# Investigation into the circumstances surrounding the death of a man, who died in April 2009 at hospital, whilst in the custody of HMP Manchester.

**Report by the Prisons and Probation Ombudsman for England and Wales**

**November 2009**

This is the report of an investigation into the circumstances surrounding the death of a man, who was a prisoner at HMP Manchester. He died in April 2009, at hospital, having been there since 28 February. He was 70 years old when he died.

The cause of death, established after a post mortem, was given as chronic obstructive pulmonary disease and ischaemic heart disease. I offer my sincere sympathy and condolences to the man's family, and to all of those affected by his loss.

The investigation was carried out on my behalf by my colleague. A review of the man's medical care in prison was carried out by the clinical reviewer, on behalf of the local Primary Care Trust. As ever, I am most grateful to her for her assistance.

I would also like to thank the Governor and staff of Manchester for their full and ready co-operation during the course of the investigation. My particular thanks go to the Safer Custody Team for their work in liaising with the investigator.

I conclude that the man was treated appropriately by staff at Manchester. My report includes two recommendations from the clinical reviewer's review which I endorse along with recognising one area of good practice.

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

**Jane Webb**
**Deputy Prisons and Probation Ombudsman** **November 2009**

**CONTENTS**

## SUMMARY

The man was born in September 1938 and lived in the Manchester area. He was convicted on 24 January 2008 of sexual offences committed many years earlier and given a four year custodial sentence.

On his arrival at Manchester a Reception Health Screen check was conducted by the prison doctor. He told the doctor that he suffered from diabetes and angina. In addition he said that he had previously had a heart attack. He was confused and uncertain about his diabetic medication levels. He was admitted to the healthcare unit and remained there until 16 September. His diabetes and general well being were monitored at least three times a day. He was encouraged to attend to his personal hygiene and ensure that he maintained an appropriate diet.

The man moved to the Vulnerable Persons Unit (VPU) and a mobility assessment was conducted by a physiotherapist. He was unable to walk long distances but was able to walk to the visiting area comfortably. He was seen walking without any sign of unsteadiness even on quick changes in direction.

The diabetic nursing specialist saw him on 5 January 2009 as there were concerns about how he was managing his diabetes. It was established that he was not taking all his prescribed medication and so he was admitted to the healthcare unit so that his diabetic treatment regime and medication could be monitored. He remained in the healthcare unit until he transferred back to the VPU on 1 February.

At 8.15am on 27 February a nurse was administering the morning treatments when VPU staff asked that the man be seen. His cell mate had reported that he had fainted earlier that morning. The nurse recorded that he had not taken his medication and appeared pale and clammy. He was advised to have his breakfast and see the doctor later that day.

The doctor went to see the man later in the afternoon but he was in the visits centre with his family. The doctor eventually saw him at 6.28pm. He had no chest pain or palpitations but was admitted to the healthcare unit for further observations and for full blood tests to be taken the following day.

Later that same evening his condition deteriorated. He had difficulty breathing and his legs and feet were severely swollen. It was decided to send him to outside hospital and an ambulance was called at 11.07pm. He was taken to the hospital.

In the early morning of 28 February a prison nurse spoke to the sister at the hospital who said that the man's organs were failing and he was in a critical condition. At 1.00am on 15 April, hospital staff contacted his family and asked them to come to the hospital. They arrived at 1.25am and the hospital doctor confirmed that he had died at 1.33am.

I find that overall the man received a standard of care whilst at Manchester that was equitable to that which he could have expected in the community. I also find that he was treated with dignity and respect in his final days. I do, however, make two recommendations regarding the process for acting on abnormal test results and urine testing protocol.

## THE INVESTIGATION PROCESS

1. The investigation was opened on 18 April 2009 by the investigator. He issued notices announcing the investigation to staff and prisoners. The notices included an invitation to anyone who wished to submit information relating to the man's death to make themselves known. In the event one prisoner came forward and was interviewed. The investigator also studied all relevant prison records, which included the man's main prison record and his medical records. The investigator returned Manchester on 9 July and interviewed four members of staff.

2. The local Primary Care Trust commissioned a clinical reviewer, a nurse, to carry out an independent review of the man's clinical care. I am grateful to her for undertaking such a thorough and timely review.

3. The investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. Upon completion, this report will be sent to the Coroner to assist his enquiries into the man's death.

4. The Senior Family Liaison Officer contacted the man's family. This gave them the opportunity to discuss the purpose of the investigation and to raise any concerns or questions that they wanted to be addressed. The family raised the following concerns:

    - He was not looked after properly
    - His health and medical needs were not met
    - He was left in filthy clothes
    - The family were unable to contact anyone at the prison to take their concerns for his health seriously.
    - In the last two weeks of his life, the number of visits allowed for the family were reduced from everyday to once a week and had to be booked. His family believed that this contributed to his failing health.

    The investigator has attempted to address the issues raised by the family within this report. I hope that it provides the family with a better understanding of the treatment given to the man before his death.

## HMP MANCHESTER

5. HMP Manchester is a Victorian local prison which takes people who are remanded into custody from courts in Greater Manchester. It has been part of the High Security Estate since 2003. The prison consists of two blocks containing a total of nine wings with a mix of single and double cells.

6. Healthcare at Manchester is provided by the local Primary Care Trust. The healthcare centre provides 24 hour nursing care and medical cover, and has beds for up to 38 patients. The Independent Monitoring Board report for 2007-08 noted that a number of the beds in the healthcare centre are used for non-clinical use, due to prison overcrowding. They also report that at least half of the prisoners on Assessment, Care in Custody and Teamwork (ACCT is used by the Prison Service to monitor and support persons deemed to be at risk of suicide or self-harm) live in healthcare, creating a time consuming amount of work for staff. Since the man's death the number of beds in healthcare centre has been reduced from 38 to 20 and patients are now admitted on clinical need only.

7. The IMB also expressed their concern that elderly prisoners with complex mental and physical needs were being held in the healthcare centre which had neither the appropriate facilities nor equipment to respond to their needs. The IMB referred in their report to an inquest into the death of a 75 year old prisoner when the Coroner commented that the healthcare centre of a category A prison was not a suitable environment for the care of the elderly and infirm.

8. Manchester was last inspected by Her Majesty's Chief Inspector of Prisons in May 2007. She also found that a number of prisoners were inappropriately admitted to the healthcare centre. She recommended that admission to the healthcare centre should be on the basis of clinical needs alone.

9. The man's death was one of 26 to occur at Manchester since April 2004, when the Ombudsman began investigating all deaths in prison custody in England and Wales. Eight of the previous 25 deaths were due to natural causes. There has subsequently been a further death at Manchester, which was not due to natural causes.

## KEY FINDINGS

10. The man was born in September 1938 and lived in the Manchester area. He was convicted on 24 January 2008 at Crown Court of historical sexual offences and given a four year custodial sentence.

11. On arrival at Manchester, the man had a Reception Health screen check with the prison doctor. The man told the doctor that he suffered from diabetes and angina. In addition he said that he had previously suffered a heart attack. He was confused and uncertain about his diabetic medication. Consequently, he was admitted to the healthcare unit so that his diabetes could be monitored.

12. Confirmation was received the next day from the man's doctor's surgery that he was prescribed:

    - Humulin (injectable insulin medication for treatment of diabetes)
    - Atenolol (for treatment of cardiovascular disease)
    - Isosorbide Mononitrate (for treatment of angina and blood pressure)
    - Pravastatin (for treatment of high cholesterol)
    - Lisinopril (for prevention of renal and retinal complications resulting from suffering from diabetes)
    - Aspirin.

13. From 26 January to 16 September the man remained on the healthcare unit and, during this period, was monitored at least three times a day by either healthcare staff or prison doctors. He was encouraged to attend to his personal hygiene and ensure that he ate an appropriate diet. He was also made aware of the laundry facilities within the prison. On 16 September, healthcare staff were satisfied that he could move to a normal location within the prison.

14. The man moved from healthcare to K wing on 17 September. He was seen a week later by a nurse for a random blood sugar test. The result of the test was high and his insulin was increased by two units. The nurse recorded that he was to be reviewed in a further seven days. She conducted the review on 30 September and recorded that his blood sugar level was within normal limits and he was to continue with the existing level of medication. He was also given advice regarding his diet.

15. On 10 October, the man moved to the Vulnerable Persons Unit (VPU) which was thought to better suit his needs. Five days later he had a mobility assessment conducted by a physiotherapist. He told her that he was unable to walk long distances but was able to walk to the visiting area comfortably. She saw him walk and recorded that there were no signs of unsteadiness even on quick changes in direction.

16. The nurse saw the man for a diabetes review on 23 October and noted that he was much better at controlling his diabetes and gave advice about injection techniques. She also gave him an influenza vaccination.

He saw the nurse again on 5 November, 7 November and 9 December for diabetic reviews. He demonstrated to her satisfaction that he was able to give himself the correct dose of medication and administer the injection correctly.

17. On 17 December, a second nurse responded to a call for urgent assistance at 7.02pm as the man had collapsed in his cell. The nurse recorded that he was orientated and alert and there were no obvious signs of injury. He was eating his tea and told her that he felt well. She checked his vital signs (blood pressure, pulse and breathing) as stable and said she would check again later. She returned at 8.25pm to find no change in him and he said that he was feeling fine. She advised him that if he felt unwell, he was to contact healthcare straight away.

18. The first nurse next saw the man on 5 January 2009 when she was concerned about how he was managing his diabetes. The nurse established that he was not taking his blood pressure tablets or his tablets for cholesterol. She arranged for him to be admitted to the healthcare unit so that his diabetic treatment regime could be monitored and ensure that he took all his prescribed medication.

19. The man remained in the healthcare unit until he transferred back to the VPU on 1 February. During this period he was monitored every day by healthcare staff. Once back on the VPU, he had two further diabetic reviews on 4 and 10 February. The first nurse recorded at the second review that though his diabetes was controlled, he seemed generally unwell. He should be referred to the prison doctor to assess whether he should return to the healthcare unit.

20. On 13 February, the prison doctor saw the man who said that he had no concerns or worries and was adamant that he felt well. The doctor recorded the man's blood pressure as 198/88 which was a very high reading. (The normal range for blood pressure is 100/70 to 140/90, varying throughout the day depending on the individual's activities. A blood pressure reading of greater than 140/90 is classed as high and a reading of 90/60 or below is classed as low.) As a result the doctor prescribed an increase in of Linisopril of 5mg to 10mg for a period of two weeks at which point the man was to have his medication reviewed.

21. The man was assessed by a third nurse on 19 February at 6.30pm after wing staff told her he had fallen off his chair and banged his head. The nurse examined him and recorded that there was no sign of any injury but referred him the doctor the next day. The following day a second prison doctor saw him and concluded that no action was required.

22. On 27 February, at midnight. a fourth nurse received a phone call from the staff on the VPU who expressed their concern about the man's physical and mental state, saying that his cell mate was also concerned. She told the wing staff that he was due to see the doctor later in the day.

23. A fifth nurse was administering the morning treatments at 8.15am when E wing staff asked that the man be seen. The nurse was told that the man's cell mate reported that he had fainted earlier that morning. The nurse recorded that he had not taken his medication and appeared pale and clammy. She advised him to have his breakfast and said that he would see the doctor later that day.

24. A sixth nurse saw the man at 10.41am in his cell as he was unable to walk over to the clinic. The nurse found him sitting in his chair. He was not sweating but appeared unkempt and his blood pressure reading was 134/78. He told the nurse that he was not in pain but he felt "knackered". She arranged for the doctor to see him in his cell later that afternoon.

25. At 11.05am a seventh nurse saw the man to give him his morning medication. The nurse recorded that he administered his insulin as prescribed. He had eight bottles of full sugar lemonade and also sauces that were high in sugar. The nurse advised him not to eat or drink these high sugar products.

26. The second prison doctor came to see the man later in the afternoon but he was in the visits centre. The doctor eventually saw him at 6.28pm, and noted that he had no chest pain or palpitations, his blood pressure was 120/88 and pulse was 66. The doctor admitted him to the healthcare unit for further observations and for full blood tests to be taken the following day.

27. Later that evening, at approximately 9.20pm, the fourth nurse grew concerned about the man. He was lying on his right side, struggling to breathe, his lips were blue and he was cold to the touch. On further examination, it was found that his legs and feet were severely swollen. She called for the assistance of an eighth nurse. Together, the nurses used extra blankets and used pillows to elevate his feet. After a period of close observation his condition had not improved so the decision was taken to send him to outside hospital.

28. An ambulance was called and arrived at 11.30pm and the man was taken to the hospital. He was escorted by two officers with the instruction that the long restraint chain was to be removed at the request of hospital staff at the hospital to assist their treatment.

29. The eighth nurse spoke to the sister at the hospital in the early morning of 28 February and was told that the man was suffering multiple organ failure and was in a critical condition. Later the same day, following a bedwatch risk assessment, the Governor authorised the removal of all restraints until such time as there was an improvement in the man's condition. Two officers remained with him. The risk assessment permitted visits from the man's family. The Governor authorised that family visits to the hospital could be allowed at anytime, without the need to contact the prison in advance.

30. Throughout the man's stay in hospital, healthcare staff maintained daily contact with the hospital to obtain update information about his condition. On 3 March, a further bedwatch risk assessment was completed. The Governor judged that the officers should remain but restraints were only to be used in the event of the man being moved from hospital or discharged back to prison

31. The man's condition suddenly deteriorated in the early hours and nursing staff at the hospital contacted his family at 1.00am to come to the hospital straight away. They arrived at his bedside at 1.25am and the hospital doctor confirmed that he had died at 1.33am. The family remained at the hospital until 2.00am.

32. The family were visited twice by the Family Liaison Officer and prison chaplain. The prison also provided financial assistance towards the funeral costs.

## ISSUES

### Clinical care

33. The clinical review showed that the man had long standing heart disease and diabetes which was not monitored closely when he was in the community and he did not attend clinics or the doctors very often.

34. On coming into custody the man's medical problems were identified and he was admitted immediately as an in patient in the healthcare unit. His diabetes was monitored medication was given in a controlled and safe environment. He remained in the healthcare unit for nine months as it took some time to achieve a reasonable level of control of his diabetes. I believe that he was treated in an appropriate and timely manner for his diabetes. The clinical reviewer makes the following recommendation which I endorse:

    **The Head of Health Care should develop, in conjunction with Manchester PCT diabetic nurse specialist, a urine testing protocol for diabetics seen in reception.**

35. The man also suffered from hypertension and his blood pressure was monitored regularly. It was recorded as high on many occasions but no action was taken until February 2009 when the prison doctor increased his hypertensive medication and it reduced quickly. The clinical reviewer makes the following recommendation which I endorse:

    **The Head of Healthcare should review the process for acting on abnormal blood pressure levels to ensure that results are promptly acted upon so that prison doctors can make timely documented clinical decisions.**

36. During February 2009 the man's health gradually deteriorated he returned to healthcare. The healthcare staff acted appropriately and in a timely manner when addressing his acute medical problems and admitted him to hospital.

### Use of restraints

37. Unfortunately there have been too many reports where I have been critical of the use of restraints when prisoners are under escort in outside hospital. It is pleasing therefore to recognise the good practice adopted by Manchester to ensure that the man was treated with dignity and respect during his final weeks in hospital. Risk assessments authorised the removal of his restraints and allowed his family unrestricted time with him.

## Family issues

38. One of the issues raised by the man's family, which has not been addressed elsewhere in the report, was that they felt they were unable to contact the prison to raise their concerns over his health. The investigator has studied all the prison documentation relating to the man and had been able to establish that, in addition to weekly visits made to the prison, his brother wrote to the Governor at Manchester during 2008 on 31 January, 29 May and 26 September raising concerns about his wellbeing.

39. On each occasion the prison responded in writing, both from healthcare and general prison operational perspectives, addressing the issues that the man's brother raised. In addition to writing to the prison, families with concerns over a prisoner's wellbeing can also contact the Safer Custody Department whose number is displayed in the Visitor Centre along with freely available leaflets giving visitors prison contact details.

40. I acknowledge that the frustration that families feel in understanding the care that their loved ones receive whilst in prison. I do believe that Manchester made sufficient effort to respond to the man's family. Ultimately he was an independent adult able to deal with his health and personal needs without his family's involvement.

## CONCLUSION

41. I recognise the concerns of the IMB regarding the location of older prisoners in Manchester, however I judge that attention was paid to the man's health needs and appropriate treatment was provided. The standard of care that he received whilst at Manchester was equitable to that which he could have expected to receive in the community.

42. I believe that the man was treated with dignity and respect during the time he was at hospital. Following his death Manchester appropriately followed the guidance given in PSO 2710, "Follow up to death in custody".

## RECOMMENDATIONS

1. The Head of Healthcare should review the process for acting on abnormal blood pressure levels to ensure that results are promptly acted upon so that prison doctors can make timely documented clinical decisions.

   *Accepted*

   *The Head of Healthcare, in conjunction with the GPs, will put into place guidelines for any clinical observations taken, which will include blood pressure, temperature, pulse and respiration. To be completed by February 2010.*

2. The Head of Health Care should develop, in conjunction with Manchester PCT diabetic nurse specialist, a urine testing protocol for diabetics seen in reception.

   *Partially Accepted*

   *Blood glucose will be monitored on all diabetics coming into reception and referrals will be made to the Diabetic Nurse Specialist. To be completed by February 2010.*