Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Gerald Coppel, a prisoner at HMP Forest Bank, on 4 February 2022

**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 Gerald Coppel died in hospital on 4 February 2022 from an abdominal aortic aneurysm while a prisoner at HMP Forest Bank. He was 73 years old. I offer my condolences to Mr Coppel's family and friends.

The clinical reviewer found that Mr Coppel received appropriate care and treatment for his abdominal aortic aneurysm diagnosis and that his care at Forest Bank was equivalent to that which he could have expected to receive in the community.

However, the clinical reviewer found that there were some occasions when staff did not take clinical observations and assess for clinical deterioration as they should have done. She also made a recommendation about clinical record keeping.

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

**Kimberley Bingham**
**Acting Prisons and Probation Ombudsman** **March 2023**

# Contents

# Summary

## Events

1. On 26 November 2019, Mr Gerald Coppel was remanded to HMP Forest Bank, charged with sexual offences. He was subsequently sentenced to nine years and five months imprisonment.

2. Before he arrived in prison, Mr Coppel was diagnosed with an abdominal aortic aneurysm (bulging of the aorta, the main blood vessel in the body) for which he was receiving ongoing screening. (An abdominal aortic aneurysm may get bigger and eventually rupture.)

3. On 18 November 2020, an ultrasound scan showed that Mr Coppel's abdominal aortic aneurysm had grown. Hospital doctors advised that if it got bigger, Mr Coppel may need surgery.

4. Prison healthcare staff met Mr Coppel regularly to review his health conditions, including his aneurysm.

5. On 8 November 2021, a prison GP saw Mr Coppel. The GP checked Mr Coppel's understanding of his aneurysm and that it was getting bigger. Mr Coppel said that he understood the risks associated with his aneurysm but did not want an operation. The GP documented that Mr Coppel had the mental capacity to make this decision.

6. On 24 January 2022, Mr Coppel told healthcare staff that he had felt "fuzzy" in the morning but was feeling better. The staff member did not take any clinical observations. That evening, a nurse saw him. She took clinical observations but did not calculate a National Early Warning Score (NEWS2, used to assess clinical deterioration). The nurse who saw him later that evening calculated a NEWS2 score which showed that Mr Coppel should be reviewed again, which she arranged for the morning.

7. Healthcare staff saw Mr Coppel several times the next day and had no concerns.

8. In the early hours of 26 January, Mr Coppel had two falls in his cell and nursing staff assessed and reviewed him. At around 8.00am, a nurse reviewed Mr Coppel again. Due to his unstable blood pressure, recurrent falls and poor general health, an ambulance was called, and Mr Coppel was taken to hospital.

9. Mr Coppel died in hospital on 4 February.

10. The post-mortem report concluded that Mr Coppel died from an abdominal aortic aneurysm.

## Findings

11. The clinical reviewer concluded that the care Mr Coppel received at Forest Bank was equivalent to that which he could have expected to receive in the community. She was satisfied that he was offered the appropriate care and treatment for his

abdominal aortic aneurysm and that staff had assessed that he had the mental capacity to refuse treatment.

12. However, the clinical reviewer found that there were occasions where clinical observations were not taken or a NEWS2 was not calculated. She also found that staff did not always record the time of their interaction with Mr Coppel.

## Recommendations

- The Head of Healthcare should ensure that staff complete and record clinical observations for all prisoners with long-term conditions who report symptoms that may indicate clinical deterioration and complete a NEWS2 score.

- The Head of Healthcare should ensure that staff record the time of their contact with a prisoner in the SystmOne clinical records.

## The Investigation Process

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

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

15. NHS England commissioned an independent clinical reviewer to review Mr Coppel's clinical care at the prison.

16. The investigator and the clinical reviewer interviewed four members of staff by telephone: two on 31 March and two on 20 April 2022. They received written information from one member of staff.

17. We informed HM Coroner for Greater Manchester West District of the investigation. They gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

18. The Ombudsman's family liaison officer contacted Mr Coppel's brother to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond to our letter.

# Background Information

## HMP Forest Bank

19. Forest Bank is a local prison holding around 1,460 men, located in the Pendlebury area of Manchester, run by Sodexo Justice Services. As a local prison, one of its primary functions is to serve the courts of Greater Manchester and the wider Northwest region.

20. Forest Bank has a 19-bed inpatient healthcare unit and 24-hour nursing provision run by Sodexo Healthcare Services.

## HM Inspectorate of Prisons

21. The most recent inspection of HMP Forest Bank was in February 2022. Inspectors reported that health services were generally well led but the applications process was not efficient enough and triage arrangements were not consistent. A good range of primary health services was available and waiting times for clinics were reasonable.

## Independent Monitoring Board

22. 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 31 October 2021, the IMB reported that healthcare services maintained a good service despite the challenges of COVID-19.

## Previous deaths at HMP Forest Bank

23. Mr Coppel was the seventh prisoner to die at Forest Bank since February 2020. Of the previous deaths, two were from natural causes, two were drug-related, one was self-inflicted, and one is awaiting classification. There are no similarities between our findings in the investigation into Mr Coppel's death and our investigation findings for the previous deaths.

# Key Events

24. On 26 November 2019, Mr Gerald Coppel was remanded in prison custody, charged with sexual offences, and sent to HMP Forest Bank. He was later sentenced to 14 years imprisonment, but this was reduced to nine years and five months on appeal.

25. Before he was sent to prison, Mr Coppel had been diagnosed with an abdominal aortic aneurysm (a bulge in the aorta, the main blood vessel that runs from the heart down through the chest and stomach) for which he was receiving ongoing screening (an abdominal aortic aneurysm may get bigger and eventually rupture). He also had several other long-term medical conditions including hypertension (high blood pressure), diabetes, liver failure, asthma, and mixed peripheral neuropathy (damaged nerves in the body's extremities such as hands and feet).

26. On 8 December 2020, following an ultrasound scan, hospital staff advised that Mr Coppel's aneurysm had grown to 5.4cm. They advised that if it continued to grow beyond 5.5cm, Mr Coppel would need to be referred to the vascular surgeons.

27. Prison healthcare staff met Mr Coppel regularly to review his health conditions, including his aneurysm.

28. On 11 June 2021, a prison nurse met with Mr Coppel to discuss his aneurysm. She told him that there was no treatment plan at this time, but he might need surgery in the future. Mr Coppel told her that even if treatment were available, he would not want it as it would be a risk to his health which was already deteriorating. The nurse discussed the risks associated with his aneurysm and that it could rupture. Mr Coppel said he understood the risks.

29. On 5 November, a nurse requested a GP appointment for Mr Coppel as he was declining any treatment for his aneurysm. An appointment was arranged for 8 November.

30. On 8 November, a prison GP saw Mr Coppel. He checked that Mr Coppel understood that his abdominal aortic aneurysm was getting bigger. Mr Coppel said that he understood the risks associated with his aneurysm but did not want an operation. The GP documented that Mr Coppel had the mental capacity and understanding to make this decision and that this would be respected.

31. On 10 January 2022, the prison's health and social care lead saw Mr Coppel who told her he had vomited black liquid and had passed black liquid during a bowel movement.

32. On 11 January, Mr Coppel saw a prison GP, who completed a 'two-week wait' referral (an urgent referral) to the colorectal cancer service that day. There is no evidence of a response to the referral by the time Mr Coppel was admitted to hospital 15 days later.

33. On 24 January, Mr Coppel was seen by social care and nursing staff. Mr Coppel reported that he had felt "fuzzy" in the morning but was feeling better. Healthcare staff did not complete or record any clinical observations following that contact.

34. That evening, Mr Coppel saw a nurse. The nurse took a set of clinical observations but no NEWS2 score was recorded. The nurse arranged for Mr Coppel to be reviewed that evening.

35. Later that evening, a nurse saw Mr Coppel. She took a set of clinical observations and calculated a NEWS2 score of 3. This indicated that Mr Coppel should be reviewed. The nurse arranged this for the morning.

36. On 25 January, Mr Coppel was seen several times by social care, nursing staff and a prison GP. At each contact no concerns or issues were reported. It was not until Mr Coppel saw a nurse that evening that a set of clinical observations were completed and a NEWS2 score. His score was 2 which indicated he should be reviewed regularly.

## Events of 26 January

37. On 26 January, at around 3.30am, a nurse looked through the window of Mr Coppel's cell and saw him on the floor of his room. She and prison staff got him back into bed and she assessed him. There was a small amount of vomit in his sink. The nurse completed a NEWS2 assessment. Mr Coppel had a NEWS2 score of 3, indicating he needed frequent monitoring. The nurse planned to review Mr Coppel later in the morning.

38. At around 4.00am, the nurse looked through the window of Mr Coppel's cell and saw him on the floor of his room. She and prison staff got him back into bed and she assessed him. The nurse completed a NEWS2 assessment. Mr Coppel again had a NEWS2 score of 3. She planned to review Mr Coppel later in the morning.

39. Shortly before 8.00am, the nurse saw Mr Coppel for a welfare check. She found him slumped in a chair but responsive. He had been incontinent of melena (black, tarry stools). Mr Coppel had a NEWS2 score of 1 (low risk). However, due to his recurrent falls, unstable blood pressure, melena and poor general health, the nurse asked for an ambulance to be called.

40. The ambulance arrived at 8.10am and took Mr Coppel to hospital. Mr Coppel was escorted by two prison officers, unrestrained.

## Events of 3 to 4 February

41. In hospital, Mr Coppel had a scan which showed his abdominal aortic aneurysm was leaking. Vascular surgeons were considering transferring him to another hospital for surgery. However, Mr Coppel declined all treatment and on 3 February, he was placed on a palliative care pathway.

42. That evening, the duty manager at the prison rang Mr Coppel's next of kin, his brother. He told him of Mr Coppel's condition and arranged for Mr Coppel's brother to visit him in hospital that evening.

43. Later that day, the prison appointed a family liaison officer who spoke to Mr Coppel's brother who was at the hospital with Mr Coppel.

44. At around 2.10am on 4 February, Mr Coppel went to the toilet in his hospital room. The officers noted that Mr Coppel was in there for about ten minutes. When he returned to his bed, the officers asked if he was alright. Mr Coppel told them he was starting to struggle and then did not respond to their further questions.

45. The two officers managed to help Mr Coppel back into bed and tried to make him comfortable. He began rubbing his stomach and groaning in pain. Staff heard Mr Coppel being sick. They turned up the lights in his room and saw he was vomiting significant amounts of blood.

46. The senior officer immediately ran to the nursing station on the ward to summon help. Despite medical intervention by hospital staff, Mr Coppel was pronounced dead by a hospital doctor at around 2.35am.

47. The hospital rang Mr Coppel's brother to tell him Mr Coppel had died. Later that morning, the family liaison officer rang Mr Coppel's brother to offer his condolences and to discuss funeral arrangements and his property being returned to the family.

## Contact with Mr Coppel's family

48. Over the following days, the prison's family liaison officer provided support and information to Mr Coppel's family.

49. Mr Coppel's funeral was held on 28 February 2022. In line with policy, the prison made a financial contribution to the cost of the funeral.

## Support for prisoners and staff

50. After Mr Coppel's death, the Director 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.

51. The prison posted notices informing other prisoners of Mr Coppel'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 Coppel's death.

## Post-mortem report

52. The post-mortem report concluded that Mr Coppel died of a ruptured abdominal aortic aneurysm (the bursting of the main blood vessel running from the heart to the chest and stomach). He also had diabetes which did not cause but contributed to his death.

# Findings

## Clinical care

53. The clinical reviewer concluded that the care Mr Coppel received at Forest Bank was equivalent to that which he could have expected to receive in the community. She was satisfied that the appropriate care and treatment was offered to Mr Coppel in respect of his diagnosis of an abdominal aortic aneurysm and that mental capacity assessments were undertaken to determine his full understanding of the risks associated with his refusal to accept treatment.

54. However, the clinical reviewer found that there were occasions on 24 and 25 January 2022 where clinical observations were not recorded and where observations were recorded but no NEWS2 score was calculated. She also found that the nurse who reviewed Mr Coppel on 26 January failed to record the time in his medical record. We recommend:

**The Head of Healthcare should ensure that staff complete and record clinical observations for all prisoners with long-term conditions who report symptoms that may indicate clinical deterioration and complete a NEWS2 score.**

**The Head of Healthcare should ensure that staff record the time of their contacts with a prisoner in the SystmOne clinical records.**

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