requested an ultrasound scan of his liver and an endoscopy to examine the lining of his gullet and stomach, to exclude complications of liver disease. An ultrasound on 27 August confirmed the diagnosis of liver cirrhosis and identified no complications. The hospital had not arranged the endoscopy before the man died.

33. For the next three months, healthcare staff continued to monitor the man. He often had headaches for which staff gave him pain relief. On 6 November, routine blood tests showed the man's clotting ratio was abnormally high and he had a low white cell count. No plan of action was recorded.

34. On 24 December, a nurse referred him to see a GP, as he was experiencing pain. The GP recorded that the man had abdomen pain, distension, diarrhoea, vomiting and a poor appetite because of his liver disease. He arranged for him to be admitted to hospital for assessment.

35. The hospital discharged the man the next day, Christmas Day. Again, there was no discharge summary and a nurse noted that she had to rely on the man's account for information about the treatment and assessment he had received in hospital. Healthcare staff continued to see the man every day. He still had mild abdominal pain and had bowel problems, for which he received medication.

36. On the afternoon of 7 January 2015, the man was unwell while he was a work. The nurse assessed him and recorded that he had flu-like symptoms. He went back to his wing to rest. The next day, nurses checked the man frequently as he had a fever. The nurse gave him paracetemol and ibruprofen and referred him to a GP. The GP saw the man at 5.48pm on 8 January. The notes of the consultation were very brief and did not record any findings.

37. On 10 January, a nurse noted the man continued to have a high temperature and referred him to a GP. The GP saw him later that day, and noted the man was having headaches every day and was sensitive to light and sound. He noted that the man was nauseous and disorientated. He considered that the man had migraine and a flu-like illness and prescribed propranolol (to alleviate migraine headaches). He arranged to see him again in two to three weeks.

38. At about 5.40pm on 12 January, an officer found the man very unwell on his bed and called for urgent healthcare assistance. Two nurses attended with resuscitation equipment. At 5.51pm, one nurse asked for a doctor and an ambulance to attend. The two nurses gave the man oxygen and took his clinical observations. His temperature, oxygen saturation levels and blood pressure were normal but his blood sugar level was very low. The GP arrived and noted that the man's level of conscious was worsening and he was becoming less responsive to voices. The GP considered he might have had a stroke.

39. Records show that the ambulance arrived at the prison at 6.33pm. Paramedics stabilised the man and took him to Salford Royal Hospital, where he was admitted with suspected liver failure and a bleed to the brain. Doctors placed him in an induced coma. On 16 January, doctors took the man off ventilation and, although he was breathing independently, he remained unresponsive. The man's condition continued to deteriorate and he died at 5.00am on 22 January.

Liaison with the man's Family

40. On 13 January, the prison appointed a prison manager, to act as their family liaison officer. The family liaison officer telephoned the man's mother to tell her that he was in hospital, but she was on holiday. The family liaison officer then contacted the man's brother and informed him.

41. The family liaison officer kept in contact with the man's brother and mother (when she got back from her holiday). The man's mother and sister were with him when he died. The family liaison officer went to the hospital after the man died and offered to meet them but they wanted to be alone at that time.

42. The Director sent a letter of condolence to the man's family offering support and assistance with the funeral costs in line with national guidance. The man's family did not respond to contact from the prison after he died. However, after receiving the draft report, the man's mother made contact with our office to ask the prison to assist with the funeral cost. The prison responded immediately to this request.

Support for staff and prisoners

43. A Director's notice informed staff and prisoners of the man's death and offered support to anyone affected. A senior officer debriefed the escort officers who had been with the man at the time of his death and offered support.

Cause of death

44. The coroner gave the cause of death as cirrhosis of the liver.

ISSUES

Clinical care

45. The clinical reviewer found that much of the man's medical care in prison was of a good standard. However, in his review, he also identified some aspects of healthcare services where he considered there was room for improvement, such as in referrals to substance misuse services. The Head of Healthcare will need to address separately those matters not covered in this report.

Monitoring the man's declining condition

46. On 21 May 2014, blood tests showed the man had abnormal blood coagulation. The clinical reviewer noted that this is a significant indicator of liver disease, and such patients need to be assessed to plan effective management of their condition. There was no record of any review or clear plan in respect of these blood tests.

47. On 6 November, blood tests showed that the man had a low white cell count and abnormally high clotting ratio (when the blood takes longer than normal to clot). There is nothing in the records to show that anyone acted on this. The clinical reviewer commented that the man's liver cirrhosis would have been the likely cause of the low white cell count and this meant his immune system was compromised. This should have alerted healthcare staff to consider the possibility of other problems responsible for the man's headaches.

48. From early January 2015, the man became increasingly unwell. On 8 January, the nurse noted he had a slightly high pulse rate and a high temperature. A doctor saw him soon afterwards, but did not note any findings. The clinical reviewer considered this was an incomplete assessment, as the doctor should have checked for a source of infection because of his high pulse rate and temperature. He noted that patients with liver disease have a compromised immune system and require very careful assessment.

49. When the GP saw the man on 10 January, he attributed the man's high temperature to a flu-like illness but his examination did not include a full ear, nose and throat examination to rule out the presence of enlarged lymph glands or ear infection. If these had been present, together with a high temperature in a patient with cirrhosis and hepatitis C, the doctor should have carried out a full assessment to consider the need for specific treatments, such as antibiotics. The GP noted that the man was sensitive to light, which is a common symptom of brain haemorrhage, yet the doctor did not carry out any basic neurological examinations. The doctor did not prescribe anything to reduce the man's temperature and his plan to assess him in two or three weeks was not appropriate.

50. The clinical reviewer noted that the man's hepatitis C and liver cirrhosis was appropriately identified at Forest Bank. He had clear treatment plans and was referred to specialists for reviews as necessary. When the man's condition deteriorated, he had multiple assessments, many of them were timely and thorough, but he was not observed closely enough for signs deterioration.

The Head of Healthcare should ensure that healthcare staff receive training to help detect and treat early warning signs of deterioration in prisoners with chronic conditions, take and record observations as required and record actions and decisions about their ongoing care in their medical records.

Communication between the prison and hospital

51. The man had five hospital admissions after he was recalled to prison in May 2014. During three of these admissions, prison healthcare staff contacted the escort officers for an update on the man's medical condition rather than speaking to hospital staff directly. We do not consider this was appropriate. Healthcare staff should have spoken directly to clinical staff at the hospital for updates about the man's treatment and condition.

52. The man left hospital several time without a discharge summary outlining his treatment and ongoing care. While this was the responsibility of the hospital, healthcare staff did little to pursue this. Without appropriate discharge information from hospital, it is difficult for healthcare staff at the prison to make proper plans for future care. The nurse told us this is a recurring problem at Forest Bank. It is important that there is good communication between the prison and local hospitals, to ensure continuity of healthcare. We make the following recommendation:

The Head of Healthcare should agree protocols with local hospitals to ensure that necessary patient information is shared between the prison and hospital to allow appropriate continuity of care.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that healthcare staff receive training to help detect and treat early warning signs of deterioration in prisoners with chronic conditions, take and record observations as required and record actions and decisions about their ongoing care in their medical records.

2. The Head of Healthcare should agree protocols with local hospitals to ensure that necessary patient information is shared between the prison and hospital to allow appropriate continuity of care.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible
1.	The Head of Healthcare should ensure that healthcare staff receive training to help detect and treat early warning signs of deterioration in prisoners with chronic conditions, take and record observations as required and record actions and decisions about their ongoing care in their medical records.	Accepted	Appropriate training will be provided to all nursing staff. Management checks will be put in place to make sure that the correct information is logged appropriately in medical records.	31 January 2016 Head of Healthcare
2.	The Head of Healthcare should agree protocols with local hospitals to ensure that necessary patient information is shared between the prison and hospital to allow appropriate continuity of care.	Accepted	Local protocols will be reviewed and agreed to make sure the correct information is shared between the prison and the hospital. All nursing staff will be made aware that they must liaise with hospital nursing staff, rather than the escort staff, when seeking updates on a patient's condition.	31 October 2015 Head of Healthcare