

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Russell West, a prisoner at HMP/YOI Forest Bank, on 8 July 2018**

**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 Russell West died on 8 July 2018 of septicaemia while a prisoner at HMP Forest Bank. He 50 years old. I offer my condolences to Mr West's family and friends.

Mr West did not have a spleen which increased his risk of developing an infection. The clinical reviewer found that healthcare staff at Forest Bank did not understand the clinical needs of a prisoner who had undergone a splenectomy. We agree with the clinical reviewer, that this aspect of Mr West's clinical care was not equivalent to that which he could have expected to receive in the community.

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**  
**Prisons and Probation Ombudsman**

**February 2020**

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# Summary

## Events

1. In February 2018, Mr Russell West was remanded to HMP Forest Bank for drug-related offences. He had been in prison before.
2. Mr West had a history of using illicit substances in prison. In 2003, he had had his spleen removed.
3. On two occasions during May 2018, prison officers reported that Mr West appeared to be under the influence of an illicit substance. Mr West denied using drugs and the results of a urine test were negative.
4. In June, Mr West complained of neck pain and a prison GP diagnosed him with a neck sprain. The GP prescribed pain killers and made a referral to a physiotherapist.
5. Early in the morning on 4 July, Mr West complained of feeling unwell and was moved to the prison's healthcare unit for further assessment. Nurses assessed Mr West as a moderate to high risk of developing sepsis and arranged for an ambulance to take him to hospital.
6. On 6 July, Mr West had a cardiac arrest in hospital and was moved to the intensive care unit. He did not regain consciousness and at 4.32pm on 8 July, it was confirmed that Mr West had died.
7. A post mortem report gave Mr West's cause of death as pneumococcal septicaemia and meningitis in a male with asplenia (the absence of a spleen) after trauma.

## Findings

8. The clinical reviewer found that healthcare staff did not understand the clinical needs of a prisoner who had undergone a splenectomy (removal of the spleen). While healthcare staff offered Mr West vaccinations in accordance with NHS England recommendations for post-splenectomy care, they did not investigate if Mr West had been vaccinated in the community or if he was taking antibiotics to reduce his risk of developing an infection.
9. Healthcare staff did not request Mr West's community medical record to ensure continuity of his clinical care.
10. The clinical reviewer concluded that Mr West's post-splenectomy care was not equivalent to that which he could have expected to receive in the community.

## Recommendations

- The Head of Healthcare should ensure that healthcare staff are aware of and understand the clinical needs of a prisoner who has undergone a splenectomy.

- The Head of Healthcare should ensure that healthcare staff request a prisoner's community medical records in line with PSO 3050.

## The Investigation Process

11. 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.
12. The investigator obtained copies of relevant extracts from Mr West's prison and medical records.
13. NHS England commissioned an independent clinical reviewer to review Mr West's clinical care at the prison.
14. Our investigation was suspended while we waited for the cause of death. This has delayed the disclosure of the initial report.
15. We informed HM Coroner for Greater Manchester West District of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
16. We wrote to Mr West's next of kin to explain the investigation and to ask if they had any matters he wanted the investigation to consider. They did not respond to our letter.
17. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly. The action plan has been annexed to this report.

## **Background Information**

### **HMP Forest Bank**

18. Forest Bank is a local prison in Salford, serving courts in the North West. It holds 1,460 remanded and sentenced men. The prison is managed by Sodexo Justice Services. Sodexo provides primary health care services. There is a 19-bed inpatient unit with 24-hour nursing cover. An agency provides GP services with doctors available on weekdays from 9.00am to 9.00pm, Saturdays 1.00pm to 5.00pm, and Sundays 9.00am to 12.00pm. There is out of hours cover at other times.

### **HM Inspectorate of Prisons**

19. The most recent inspection of HMP Forest Bank was in May 2019. Inspectors reported that initial health screening was undertaken promptly and attendance rates at secondary health assessments had improved. Staff made appropriate referrals to other clinicians from these initial assessments. Urgent same -day GP appointments were available and there was a wide range of nurse-led clinics to carry out triage and administer treatments.

### **Independent Monitoring Board**

20. 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 October 2017, the IMB were satisfied with the overall quality of healthcare provision. They reported that there was a wide range of services, reasonable access to GPs and emergency appointments were dealt with in line with NHS standards.

### **Previous deaths at HMP Forest Bank**

21. Mr West was the third prisoner to die of natural causes at HMP Forest Bank since January 2016. There were no significant similarities between the circumstances of Mr West's death and those previously investigated.

## Key Events

22. On 24 February 2018, Mr Russell West was remanded to HMP Forest Bank for drug-related offences.
23. A nurse completed Mr West's reception health screen when he arrived at Forest Bank and noted that he had a history of using cannabis and cocaine during a previous prison sentence. He noted Mr West had his spleen removed in 2003 and was taking antibiotics. Mr West refused vaccinations for hepatitis B, measles, mumps and rubella and meningitis C. He gave permission for healthcare staff to request his community medical records. There is no evidence that this took place.
24. On 26 February, a nurse completed Mr West's secondary health screen. Mr West again refused vaccinations for hepatitis B, measles, mumps and rubella and meningitis C. There is no evidence in Mr West's medical record that the nurse discussed Mr West's splenectomy or made enquiries to establish if he was taking prophylactic antibiotics (to prevent a bacterial infection) in the community.
25. On 1 May, prison officers reported to healthcare staff that Mr West appeared to be under the influence of an illicit substance. A nurse assessed Mr West and made a referral to the substance misuse team. Staff did not find any evidence of illicit substance use in Mr West's cell. The next day, a member of the substance misuse team saw Mr West and gave him harm reduction advice and told him how to seek support from the substance misuse recovery team. There is no evidence that Mr West contacted the recovery team.
26. On 15 May, prison officers reported again that Mr West appeared to be under the influence of an illicit substance. A nurse attended and found Mr West vomiting. Mr West's oxygen saturation level was low (93%) and he began to have a seizure. The nurse gave Mr West diazepam (a drug used in an emergency to stop seizures). Mr West's condition deteriorated and the nurse radioed an emergency code blue (to indicate an emergency when a prisoner is unconscious, or having breathing difficulties) and the control room called an ambulance. Paramedics arrived and took Mr West to hospital.
27. Hospital doctors diagnosed Mr West with a vasovagal syncope (fainting caused by a temporary reduction in blood flow to the brain). Mr West returned to Forest Bank on 16 May and was assessed by a nurse. Mr West denied using illicit substances. On 17 May, the results of a urine test were negative for illicit substances.
28. There is nothing more of significance in Mr West's medical record until 26 June.
29. On 26 June, a nurse saw Mr West after he complained of neck pain. Nurse Jackson did not find any evidence of injury to Mr West's neck and he was not suffering from numbness or weakness in that area. The nurse prescribed paracetamol (pain killer) and ibuprofen (anti-inflammatory pain killer) and made a referral to a prison GP.
30. On 28 June, a nurse examined Mr West and noted that he was hunched over to the left-side when he walked. The nurse noted that he was likely to be suffering from torticollis (a twisted and tilted neck). A prison GP, prescribed diazepam (to treat muscle spasms) and naproxen (pain killer).

31. On 29 June, a prison GP examined Mr West and diagnosed a neck sprain. She increased his dose of diazepam and prescribed codeine (pain killer). The same day, a physiotherapist assessed Mr West and said he would receive on-going physiotherapy treatment.

## **Events of 4 July**

32. At approximately 5.13am, Mr West's cellmate rang the cell bell because Mr West was feeling unwell. Prison officers attended and asked healthcare staff to assess Mr West. A nurse attended and noted that Mr West had vomited on the cell floor. She arranged for him to be taken to the prison's healthcare unit for further assessment.
33. Mr West's oxygen saturation level was normal (98%), his blood pressure was high (184/102mmHG) and his pulse rate was fast (112 bpm). The nurse assessed him using the Modified Early Warning Score (MEWS) and noted that his score was 4 (a medium score that requires a clinician to decide if a patient requires an increase in observations and clinical care). The nurse also assessed his risk of sepsis and noted that he was within the moderate to high risk criteria of developing sepsis. She arranged for an ambulance to take him to hospital. Two prison officers accompanied Mr West and did not use restraints.
34. On 6 July, Mr West had a cardiac arrest and was moved to the intensive care unit. Mr West did not regain consciousness and at 4.32pm on 8 July it was confirmed that Mr West had died.

## **Contact with Mr West's family**

35. A Father, from the prison's chaplaincy team, acted as the prison's family liaison officer (FLO). On 6 July, he telephoned Mr West's next of kin and told them that Mr West was in hospital and arranged for her to visit.
36. Mr West's next of kin and the FLO were at the hospital when Mr West died on 8 July. The FLO offered Mr West's next of kin his condolences and support.
37. Mr West's funeral was held on 15 August. The prison contributed to the cost of the funeral in line with national policy.

## **Support for prisoners and staff**

38. After Mr West's death, a prison manager debriefed the escort officers to ensure they had the opportunity to discuss any issues arising and to offer support. The staff care team also offered support.
39. The prison posted notices informing other prisoners of Mr West'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 West's death.

## **Post-mortem report**

40. The post-mortem examination found that Mr West died from pneumococcal septicaemia and meningitis in a male with asplenism (the absence of a spleen) after trauma.

# Findings

## Clinical care

41. Mr West arrived at Forest Bank after having a splenectomy in 2003. The clinical reviewer said that, as the spleen is responsible for fighting infections, after a splenectomy there is an increased risk of severe infection for the remainder of the patient's life. This can be reduced by immunisation and prescribing prophylactic antibiotics.
42. NHS England recommends that people with an absent or dysfunctional spleen should receive vaccinations to protect against Hib/meningitis C, MenACWY, pneumonia and influenza. Patients should also be offered life-long prophylactic antibiotics.
43. The clinical reviewer found that while Mr West was offered and refused vaccinations when he arrived at Forest Bank, there is no evidence that healthcare staff investigated if he was fully vaccinated in accordance with NHS England recommendations. Mr West was not prescribed prophylactic antibiotics at Forest Bank.
44. The clinical reviewer was not satisfied that healthcare staff understood the needs of a prisoner who had undergone a splenectomy and that Mr West was at an increased risk of developing a serious infection. Healthcare staff did not recognise the importance of the need to establish if Mr West had been fully vaccinated and if he was taking prophylactic antibiotics. The clinical reviewer concluded that Mr West's post-splenectomy care at Forest Bank was not equivalent to that which he could have expected to receive in the community. We agree. We recommend that:

**The Head of Healthcare should ensure that healthcare staff are aware of and understand the clinical needs of a prisoner who has undergone a splenectomy.**

45. PSO 3050, Continuity of healthcare for prisoners, says that when a prisoner enters a prison, efforts should be made to retrieve information from their GP or other relevant service they have recently been in contact with. The prisoner's consent should be obtained before doing this. During his first reception health screen, Mr West gave his consent to a nurse to obtain his community medical records. The clinical reviewer found that healthcare staff did not obtain Mr West's community medical record and therefore failed to establish his ongoing clinical care needs, specifically in relation to his post-splenectomy care. We note the clinical reviewer's opinion that this may not have affected the eventual outcome for Mr West. We recommend that:

**The Head of Healthcare should ensure that healthcare staff request a prisoner's community medical records in line with PSO 3050.**

46. The clinical reviewer concluded that the other aspects of Mr West's clinical care were of a satisfactory standard. Healthcare staff appropriately investigated his neck pain and referred him to a physiotherapist. Mr West did not have any symptoms that indicated that he had a respiratory tract infection or any other underlying

infection. When Mr West's condition deteriorated, we are satisfied that he was quickly moved to hospital.

47. We make no recommendation.

## **Inquest**

48. At the inquest, which took place between 5 and 9 February 2024, the Coroner concluded that Mr West died of natural causes.

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