Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Kevin Forrester, a prisoner at HMP Holme House, on 4 August 2020

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 Kevin Forrester died in hospital from an infection of the heart on 4 August 2020, while a prisoner at HMP Holme House. He was 39 years old. I offer my condolences to Mr Forrester's family and friends.

Mr Forrester was sent to hospital on 2 August, when a nurse suspected that he was very unwell. Mr Forrester was admitted to hospital for further tests, but on 4 August he had a seizure and did not regain consciousness.

The clinical reviewer found that the standard of care Mr Forrester received at Holme House was partly equivalent to that which he could have expected to receive in the community.

The clinical reviewer was concerned that Mr Forrester's reception health screenings were not carried out in line with guidelines, she was also concerned and that the staff that were completing health screenings were not trained to do so.

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

Sue McAllister, CB
Prisons and Probation Ombudsman **May 2021**

Contents

Summary 1

The Investigation Process 2

Background Information ..... **Error! Bookmark not defined.**

Key Events ..... **Error! Bookmark not defined.**

Findings 6

Summary

Events

1. On 25 November 2019, Mr Kevin Forrester was remanded in custody for supplying drugs. He was subsequently sentenced to three years in prison. On 7 February 2020, he was moved to HMP Holme House.

2. Mr Forrester had a history of substance misuse and was on a methadone programme. It was also noted that Mr Forrester had Hepatitis C, Endocarditis (a rare heart condition) and had previously had a Deep Vein Thrombosis.

3. Over the next six months, a prison GP reviewed Mr Forrester regularly because he said he had jaw and ankle pain. The GP prescribed Mr Forrester with painkillers and referred him to the hospital for further investigations.

4. On 2 August, Mr Forrester said that he had chest pains, the prison nurse assessed Mr Forrester, but did not know why he was in pain, the nurse said that he looked clinically unwell and needed to go to hospital. Two prison officers took Mr Forrester to hospital, he was restrained using single cuffs (when the prisoner's wrist is attached to a prison officer's wrist by a set of cuffs).

5. Mr Forrester was admitted to hospital for further tests, however, on 4 August he suddenly had a seizure and died.

6. The post-mortem report concluded that Mr Forrester died from blood in the sac of the heart caused by an infection.

Findings

7. The clinical reviewer found that the care Mr Forrester received was partly equivalent to that he could have expected to receive in the community. She was concerned that Mr Forrester's health care screenings were not completed in line with National Institute for Health and Care Excellence (NICE) guidelines, she was also concerned that the healthcare staff that were carrying out the screenings had not been trained to do so.

8. The clinical reviewer was also concerned that Mr Forrester missed two appointments which caused a delay and meant that he had to be referred again. Furthermore, while Mr Forrester was in hospital, healthcare staff did not make any contact with the hospital so did not receive any update on Mr Forrester's condition.

Recommendations

- The Head of Healthcare should ensure that, all staff undertaking reception and secondary health screenings are trained to do so, and that all reception screenings are completed in line with NICE guidance.

- The Head of Healthcare should find out why Mr Forrester missed two healthcare appointments and if this was because of a failing of internal procedures.

- The Head of Healthcare should ensure that there is a process in place for daily communication with hospitals when a prisoner is being cared for there.

The Investigation Process

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

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

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

12. We informed HM Coroner for Teesside and Hartlepool of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

13. One of the Ombudsman's family liaison officers contacted Mr Forrester's mother to explain the investigation and to ask if the family had any matters they wanted the investigation to consider. She did not respond.

14. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

15. The clinical reviewer found a factual inaccuracy which has now been amended.

Background Information

HMP Holme House

16. HMP Holme House is a Category C training prison holding over 1,200 men. G4S provides health services at the prison. There is a 24-hour healthcare inpatient unit with 16 beds.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Holme House was in February 2020. Inspectors reported that, there was a range of nurse-led clinics, and patients with long-term conditions or complex needs were monitored and reviewed appropriately. Although there was no lead nurse for long-term conditions, two senior nurses were currently undertaking training to take on this role. Health services staff liaised with the GP and external specialists to ensure a coordinated approach.

18. Arrangements for dealing with medical emergencies were comprehensive, and further enhanced by the addition of a paramedic to the team since the previous inspection. Registered clinical staff were trained in immediate life support and had access to suitable and regularly checked equipment. Officers we spoke to were familiar with the emergency code protocol, and ambulances were called promptly in an emergency.

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 December 2019, the IMB reported that, the waiting time to see a GP was, at times, between five and six weeks, with some provision for urgent cases. Review lists were eight weeks. This is far in excess of that in the community.

20. An improvement board was in place for most of the year to address the issues concerning healthcare, however, our observations are that, up until September 2019, little progress was made in some significant areas.

Previous deaths at HMP Holme House

21. Mr Forrester was the 14th prisoner to die at Home House since August 2018. Of the previous deaths nine were from natural causes, one was drug related, two were self-inflicted and in one case no cause of death was ascertained. There were no similarities between the circumstances of Mr Forrester's death and previous deaths at the prison.

Key Events

22. On 25 November 2019, Mr Kevin Forrester was remanded in custody for supplying drugs. He was subsequently sentenced to three years in prison. He was sent to HMP Durham.

23. On 15 January 2020, Mr Forrester saw the prison dentist. Mr Forrester told the dentist that before he came to prison, he had had a broken jaw which had been surgically transfixed. Mr Forrester also said that he thought the fixation had dislodged and that was why he was in pain. The dentist made a referral for Mr Forrester to be seen by the maxillofacial consultant at the hospital.

24. On 7 February, Mr Forrester was moved to HMP Holme House. A nurse completed the reception health screen. She noted that Mr Forrester had a history of substance misuse and was on a methadone programme. Mr Forrester also told the nurse that he had Hepatitis C, Endocarditis (a rare heart complication cause by bacteria entering the blood stream and settling in the heart lining, heart valve or blood vessel) and had previously had a Deep Vein Thrombosis (DVT).

25. On 9 February, a nurse completed Mr Forrester's secondary reception screening.

26. On 12 February, Mr Forrester saw a nurse from the drug and alcohol recovery team for an assessment. During the assessment Mr Forrester told her that his jaw was hurting, and he was waiting to be seen at the hospital. She passed this information to healthcare admin.

27. Later that day, a nurse saw Mr Forrester because he had a swollen ankle. She was concerned that it may be a DVT, so she referred him to the prison GP. The following day Mr Forrester was seen by a prison GP. She examined his ankle and said that there was no evidence of a DVT, but she made a referral for him to be seen at hospital for an ultra sound scan.

28. Over the next six months Mr Forrester continued to have pain in his jaw and ankle. A prison GP prescribed Mr Forrester with strong painkillers and the prison contacted the hospital to find out when he would be seen by the maxillofacial surgeon. The hospital said that because of COVID he would not be seen for a few months. It was also noted that he was still waiting for an ultrasound scan on his ankle.

29. On 2 August at 2.42pm, Mr Forrester told an officer that he did not feel very well and had pains in his chest. The officer called for a nurse to come and see Mr Forrester. A nurse attended. Mr Forrester told the nurse that he had pain in his chest, his back and down his left side. He said the pain felt the same as when he had endocarditis.

30. The nurse took Mr Forrester's observations. He recorded that Mr Forrester had National Early Warning Score (NEWS) score of 5 (NEWS – a tool used to identify clinical deterioration in adult patients – a score of 5 indicates medium clinical risk and recommends an urgent assessment by a clinician). The nurse took blood

tests and completed an electrocardiogram (ECG), but he could not find a cause for Mr Forrester's pain. He said that Mr Forrester needed to go to hospital to be assessed further.

31. Mr Forrester was escorted to hospital by two officers and was restrained using the single cuffing method (when the prisoner's wrist is attached to a prison officer's wrist by a set of cuffs). Mr Forrester was admitted to hospital for further tests.

32. On 4 August, Mr Forrester suddenly had a seizure and became unresponsive. Hospital staff started cardiopulmonary resuscitation, but Mr Forrester died a few minutes later.

Contact with Mr Forrester's family

33. On 4 August 2020, the prison was told that Mr Forrester was very unwell, so they appointed a family liaison officer (FLO). While the FLO was finding out Mr Forrester's next of kin details, the prison received a phone call to say that Mr Forrester had died. Mr Forrester's mother was listed as his next of kin, so the FLO went to her house to break the news of his death.

34. Mr Forrester's funeral was on 18 August, the prison paid for the funeral in line with national guidelines.

Support for prisoners and staff

35. After Mr Forrester's death, two prison managers debriefed the staff involved to ensure they had the opportunity to discuss any issues arising, and to offer support.

36. The prison posted notices informing other prisoners of Mr Forrester's death, and offered support.

Post-mortem result

37. The post-mortem report concluded that Mr Forrester died from Hemopericardium (blood in the sac of the heart) caused by Infective Endocarditis (an infection of the inner lining of the heart)

Findings

Clinical Care

38. The clinical reviewer concluded that the care that Mr Forrester received at Holme House was of a mixed standard and in parts equivalent to that which he could have expected to receive in the community.

39. The clinical reviewer was concerned that when Mr Forrester had his first and second health screen, neither nurse looked at Mr Forrester's health records and did not find out that he had ongoing hospital appointments. Furthermore, when a nurse was asked why she did not look at Mr Forrester's previous medical history, she said that she would not have had access to look at these records and it was not a requirement. She said that the purpose of a day two screen was to ask a series of questions and complete a questionnaire.

40. When the clinical reviewer spoke to the Head of Healthcare, she said that Mr Forrester's health records should have been checked as part of the transfer reception screening process and that Mr Forrester's outstanding hospital appointments should have been noted and actioned. She also said that not all healthcare staff were trained to complete reception screenings. She said that she was new to post and was in the process of training staff. She also accepted that the health care screenings were not completed in line with National Institute for Health and Care Excellence (NICE) guidelines.

41. The clinical reviewer is also concerned that on 22 July, the hospital reported that Mr Forrester had missed two appointments to be seen by the maxillofacial surgeon and a new referral would have to be made. When the clinical reviewer asked the Head of Healthcare how this had happened, she said that Holme House had not received any appointments for Mr Forrester.

42. Additionally, when Mr Forrester was in hospital, healthcare staff at Holme House should have called the hospital to find out more about Mr Forrester's condition and what support he would have needed had he returned to prison. No one from healthcare contacted the hospital for an update throughout Mr Forrester's stay in hospital. We, therefore, make the following recommendations:

    The Head of Healthcare should ensure that, all staff undertaking reception and secondary health screenings are trained to do so and that, all reception screenings are completed in line with NICE guidance.

    The Head of Healthcare should find out why Mr Forrester missed two healthcare appointments and if this was because of a failing of internal procedures.

    The Head of Healthcare should ensure that there is a process in place for daily communication with hospitals when a prisoner is being cared for there.

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