Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Brian Salisbury a prisoner at HMP Preston on 14 October 2015

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Brian Salisbury died on 14 October 2015 of a heart attack at HMP Preston. He was 61 years old. I offer my condolences to Mr Salisbury's family and friends.

Mr Salisbury was profoundly deaf and his preferred means of communication was through British Sign Language. I am concerned that there was inadequate use of an interpreter, particularly to assess Mr Salisbury's health when he first arrived at the prison. While Mr Salisbury's death was sudden and unexpected, there appears to have been too much focus on managing Mr Salisbury's mental health problems, rather than managing and monitoring his chronic physical health conditions, which included high blood pressure and diabetes.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **May 2016**

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Summary

Events

1. Mr Brian Salisbury was remanded to HMP Preston in July 2015. He had several existing chronic health problems, including hypertension (high blood pressure), diabetes and possible dementia. Mr Salisbury was profoundly deaf and his preferred means of communication was British Sign Language (BSL). He could also lip read and communicate in writing. Staff did not use an interpreter for initial health assessments.

2. It took three days for healthcare staff to request Mr Salisbury's community medical records and it was four days before he received his prescribed medication. Healthcare staff monitored his medication frequently but did not check his blood pressure and blood sugar levels regularly.

3. On 27 July, Mr Salisbury's daughter phoned the prison, as she was concerned about her father's wellbeing. The next day he was admitted to the prison's mental health inpatient unit.

4. On 20 August, a prison GP sent Mr Salisbury to hospital after an abnormal electrocardiogram test. Hospital staff initially suspected a heart attack, but his symptoms resolved and a consultant discharged him the next day.

5. Mr Salisbury's mental health deteriorated and, on 3 September, a psychiatrist considered he should be transferred to a secure hospital. On 18 September, a hospital psychologist assessed him and confirmed his suitability for admission. The prison arranged for Mr Salisbury to move to the hospital on 14 October.

6. At approximately 8.45am on 14 October, a member of healthcare staff found Mr Salisbury unresponsive in his cell. Officers and healthcare staff responded promptly, radioed an emergency code and began cardiopulmonary resuscitation. Paramedics arrived quickly, but, sadly, they were unable to revive Mr Salisbury.

Findings

7. Mr Salisbury was profoundly deaf and initially healthcare staff found it difficult to communicate effectively with him. This meant information from initial health screens was incomplete. It took several days to seek information from Mr Salisbury's community GP, which delayed him receiving his medication. It took too long to arrange a sign language interpreter and no one sought the help of an advocacy service, which Mr Salisbury had used in the community. This meant there were continuing communication problems.

8. The clinical reviewer did not consider that healthcare staff at Preston managed Mr Salisbury's physical health conditions in line with National Institute for Care and Health Excellence (NICE) guidance. Staff appeared to prioritise Mr Salisbury's mental health problems rather than identifying and addressing his physical health needs. We found no evidence that Mr Salisbury was offered a second health screen after he arrived and there were no care plans to manage and monitor Mr Salisbury's hypertension or diabetes.

Recommendations

- The Governor and Head of Healthcare should ensure that accredited sign language interpreting services are used for prisoners who are deaf or hearing impaired, and reliant on sign language, whenever matters of accuracy or confidentiality are a factor.
- The Head of Healthcare should ensure that healthcare staff routinely request community medical records for newly arrived prisoners and offer prisoners a full general health assessment within a week of their arrival, in line with PSO 3050.
- The Head of Healthcare should ensure that all patients with complex health needs have clear personalised care plans, consistent with NICE guidelines, and that both primary physical health and mental health care teams effectively share information to ensure a coordinated approach to care.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Preston informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

10. The investigator visited HMP Preston on 21 October and obtained copies of relevant extracts from Mr Salisbury's prison and medical records.

11. NHS England commissioned a clinical reviewer to review Mr Salisbury's clinical care at the prison.

12. The investigator and a colleague of the clinical reviewer interviewed five members of staff at HMP Preston on 24 November.

13. We informed HM Coroner for Preston and West Lancashire District of the investigation who gave us the provisional cause of death. We have sent the coroner a copy of this report.

14. One of the Ombudsman's family liaison officers contacted Mr Salisbury's daughter, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. His daughter had a number of concerns including:

    - Mr Salisbury had deteriorated physically and mentally very quickly because of his dementia and she was concerned about the standard of care he had received.
    - She wanted to know whether Mr Salisbury could communicate properly in prison, and whether he had a pen and paper at all times.
    - She asked if he got sufficient help to stop smoking when he was admitted to the healthcare unit.
    - She was concerned about the management and provision of medication for his diabetes and hypertension.
    - She asked what happened when Mr Salisbury complained of chest pain the day before he died and whether anyone had checked him on the morning he died.
    - She wanted to know more about the resuscitation attempt.

15. Mr Salisbury's family received a copy of the initial report. They pointed out some factual inaccuracies and/or omissions. This report has been amended accordingly. Mr Salisbury's family also raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

16. The initial report was shared with the prison service. The prison service did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Preston

17. HMP Preston is a local prison holding up to 842 men. Lancashire Care Foundation Trust provides healthcare services at the prison. There is an inpatient unit for up to 30 prisoners, which is used as a regional facility, including for end of life care.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Preston was in April 2014. Inspectors reported that, overall, healthcare was safe and decent. Staff in the inpatient unit gave good support to patients with complex needs. However, some aspects of the environment and regime needed improvement.

Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to September 2015, the IMB reported that the primary care team at Preston provided a wide range of services and care. However, due to staff shortages, chronic disease clinics were not being run as planned and there was a three week waiting time for a GP appointment, which was too long.

Previous deaths at HMP Preston

20. Mr Salisbury was the sixth person to die of natural causes at HMP Preston since March 2014. There were no significant similarities with the circumstances of the other deaths.

Key Events

21. On 24 July 2015, Mr Brian Salisbury was remanded to HMP Preston charged with arson. He was 61 years old with several health problems, including diabetes, hypertension (high blood pressure) and possible dementia.

22. Mr Salisbury was profoundly deaf. His preferred and first language was British Sign Language (BSL) and although he could lip read and communicate in writing he found this more difficult. The prison gave him pens, paper and communication cards. Mr Salisbury had memory problems and had been assessed as lacking mental capacity to take decisions about his care and treatment when he was in the community. He had received help several times a day from family, carers and an advocate (an independent person who helps someone with mental health problems express their views and preferences about their treatment).

23. Nurse A carried out an initial health screen to assess Mr Salisbury's immediate and ongoing health needs, but without a BSL interpreter. The nurse noted that Mr Salisbury did not have his mental health medication with him and referred him for a mental health assessment. She did not identify any specific physical health problems but noted that she had had difficulty communicating with Mr Salisbury.

24. On 25 July, Nurse B saw Mr Salisbury for a mental health assessment. She did not use a BSL interpreter and also had difficulty communicating. The nurse recorded no specific concerns, but noted that Mr Salisbury had not received his prescribed medication.

25. On 27 July, Mr Salisbury's daughter spoke to Nurse C by phone as she was concerned about her father's emotional and physical health. She gave the nurse details of her father's medical history, current medication, and said that he suffered from confusion and poor memory. The nurse requested details of Mr Salisbury's medication from his community GP. The next day, she arranged for Mr Salisbury to move to the prison's mental health inpatient unit and he received his prescribed medications.

26. Mr Salisbury smoked cigarettes, but smoking was not allowed in the inpatient unit. Healthcare staff offered him support to stop smoking and gave him appropriately dosed, high strength nicotine patches.

27. On 4 August, a prison psychiatrist tried to see Mr Salisbury but there was no BSL interpreter available, so he postponed the appointment. On 11 August, The doctor saw Mr Salisbury with an interpreter and conducted a mini mental state examination. He suspected Mr Salisbury suffered from a form of dementia and requested his GP records. Later the same day, Nurse C completed a falls risk assessment, as Mr Salisbury had limited mobility and was often unsteady on his feet. Mr Salisbury's daughter acted as an interpreter.

28. On 20 August, a locum GP, Dr B, reviewed Mr Salisbury's hypertension and diabetes and noted that he was experiencing abdominal pain, headaches and vomiting. The doctor suspected he was suffering from indigestion and prescribed gaviscon and lansoprazole (to help reduce stomach acid). After an abnormal

electrocardiogram (ECG – a test of the electrical activity of the heart) later that day, the doctor decided to send Mr Salisbury to hospital.

29. Mr Salisbury arrived at the Royal Preston Hospital just after 9.00pm that evening. Two prison officers escorted him and used handcuffs to restrain him, the standard procedure for remanded prisoners. (We would have expected to see more healthcare input into the risk assessment for restraints but accept that there was little to indicate that Mr Salisbury was at reduced risk at the time.) Hospital staff suspected a heart attack and admitted him for further tests. On 21 August, a hospital consultant considered the results of the tests were satisfactory and discharged Mr Salisbury. No follow up was required.

30. On 3 September, the prison psychiatrist reviewed Mr Salisbury without an interpreter after nurses reported a deterioration in his overall presentation and behaviour. The doctor noted that Mr Salisbury did not recognise him and he was concerned about his increasingly disinhibited behaviour as he was writing sexually offensive graffiti and goading other prisoners. On 4 September, the doctor referred Mr Salisbury for specialist mental health services in a secure setting. Later that day, he received Mr Salisbury's community medical records, reviewed the results of a CT scan taken in May, and diagnosed vascular dementia.

31. On 18 September, a consultant psychologist from a secure hospital assessed Mr Salisbury and, on 23 September, confirmed he was suitable for admission. It was planned that Mr Salisbury would transfer to the hospital on 14 October.

32. At 1.34pm on 13 October, Nurse D observed Mr Salisbury rubbing his abdomen and he appeared to be complaining of a stomach ache. She took his clinical observations and noted that his blood pressure was slightly raised at 150/90, his pulse rate was normal (75 bpm) and he did not have a temperature. As Mr Salisbury did not complain of further discomfort, the nurse did not take any other action.

Events on 14 October

33. At 6.33am on 14 October, Nurse E noted that Mr Salisbury had slept well. At 7.30am, Nurse F completed an hourly observation check and ticked the box to indicate that Mr Salisbury was asleep and breathing. At approximately 8.35am, a healthcare support worker went to Mr Salisbury's cell to unlock him for his medication. The healthcare support worker noticed there was no movement in Mr Salisbury's chest and shook his leg to try to wake him. He did not respond and she called for help.

34. At 8.38am, Nurse G arrived. Mr Salisbury was lying on his left side on the bed and she could not wake him. She checked his pulse and airway then radioed a code blue medical emergency (used to indicate circumstances such as when a prisoner is unresponsive, unconscious or not breathing). The control room called an ambulance and the nurse asked a prison manager, A, to bring a defibrillator. She moved Mr Salisbury on his back to begin cardiopulmonary resuscitation (CPR). She decided that the bed was firm enough to allow effective CPR.

35. At 8.45am, Nurse H and Nurse J arrived and helped with the resuscitation attempt. Nurse H attached the defibrillator, which found no shockable heart rhythm. The nurses continued with CPR until paramedics arrived at 8.55am. The paramedics took over emergency treatment but, at 9.22am, recorded that Mr Salisbury had died.

Contact with Mr Salisbury's family

36. Mr Salisbury's daughter lived in Cumbria and, at 9.45am, the Governor, contacted HMP Haverigg (in Cumbria) who agreed to send a family liaison officer to inform Mr Salisbury's daughter that he had died. However, when the officer from Haverigg got to her home she found that his daughter had left to visit her sister in Preston. At 11.55am, the governor rang Mr Salisbury's daughter to establish where she was. Although she had not yet reached her sister's, she was with her son, and he informed her that Mr Salisbury had died.

37. A prison chaplain acted as the prison's family liaison officer. At 3.00pm, the governor, the prison chaplain, and a prison manager visited Mr Salisbury's daughter at her sister's house in Preston and offered their condolences and support. On 15 October, the prison chaplain and prison manager met Mr Salisbury's daughter and her sister at the prison to return their father's belongings. The prison chaplain gave ongoing support until Mr Salisbury's funeral on 30 October. The prison contributed to the costs, in line with national policy.

Support for prisoners and staff

38. After Mr Salisbury's death, a prison manager debriefed the staff involved in the emergency response and offered support and that of the staff care team.

39. The prison posted notices informing staff and prisoners of Mr Salisbury's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Salisbury's death.

Cause of death

40. The coroner gave the preliminary cause of death as acute myocardial ischaemia and coronary thrombosis (a heart attack) with a background of hypertensive heart disease (a complication of high blood pressure).

Findings

Communicating with Mr Salisbury

41. When Mr Salisbury arrived at Preston, healthcare staff found it difficult to communicate with him as he was profoundly deaf. Nurse D told us that Mr Salisbury always had access to communication cards and pens and paper, but Mr Salisbury had difficulty with this and his preferred means and communication and first language was through British Sign Language (BSL).

42. Nurse A carried out Mr Salisbury's initial health screen without a BSL interpreter. This meant she was unable to obtain a clear medical history or the names of the medications he had been prescribed.

43. There was no BSL interpreter present when Nurse B met Mr Salisbury for an initial mental health assessment, which was therefore inadequate. While we accept that it might have been difficult for the prison to arrange an interpreter for these initial assessments, once the communication difficulties were identified they should have been repeated with an interpreter present.

44. Staff tried to respond to Mr Salisbury's communication needs but there was no coordinated response. The mental health team drew up a communication care plan, which included the use of interpreters, but no one took responsibility for ensuring its implementation. The first use of a BSL interpreter was not until 11 August, 18 days after Mr Salisbury first arrived at Preston. There were a number of occasions when there was no interpreter present for assessments.

45. The clinical reviewer noted that Mr Salisbury's daughter was involved in some assessments as an interpreter and more could have been done to engage her proactively. This would have improved communication, helped Mr Salisbury cope with the prison environment and possibly lessened the changes in his behaviour. There is no record that anyone tried to arrange for an advocate (as he had in the community) to help with his communication and understanding.

46. Mr Salisbury had a significant disability and should have been supported to communicate in his preferred method, BSL, particularly during healthcare assessments. All the staff we interviewed accepted that there needed to be better access to interpretation services. We make the following recommendation:

    The Governor and Head of Healthcare should ensure that accredited sign language interpreting services are used for prisoners who are deaf or hearing impaired, and reliant on sign language, whenever matters of accuracy or confidentiality are a factor.

Healthcare procedures for newly arrived prisoners

47. Prison Service Order (PSO) 3050 – Continuity of Healthcare for Prisoners - requires that prison staff should try to obtain relevant information from the prisoner's GP or other relevant health services the prisoner has recently been in contact with, when new prisoners arrive in reception. In Mr Salisbury's case, the communication problems meant that it was all the more important that healthcare

staff should obtain Mr Salisbury's community medical records for up to date information. However, no one requested any information from Mr Salisbury's GP until Mr Salisbury's daughter contacted the prison, on 27 July, three days after he arrived.

48. The delay in requesting this information meant it was four days before Mr Salisbury received his prescribed medication for his mental health, diabetes and hypertension. The clinical reviewer noted that it does not appear that this caused Mr Salisbury any harm but in other cases such a delay could pose a significant risk to other newly arrived prisoners.

49. PSO 3050 also requires that newly arrived prisoners should be offered a general health assessment in the week after first reception. This assessment is expected to be equivalent to a primary care assessment when registering with a new practice in the community. There is no record that Mr Salisbury was offered or had such an assessment after he arrived, which would have been an opportunity for a more in depth assessment of his conditions and ongoing treatment and allowed time to arrange an interpreter. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff routinely request community medical records for newly arrived prisoners and offer prisoners a full general health assessment within a week of their arrival, in line with PSO 3050.

Clinical care

50. The clinical reviewer considered that healthcare staff did not manage Mr Salisbury's hypertension in line with National Institute for Health and Care Excellence (NICE) guidance. Although he received appropriate medication there was no evidence of a care plan and there was no record that healthcare staff routinely monitored his blood pressure to ensure the medication was effective.

51. The clinical reviewer also found that the management of Mr Salisbury's diabetes fell below the standard specified in NICE guidance. There was no care plan or regular monitoring of his blood sugar levels, which were recorded only on an ad hoc basis.

52. It appears that healthcare staff prioritised Mr Salisbury's mental health treatment. Mental health staff reviewed him frequently, he was assessed by a psychiatrist and psychologist and arrangements were agreed to move him to a secure hospital. However, we consider insufficient priority was given to Mr Salisbury's physical health. There was only limited sharing of information between the mental health team and the primary health team, and no lead clinician responsible for coordinating his overall care. This meant that his chronic physical conditions were not effectively managed. In our recent thematic report on Prisoner Mental Health, published in January 2016, we noted that communication between primary physical health services and mental health services can be poor and this can sometimes mean that physical conditions are overlooked when there are more prevalent mental health symptoms or vice versa.

53. The clinical reviewer concluded that, although there was some evidence of compassionate care from healthcare staff at Preston, the overall standard of care

and treatment Mr Salisbury received was not equivalent to that he could have expected to receive in the community. We make the following recommendation:

The Head of Healthcare should ensure that all patients with complex health needs have clear personalised care plans, consistent with NICE guidelines, and that both primary physical health and mental health care teams effectively share information to ensure a coordinated approach to care. .

Emergency response

54. Mr Salisbury was in the healthcare centre so healthcare staff attended immediately. The clinical reviewer noted the resuscitation attempt as an example of good practice and team work. A nurse coordinated the resuscitation attempt and paramedics arrived at Mr Salisbury's cell without delay. Sadly, Mr Salisbury could not be revived, but we consider that there was a quick and appropriate emergency response when Mr Salisbury was found unresponsive

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