Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Russell Forte a prisoner at HMP High Down on 27 April 2017

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*

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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.

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

Mr Russell Forte died on 27 April 2017, while a prisoner at HMP High Down. He died of a blocked artery between his heart and lungs, caused by a blood clot in his left leg. He was 68 years old. I offer my condolences to his family and friends.

Although it is unlikely to have changed the outcome for Mr Forte, healthcare staff should have urgently investigated his health issues on 27 April to find out what was wrong. While we are concerned that Mr Forte's clinical care was not equivalent to that which he could have expected to receive in the community, we are satisfied that the emergency response was prompt and appropriate.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman **November 2017**

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Summary

Events

1. On 17 February 2017, Mr Russell Forte was sentenced to four years and six months in prison for having indecent images of children and was sent to HMP High Down. At his initial health assessment, healthcare staff found no significant issues.

2. A prisoner and a friend of Mr Forte said that on 25 April, two days before his death, Mr Forte felt ill in education. He also said that Mr Forte did not go to education the following day (26 April) because he was planning to see a doctor. There are no records to confirm this.

3. On 25 April 2017, Mr Forte spoke to his daughter by telephone. She said that he told her he did not feel well and that he had been to see a nurse who took his basic observations and a blood test.

4. At 9.46am on 27 April, Mr Forte went to the medication hatch and told an associate practitioner that he had had dizzy spells, fainting and nausea for two days. She said that his blood pressure was low (91/65) and his pulse rate high (90 beats per minute).

5. She passed the information on to the duty prison GP, who asked for blood tests and an electrocardiogram (ECG - a reading of the electrical activity of the heart) to be done. The GP offered to review Mr Forte later that day.

6. A prison officer took Mr Forte to the prison's healthcare department. When Mr Forte stopped halfway to rest, a nurse assisted and recorded his blood oxygen level as normal (98%) and his pulse as low (55 beats per minute). They used a wheelchair to get him there.

7. A nurse saw Mr Forte in the outpatient department. He took blood tests and an ECG, and confirmed again that Mr Forte's blood pressure was low (90/60). The nurse told a doctor that he thought it was due to anxiety. There were no significant findings with the blood test or the ECG.

8. At 12.00pm, Mr Forte collapsed outside his cell. Two prison officers helped him. They called a medical emergency code red (which indicates that a prisoner is bleeding or has a serious burn) and placed him in the recovery position.

9. A nurse saw Mr Forte was breathing and talking. They helped him into his cell and placed him on the bed. His blood pressure was low (80/55), his pulse rate low (35 beats per minute), and blood oxygen level normal (99%). He was unsteady and they laid him down.

10. The nurse spoke to the doctor by telephone and asked for an ambulance. When he returned to the cell, he said Mr Forte's condition had worsened. Mr Forte was cold, clammy and struggling to breathe. The nurse gave him oxygen but Mr Forte stopped breathing.

11. A prison officer radioed that Mr Forte had had a cardiac arrest. Staff laid Mr Forte on his back. The nurse tilted back his head, gave him a pre-cordial thump

(a medical procedure used in a cardiac arrest) and started chest compressions. A nurse inserted a tube through Mr Forte's mouth into the airway, and another nurse used a defibrillator, which, on two occasions, advised no shock.

12. An ambulance arrived promptly at the prison. Paramedics took over resuscitation efforts. At 1.32pm, after 45 minutes of trying to resuscitate Mr Forte, they stopped resuscitation.

13. On 29 April, Mr Forte's other daughter received an undated letter written by him. In the letter, he told his daughter he was unwell and explained his symptoms. He told her he had been to see the healthcare team.

Findings

Clinical care

14. Mr Forte's daughter spoke to Mr Forte two days before his death. She said he told her he was not well and had spoken to a member of the healthcare team who took his blood pressure and a blood test. Mr Forte said the same things in an undated letter to his other daughter, which he appears to have written a few days before his death. In the light of the phone call and letter, the family are concerned that Mr Forte told healthcare staff two days before his death that he was unwell.

15. While there is evidence that Mr Forte telephoned his daughter on 25 April, there is no record that he spoke to any healthcare staff before he went to the medication hatch on the morning of 27 April. No one from healthcare remembers seeing Mr Forte in the days before 27 April, and there is no entry in his medical record. Without evidence, we cannot conclude whether or not the healthcare team knew Mr Forte was unwell in the days before his death.

16. The first record of Mr Forte telling healthcare staff that he was unwell is on 27 April. The clinical reviewer said that while it was not easy to diagnose a blocked artery between Mr Forte's heart and lungs, caused by a blood clot, healthcare staff knew that Mr Forte had low blood pressure, palpitations and was fainting. He concluded that healthcare staff should have investigated this urgently, particularly as Mr Forte's ECG reading was normal.

17. Healthcare staff did not act decisively or promptly enough on 27 April, to find out why Mr Forte's blood pressure was low. Despite this, it is unlikely that the outcome would have changed for Mr Forte, even if he had been admitted to hospital earlier that day.

18. The care Mr Forte received was not equivalent to that which he could have expected to receive in the community, where a patient with low blood pressure would be referred immediately to a doctor. When no obvious cause was found for the fainting, dizziness and low blood pressure, Mr Forte should have been sent to hospital.

Emergency response

19. The officer called a medical emergency code red when a code blue (which indicates that a prisoner is unconscious or not breathing) was more appropriate.

However, an officer also radioed that Mr Forte had suffered a cardiac arrest, which meant that the ambulance crew were given the appropriate information. Staff started cardiopulmonary resuscitation promptly and used a defibrillator.

Recommendations

- The Head of Healthcare should review how prisoners with low blood pressure are managed and ensure that staff respond appropriately.

The Investigation Process

20. The investigator issued notices to staff and prisoners at HMP High Down informing them of the investigation and asking anyone with relevant information to contact him. Two prisoners contacted him, whom he interviewed them on 5 June.

21. The investigator obtained copies of relevant extracts from Mr Forte's prison and medical records.

22. The investigator interviewed three members of staff and two prisoners at High Down on 5 June.

23. NHS England commissioned a clinical reviewer to review Mr Forte's clinical care at the prison. The investigator and clinical reviewer jointly interviewed three members of staff at High Down on 15 June.

24. We informed HM Coroner for Surrey of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

25. One of the Ombudsman's family liaison officers contacted Mr Forte's daughter to explain the investigation process and to invite any questions or concerns the family may have about his care. Mr Forte's daughter raised a number of issues, including that her father had contacted her and her sister to say that he was short of breath and had passed out in the days before he died.

26. Mr Forte's family received a copy of the initial report. The solicitor representing Mr Forte's daughter wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

27. We shared the initial report with the Prison Service. There were two factual inaccuracies and this report has been amended accordingly.

Background Information

HMP High Down

28. HMP High Down is a local prison in Surrey, which at the time of Mr Forte's death, held up to 1,150 men. Central and North West London NHS Foundation Trust provides primary health services and in-reach mental health care. The healthcare unit has inpatient facilities with 24-hour nursing cover.

HM Inspectorate of Prisons

29. The most recent inspection of High Down was in January 2015. Inspectors reported that health services were good overall but staff shortage resulted in too many cancelled appointments. Prisoners had prompt access to a range of pharmacy services, which reduced the need for GP appointments. Inspectors considered this good practice.

Independent Monitoring Board

30. 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 December 2016, the IMB said the prison was yet to see significant changes since the appointment of an Executive Governor when it became a reform prison in April 2016. They said it had been a challenging year in which a restricted regime had operated for four months for safety reasons due to a shortage of operational staff. They said that prisoners' healthcare had suffered because clinics had been cancelled due to the shortage of uniformed staff.

Previous deaths at HMP High Down

31. There have been no previous deaths due to natural causes at High Down since April 2016.

Key Events

32. On 17 February 2017, Mr Russell Forte was sentenced to four years and six months in prison for having indecent images of children. He was sent to HMP High Down. At his initial health assessment, a healthcare assistant said Mr Forte was fit, took no medication and his medical history did not identify any significant health issues.

33. A prisoner and a friend of Mr Forte told us that on the Tuesday (25 April), two days before his death, Mr Forte felt ill in education and they got him a glass of water. He also said that Mr Forte did not go to education the following day (26 April) because he was planning to see a doctor. There are no records to confirm this.

34. On 25 April, Mr Forte's daughter spoke to him by telephone. She said that he told her he did not feel well and he had been to see a nurse who took his basic observations and a blood test. He said he would have the results the next day.

35. On 27 April, Mr Forte went to the medication hatch and told an associate practitioner that he had had dizzy spells, fainting and nausea for two days. She said his blood pressure was low (91/65) and his pulse rate high (90 beats per minute).

36. The associate practitioner passed this information to the duty GP, who asked for blood tests and an ECG and offered to review Mr Forte later that day.

37. An officer took Mr Forte to the prison's healthcare department. Mr Forte walked very slowly and stopped to rest, and then used a wheelchair. A nurse assisted and recorded Mr Forte's blood oxygen level as normal (98%) and that he had a low pulse (55 beats per minute).

38. A nurse saw Mr Forte in the healthcare department and took blood tests, an ECG and blood pressure, which was low (90/60). The normal range is between 90-120/60-80. There were no significant findings with the blood test or the ECG. The nurse told a prison GP that he believed the low blood pressure was caused by anxiety. He did not make an entry in Mr Forte's medical record but noted on the ECG that Mr Forte did not have chest pain or shortness of breath. An officer took Mr Forte back to his cell by wheelchair.

39. At 11.23am, a prison GP read Mr Forte's medical record. She noted that a nurse should check Mr Forte's blood pressure that afternoon and let her know the result.

40. At 12.00pm, an officer saw some prisoners asking for help outside Mr Forte's cell. She responded with another officer and saw that Mr Forte had collapsed on the floor. She called a medical emergency code red and placed him in the recovery position.

41. A nurse responded and saw Mr Forte was breathing and talking. He said he was weak and light headed. He was incontinent of urine. They helped him into his cell and placed him on the bed. His blood pressure was low (80/55), his pulse rate low (35 beats per minute), and blood oxygen level normal (99%). He was unsteady and they laid him down.

42. The nurse spoke to a prison GP by telephone and then asked for an ambulance to attend. When he returned to the cell, he said that Mr Forte's condition was worse: he was cold, clammy, and struggling to breathe. He gave him oxygen but Mr Forte stopped breathing.

43. An officer radioed that Mr Forte had had a cardiac arrest and asked all healthcare staff to attend. They laid Mr Forte flat on his back, and the nurse tilted his head back, gave him a pre-cordial thump (a medical procedure used in a cardiac arrest) and started chest compressions.

44. Officers and healthcare staff went to the cell. A nurse intubated Mr Forte. Another nurse applied a defibrillator and twice checked for shockable rhythm but no shock was advised.

45. At 12.37pm, an ambulance arrived at the prison, and paramedics arrived at the cell within ten minutes. They took over resuscitation attempts, but stopped at 1.32pm when Mr Forte was pronounced dead.

46. On 29 April, Mr Forte's other daughter received an undated letter from her father, probably posted a day or two before his death. He said in the letter that he had not gone to education and was not well. He also said that he had gone to the healthcare unit who told him to ring the cell bell if his symptoms recurred. He said he went to the 'meds' today with no joy and he did not know what else to do.

Contact with Mr Forte's family

47. After Mr Forte's death, High Down appointed an officer as the family liaison officer. At 4.00pm on 27 April, the officer and Governor visited Mr Forte's daughter and broke the news of his death. They offered their support and condolences. Mr Forte's funeral was held on 12 May. The prison contributed towards the cost in line with national policy.

Support for prisoners and staff

48. After Mr Forte's death, the Deputy Governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

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

Post-mortem report

50. A post mortem examination found that the cause of Mr Forte's death was a blockage in the artery between his heart and lungs (bilateral pulmonary artery emboli), caused by a blood clot in his left leg (deep vein thrombosis).

Findings

Clinical care

51. A prisoner and a friend of Mr Forte told us that on 25 April, two days before his death, Mr Forte felt ill in education and they got him a glass of water. He also said that Mr Forte did not go to education the following day (26 April) because he was planning to see a doctor. There are no records to confirm this.

52. Mr Forte's daughter spoke to Mr Forte on the phone two days before his death. She told us that he told her then that he was unwell and that he had spoken to a member of healthcare staff who had taken his blood pressure and a blood test. There is evidence that Mr Forte telephoned his daughter but there is no record of their conversation.

53. On 29 April, Mr Forte's other daughter received a letter from her father, probably posted a few days before his death. He said in the letter that he had not gone to education and was not well. He also said that he had gone to the healthcare unit who told him to ring the cell bell if his symptoms recurred. He said he went to the 'meds' today with no joy and he did not know what else to do.

54. In the light of the phone call and the letter, the family have expressed concern that Mr Forte told healthcare that he was unwell in the days before his death, but that nothing was done.

55. However, there is nothing in Mr Forte's medical notes to show that he spoke to anyone from healthcare before 27 April, and no one from the healthcare team remembers speaking to Mr Forte before that day. In the absence of any medical record to confirm what happened, we cannot reach a conclusion about whether or not the healthcare team knew that Mr Forte was unwell in the days before his death.

56. We agree with the clinical reviewer's concern that healthcare staff did not act decisively enough on 27 April, to investigate what was wrong with Mr Forte. Despite this, it is unlikely that the outcome would have changed, even if Mr Forte had been admitted to hospital earlier that day.

57. The clinical reviewer said that it is not easy to diagnose a blocked artery and Mr Forte had no risk factors for deep vein thrombosis or a pulmonary embolism. However, he said that Mr Forte's low blood pressure, palpitations and history of fainting should have been investigated as a matter of urgency when he reported them on 27 April, particularly as his ECG reading was normal.

58. This did not happen. We are concerned that the care that Mr Forte received was not equivalent to that which he could have expected to receive in the community, where a doctor would have seen him immediately. If a doctor had not been able to identify the cause of Mr Forte's symptoms, he would have been admitted to hospital and we would have expected the prison to have done the same. We make the following recommendation:

59. The Head of Healthcare should review how prisoners with low blood pressure are managed and ensure that staff respond appropriately.

Emergency response

60. The officer called a medical emergency code red (used when prisoners are bleeding) when a code blue (which indicates that a prisoner is unconscious or not breathing) was more appropriate. While it would have been better for staff to call the correct code, in these circumstances, it did not make a difference as healthcare staff responded quickly and appropriately with the correct emergency equipment, and we therefore do not make a recommendation.

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