

**Prisons &
Probation**

Ombudsman
Independent Investigations

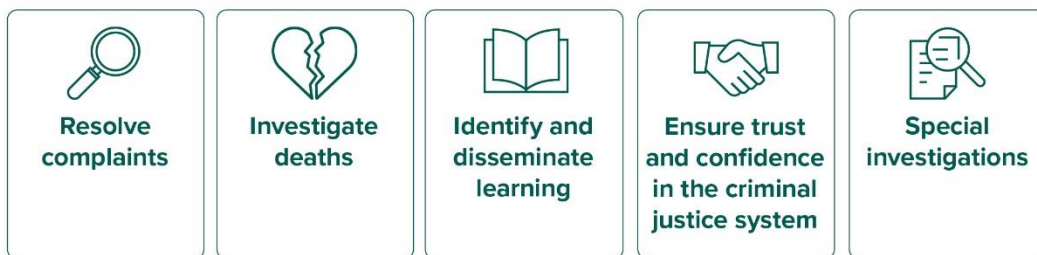
Independent investigation into the death of Mr Raymond Lucy, a prisoner at HMP/YOI Forest Bank, on 11 July 2019

A report by the Prisons and Probation Ombudsman

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE



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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.

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 Raymond Lucy died on 11 July 2019 of chronic obstructive pulmonary disease (COPD) and heart disease at HMP Forest Bank. He was 63 years old. I offer my condolences to Mr Lucy's family and friends.

Mr Lucy had been diagnosed with COPD before he entered prison. He was seen on numerous occasions by prison GPs when he complained of feeling short of breath. The clinical reviewer is satisfied that the standard of healthcare Mr Lucy received at Forest Bank was of a reasonable standard and equivalent to that he could have expected to receive in the community.

The clinical reviewer did however note that healthcare staff did not record a National Early Warning Score (NEWS) for Mr Lucy during their initial encounters, which would have been good practice. Also, no action was taken in response to Mr Lucy's low blood pressure readings in January 2019.

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

July 2020

Contents

Summary	3
The Investigation Process.....	5
Background Information.....	6
Key Events.....	8
Findings	13

Summary

Events

1. On 19 January 2019, Mr Raymond Lucy was remanded in custody at HMP Forest Bank for firearm and offensive weapon-related offences.
2. Mr Lucy had chronic obstructive pulmonary disease (COPD - the term for a group of lung conditions that cause breathing difficulties), asthma, back pain and depression. He took prescribed medication for the treatment and management of his conditions.
3. Mr Lucy was reviewed regularly by members of the healthcare team in accordance with his care plans. He was prescribed a nebuliser (a device used to administer medication in the form of mist into the lungs) but continued to report feeling wheezy and short of breath. Mr Lucy had chest X-rays and blood tests and was prescribed antibiotics.
4. On 11 July 2019, Mr Lucy's cellmate found him unconscious on his bed shortly after 7.00am. He alerted a prison officer who radioed a medical emergency code. Prison and healthcare staff were at Mr Lucy's cell almost immediately and the control room called an ambulance. Healthcare staff and paramedics tried to resuscitate Mr Lucy but at 7.50am, a paramedic confirmed that he had died.
5. A post-mortem examination found that the cause of Mr Lucy's death was an acute exacerbation (flare-up) of COPD, in combination with coronary artery atheroma (a blockage in the arteries around the heart) and cardiac enlargement (an enlarged heart).

Findings

6. Overall, the clinical reviewer was satisfied that the care Mr Lucy received at Forest Bank was of a reasonable standard and at least equivalent to that he could have expected to receive in the community.
7. The clinical reviewer did, however, note that staff did not record a National Early Warning Score (NEWS) after their initial encounters with Mr Lucy. This would have provided a baseline against which any future NEWS could be assessed, and would have been good practice.
8. The clinical reviewer also noted that no action was taken in response to Mr Lucy's low blood pressure readings in January 2019.

Recommendations

- The Head of Healthcare should ensure that staff use the National Early Warning Score (NEWS) assessment tool and follow the recommended clinical escalation procedures.

- The Head of Healthcare should ensure that blood pressure monitoring and recording is undertaken in line with NHS recommendations.

The Investigation Process

9. HMPPS notified us of Mr Lucy's death on 11 July 2019.
10. 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 her. No one responded.
11. The investigator obtained copies of relevant extracts from Mr Lucy's prison and medical records.
12. NHS England commissioned an independent clinical reviewer to review Mr Lucy's clinical care at the prison.
13. We informed HM Coroner for Greater Manchester West District of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
14. One of the Ombudsman's family liaison officers contacted Mr Lucy's next of kin, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Lucy's next of kin expressed concern about the medical treatment Mr Lucy received in prison, including difficulty in getting repeat medication.
15. We sent a copy of the initial report to Mr Lucy's next of kin. She did not make any comments.
16. The initial report was shared with HMPPS. They did not find any factual inaccuracies.

Background Information

HMP Forest Bank

17. HMP Forest Bank is a local prison in Salford, serving courts in north west England. It holds 1,460 remanded and sentenced men. The prison is managed by Sodexo Justice Services, who also provide primary healthcare services.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Forest Bank was in May 2019. Inspectors found that health services had improved since the last inspection. There was evidence of learning from deaths in custody and serious untoward incidents, which had resulted in some changes to health services.
19. Healthcare appointments were prioritised according to need and prisoners who required an emergency response or had urgent needs were seen immediately. Emergency equipment, including defibrillators and oxygen were placed strategically across the prison and checked daily.
20. Initial health screening was undertaken promptly and attendance rates at secondary health assessments had improved. There was a wide range of nurse-led clinics. Patients with long-term conditions were regularly reviewed by competent staff with care plans and evidence based practices. External healthcare appointments were well managed with few cancellations for security reasons.
21. Inspectors considered the inpatient unit poor. It was stark and excessively noisy with no permanent nursing presence.

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 2017, the IMB reported that the healthcare department provided a wide range of services both internally and externally. At the time of the report there had been a recent management restructure and the appointment of a new Head of Healthcare who had implemented many changes.
23. The Board reported that prisoners requiring treatment could be seen at very short notice, with triage services running five days a week. Waiting time for GP appointments averaged 7-8 days and emergency appointments were in line with NHS standards.

Previous deaths at HMP Forest Bank

24. Mr Lucy was the eighth prisoner to die at Forest Bank since April 2017. Of the previous deaths, one was self-inflicted, one was drug-related and five were from

natural causes. There are no similarities between our findings in the investigation of Mr Lucy's death and the other deaths.

Key Events

25. On 19 January 2019, Mr Raymond Lucy was remanded in custody, charged with firearm and offensive weapon-related offences, and sent to HMP Forest Bank.
26. Mr Lucy had chronic obstructive pulmonary disease (COPD – the term for a collection of serious lung diseases including chronic bronchitis and emphysema), asthma, back pain and depression. He took prescribed medication for the treatment and management of his conditions.
27. On 19 January at 3.14pm, a prison GP examined Mr Lucy and recorded his medical history. She noted his medication which included inhalers for his COPD and asthma, sertraline for depression and amitriptyline for back pain. She put him on the ‘chronic disease clinic’ waiting list for review.
28. The prison GP discussed alcohol consumption. Mr Lucy said he felt shaky, sweaty and low when he did not have access to alcohol. He also reported experiencing panic attacks. She started Mr Lucy on an alcohol detoxification programme and prescribed a reducing dose of chlordiazepoxide, a drug used to treat alcohol withdrawal symptoms.
29. Between 21 and 26 January, Mr Lucy was reviewed twice daily under the alcohol withdrawal programme by staff from the Integrated Substance Misuse Service. His physical observations were recorded and on 25 and 26 January his blood pressure was recorded as low. There is nothing in the medical record to indicate that action was taken.
30. On 21 January, Mr Lucy began a smoking cessation programme and was prescribed nicotine replacement therapy. (He did not smoke for four weeks but on 18 February, he was discharged from the programme after purchasing smoking-related products.)
31. On 30 January, a nurse examined Mr Lucy who reported shortness of breath. He said that he was more out of breath than usual. She recorded his clinical observations which were within the normal range for COPD patients. Mr Lucy also gave a sputum sample for examination which was also normal.
32. On 1 February, Mr Lucy reported struggling with his breathing. A nurse recorded that his colour was good, his oxygen saturation levels were 95% and he could speak in full sentences. She noted that there was nothing to indicate a worsening of his COPD.
33. However, the next day a prison GP examined Mr Lucy after he reported wheezing, shortness of breath and a cough with green sputum for the last four days. The prison GP diagnosed a worsening of Mr Lucy’s COPD symptoms, possibly caused by an infection. He prescribed a course of antibiotics and an anti-inflammatory drug used to treat breathing disorders.
34. On 14 February, a nurse from the Integrated Substance Misuse Service examined Mr Lucy. He appeared a little confused at times and said he felt low

and that he would probably benefit from some support from mental health services. Mr Lucy was due to appear in court the next day and asked to see the nurse again if he was returned to prison. A care plan was completed and recorded in Mr Lucy's medical record.

35. The nurse reviewed Mr Lucy again on 18 February. He told her that his court case had been adjourned, causing him stress and anxiety. He said that he knew how to get help if he needed it. Later the same day, a nurse saw Mr Lucy to review his COPD. The nurse recorded that he had a basic understanding of the disease but not of how it would progress. She created a COPD care plan and gave Mr Lucy information and leaflets about the disease. She listed Mr Lucy for a GP review to consider a referral to secondary services.
36. On 1 March, a prison GP examined Mr Lucy who said he felt wheezy. Mr Lucy had a quiet wheeze when breathing out, poor air entry, but no abnormal lung sounds. A prison GP added inhalers to Mr Lucy's repeat prescription.
37. On 2 March, a prison GP saw Mr Lucy after he reported shortness of breath during the night. The prison GP noted that Mr Lucy was short of breath at rest with widespread wheezing and abnormal lung sounds to the left base of the lung. The prison GP referred Mr Lucy for a chest X-ray and blood tests. She also prescribed nebulisers (a machine that changes liquid medication to a fine mist for inhalation). The prison GP scheduled to see him again to discuss the results.
38. On 4 March, Mr Lucy did not attend to collect his repeat medication. No reason or follow up is recorded.
39. On 12 March, Mr Lucy spoke to a nurse in triage to ask about having a back brace brought in. She advised him that this would have to go through security. He also asked for emergency antibiotics. She told him that these could not be provided unless there was a medical need. She also noted that Mr Lucy looked much brighter and that his chest sounded better.
40. The result of Mr Lucy's blood tests also came back that day: they were normal with no further action required.
41. Mr Lucy had a chest X-ray on 22 March. The results, discussed with a prison GP on 25 March, were compatible with COPD but with some possible density noted on the right heart border. The prison GP requested a second X-ray with a view from the side.
42. On 28 March, a prison GP, prescribed repeat antibiotics and steroids.
43. On 11 April, Mr Lucy attended court and was convicted of firearm and offensive weapon offences. He was sentenced to 20 months in prison and returned to Forest Bank.
44. A nurse saw Mr Lucy on 18 April and created an asthma care plan. The next day a prison GP saw him to discuss the results of his second X-ray. These showed an area of the lung that had filled with liquid instead of air. The prison GP prescribed antibiotics and scheduled a review with an X-ray in six weeks' time.

45. On 30 April, Mr Lucy spoke to a nurse about a back brace and stronger painkillers for his back pain. The nurse put him on the waiting list to see a GP to review his medication. A clerical assistant later contacted the orthotics department at a hospital who advised her that Mr Lucy's previous back brace had been discontinued and that he would need a referral to find an alternative. There is nothing in the medical record to indicate that a referral was made.
46. On 20 May, a prison GP saw Mr Lucy after he reported an enlargement of his right breast. Mr Lucy said that he had only noticed it recently. The prison GP did not find any lumps, but he referred Mr Lucy for a blood test. The prison GP also prescribed regular nebuliser capsules.
47. A nurse saw Mr Lucy shortly afterwards in the respiratory clinic and noted that he was happy with his current management plan for COPD and asthma. Mr Lucy said he had difficulty getting nebuliser capsules but the nurse could see in the medical record that a prison GP prescribed them. Mr Lucy demonstrated good inhaler technique.
48. The result of the blood test taken on 29 May indicated a high serum follicle stimulating hormone count (which may indicate a hormonal imbalance because the testes are not working correctly) and on 6 June, a prison GP referred Mr Lucy to the breast surgeon and for an X-ray. The X-ray was arranged for 24 June and the hospital appointment for 27 June.
49. On 19 June, Mr Lucy attended for a chest X-ray from the visiting X-ray service. The results showed his heart was normal size but both lungs showed chronic lung changes, most likely due to COPD. There was scarring at the bases of the lungs and some coarsened broncho-vascular markings behind both lower heart borders (an indication of chronic bronchitis). Antibiotics, with a later follow up appointment, were advised.
50. On 26 June, Mr Lucy failed to attend a GP appointment. No reason or follow up is recorded.
51. On 27 June, Mr Lucy attended his appointment at the breast clinic at a hospital. Following examination, he was diagnosed with bilateral gynaecomastia, a benign enlargement of the male breasts.
52. On 4 July, a nurse saw Mr Lucy for a review of his COPD. Mr Lucy told the nurse that he was struggling, using his nebuliser daily and sometimes more frequently. He said that he got breathless walking up stairs. The nurse referred Mr Lucy for a spirometry (a test used to measure how well the lungs are working). The nurse noted that she felt a referral to secondary specialist care was needed in relation to Mr Lucy's COPD and listed him for a GP appointment.
53. Mr Lucy scored 4 on the Medical Research Council Breathlessness scale. The scale describes the range of respiratory disability from 1 (none) to 5 (almost complete incapacity).
54. On 9 July, a nurse examined Mr Lucy who said that he was having difficulty breathing in the hot weather. She could see from his records that Mr Lucy had

had a recent review of his COPD and been referred for a spirometry test. She sent a 'task' to the admin support to see if this could be done as soon as possible. She noted that Mr Lucy was talking in full sentences, his oxygen saturation levels were 96% (95%-100% are considered normal) and his temperature was normal. She advised Mr Lucy to increase his nebuliser intake and planned to speak to prison staff about him having longer periods outside of his cell during hot weather.

Events of 10 and 11 July

55. On 10 July at about 5.00pm, Mr Lucy returned to his cell after receiving a visit. His cellmate said he seemed very happy and talked about the visit and about seeing his next of kin. They spent the evening watching television. Mr Lucy's cellmate said that Mr Lucy telephoned his next of kin and described him as normal and in good spirits.
56. His cellmate said that Mr Lucy did not use his nebuliser that evening, which was unusual, and that he fell asleep first. He was unsure of the time but said it was still light. His cellmate heard Mr Lucy's nebuliser in the night, but the two did not speak.
57. His cellmate woke when the cell was unlocked the next morning. He could hear Mr Lucy's nebuliser but could see the face mask on the floor. He went to put Mr Lucy's face mask back on but could tell immediately that something was wrong. He rang the cell bell but the door was unlocked so he went out.
58. On 11 July, shortly after 7.00am, two officers began unlocking the cells on Mr Lucy's wing. They unlocked Mr Lucy's cell and had moved on when his cellmate approached them and told them that that Mr Lucy was not breathing and that he thought he was dead. His cellmate was crying.
59. The officers returned with his cellmate to his cell. An officer went in first and saw Mr Lucy on his bed, slumped against the wall with his legs hanging over the side. He noticed the tubes from Mr Lucy's nebuliser on the floor. An officer could not rouse Mr Lucy and radioed a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties).
60. The officer was joined almost immediately by other officers and healthcare staff. The control room called an emergency ambulance.
61. A nurse was the first nurse to enter the cell, followed by another nurse and others. Mr Lucy was on his bed, on top of the covers, with his head at the foot end. He was pale, clammy and unresponsive with no pulse or signs of breathing. His pupils were dilated.
62. Mr Lucy was lifted onto the floor and a nurse inserted an airway. Healthcare staff began cardiac compressions. A defibrillator was attached to Mr Lucy's chest but no heart rhythm was detected and no shock advised. Healthcare staff continued cardiopulmonary resuscitation (CPR) until 7.20am when paramedics arrived and took over.

63. The paramedics continued CPR and gave Mr Lucy adrenalin and naloxone. At 7.50am, despite the best efforts of all concerned, a paramedic confirmed that Mr Lucy was dead. All attempts to revive him were stopped.

Contact with Mr Lucy's family

64. On 11 July 2019 at 8.30am, an officer was appointed as the prison's family liaison officer (FLO) with another officer as his deputy. Mr Lucy had named his partner as his next of kin and at 9.30am, the FLO and deputy visited her at her home address. The FLO informed Mr Lucy's next of kin of his death and the officers offered their condolences.
65. Mr Lucy's next of kin was understandably shocked and upset. She telephoned her next of kin and very soon her next of kin came to the address to offer support. The officers again offered their condolences.
66. The FLO kept in contact with Mr Lucy's next of kin about the funeral arrangements. On 19 July, the deputy returned Mr Lucy's property to the family and on 23 July, Mr Lucy's next of kin visited the prison with her next of kin.
67. Mr Lucy's funeral took place on 26 July 2019. The prison contributed towards the cost in line with Prison Service instructions. The FLO remained in contact with the family after the funeral, notably on 25 September, the day before what would have been Mr Lucy's birthday.

Support for prisoners and staff

68. After Mr Lucy's death, a senior prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. Mr Lucy's cellmate was removed from his cell immediately and spoken to by staff who offered support.
69. The prison posted notices informing other prisoners of Mr Lucy'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 Lucy's death.

Post-mortem report

70. A post-mortem examination found that the immediate cause of Mr Lucy's death was an acute exacerbation (flare-up) of COPD, in combination with coronary artery atheroma (a blockage in the arteries around the heart) and cardiac enlargement (an enlarged heart).

Findings

71. Mr Lucy had been diagnosed with COPD before he entered prison. COPD is the name for a group of lung conditions that cause breathing difficulties. The damage to the lungs caused by COPD is permanent, but treatment can help slow down the progression of the condition. The outlook for COPD varies from person to person. The condition cannot be cured or reversed, but for many people, treatment can help keep it under control so it does not severely limit their daily activities. But in some people, COPD may continue to get worse despite treatment, eventually having a significant impact on their quality of life and leading to life-threatening problems.
72. The clinical reviewer noted that Mr Lucy's chronic health conditions were identified at his initial health screen at Forest Bank and his care was planned in accordance with NICE (National Institute for Health and Care Excellence) guidance.
73. Mr Lucy was seen on numerous occasions by prison GPs when he complained of feeling short of breath. The clinical reviewer is satisfied that appropriate actions were taken each time. Antibiotics and anti-inflammatory medication were prescribed along with inhalers and nebulisers to manage his shortness of breath. Mr Lucy was also referred appropriately for chest X-rays and blood tests.
74. The clinical reviewer was satisfied that, overall, the care Mr Lucy received at Forest Bank was of a reasonable standard and at least equivalent to that he could have expected to receive in the community.
75. She did, however, identify some concerns.
76. In April, Mr Lucy enquired about the supply of a back brace for ongoing back pain. It was suggested that Mr Lucy would need a referral to the Orthotics Department in a hospital. There is nothing recorded in the health record to suggest that this referral was completed.
77. On 18 February and again on 5 July, a nurse recommended that consideration be given to referring Mr Lucy to secondary services for management of his COPD. There were no recorded actions in response to these recommendations.
78. The clinical reviewer also noted that there were no recordings of a National Early Warning Score (NEWS) after any of the initial encounters with Mr Lucy. The use of NEWS is considered good practice and it would have been useful to have a baseline score as a reference in assessing Mr Lucy's health needs. We make the following recommendation,

The Head of Healthcare should ensure that staff use the National Early Warning Score (NEWS) assessment tool and follow the recommended clinical escalation procedures.
79. The clinical reviewer also noted that there was no record of any actions taken after low blood pressure readings were recorded during Mr Lucy's alcohol

withdrawal programme on 25 and 26 January 2019. We make the following recommendation:

The Head of Healthcare should ensure that blood pressure monitoring and recording is undertaken in line with NHS recommendations.

Inquest

80. The inquest, heard on 4 October 2023, concluded that Mr Lucy died from natural causes.

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