PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the death of a man in July 2011 at HMP Manchester

Report by the Prisons and Probation Ombudsman for England and Wales

October 2012

This is the investigation report into the circumstances surrounding the death of a man, a Polish national, who was a prisoner at HMP Manchester. On the morning of his death, the man was found hanging from the window bars in his cell. Staff tried to resuscitate him, but their attempts were unsuccessful. I offer my condolences to his family and friends.

A clinical reviewer was appointed to review the man's clinical care. Manchester prison co-operated fully with the investigation. I apologise for the delay in issuing this report.

The man had been on remand at Manchester since 25 April 2011. He behaved unusually, sometimes violently, and assessments of both his physical and mental health were undertaken. He appeared to speak and understand English well but was uncommunicative and unwilling to offer much information about his medical history, even to Polish speaking staff. Despite the concern about his behaviour and demeanour, he never harmed himself or expressed thoughts of doing so, and staff did not believe that he was a risk to himself. He spent time in both the segregation and healthcare unit. He was in a cell in the healthcare unit when he hanged himself. I understand that such cells at Manchester no longer have window bars and all the windows are being modified to reduce ligature points.

The man's unpredictable and aggressive behaviour resulted in the prison deciding that three prison officers needed to be present each time his cell was opened. Sometimes sufficient officers were not available and doctors were forced to talk to him through his door when trying to make important health assessments. This is not an acceptable, particularly when mental health issues are involved.

Suicide and self-harm monitoring procedures were not used to try to safeguard the man. While he had shown no previous signs of intending to harm himself, unusual behaviour and possible mental illness are indicators of higher risk. Given how little was known about the man, it might have been better for staff to have taken a more cautious approach, but this was a close judgement call.

The man was not formally assessed as having a diagnosed mental illness and in May 2011, two months before he died, a hospital psychiatrist judged he had behavioural problems rather than a mental illness. Nevertheless, insufficient efforts were made to identify his home area and community GP when he first arrived at the prison. This meant that arrangements to transfer the man to a secure hospital for assessment stalled because there was confusion about which health authority was responsible. A serious question must remain about whether prison was a suitable environment for someone like the man, but the investigation concludes it would have been difficult for the prison to have foreseen his intention to hang himself.

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.

Nigel Newcomen
Prisons and Probation Ombudsman **October 2012**

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SUMMARY

1. The man moved to the UK from Poland to work and study and lived in the Leeds area. He appeared at Salford Magistrates' Court in April 2011. Although he was bailed the following day. He was later arrested again and appeared in Salford Magistrates' Court towards the end of April and was sent to HMP Manchester.

2. It would seem that the man could speak and understand English, but he did not cooperate with staff during the reception process on arrival at Manchester. He refused to answer questions and follow instructions, and it was considered that there might be an underlying mental health issue causing his behaviour.

3. Over the coming weeks, the man's erratic behaviour continued, and he was moved to the healthcare centre. He spent a period of time in hospital due to stomach problems, and he was also assessed by psychiatrists. No formal mental health diagnosis was made and no physical reason for his behaviour was determined. On his return to Manchester, he was located in the healthcare centre, although he spent some time in the segregation unit following episodes of antisocial behaviour.

4. In the early morning on the day of the man's death, he pressed his cell bell repeatedly but refused to communicate with staff. However, he eventually settled and went to sleep. At 8.15am, a member of staff went to ask him about his meal choices for the day and saw that he was in a slumped by the window at the back of his cell with a ligature around his neck. Staff immediately entered the cell, removed the ligature from him and attempted cardio pulmonary resuscitation (CPR). However, at 8.35am paramedics confirmed that he had died.

5. With the assistance of the Polish consulate, the man's relatives were located and informed of his death. The man's body was repatriated to Poland where his funeral took place.

THE INVESTIGATION PROCESS

6. The investigation was opened when the investigator visited HMP Manchester to collect relevant information regarding the man. Notices were issued announcing the investigation to staff and prisoners. One prisoner wrote to the investigator in response to the notices of the investigation, but was not interviewed as his concerns did not relate to the man's death.

7. The investigator visited the prison again on 23, 24 and 25 August. During these visits he interviewed five members of staff and spoke to three prisoners who worked as cleaners in the healthcare centre. The investigator returned on 13 September when he interviewed a further five members of staff. Initial feedback from the investigation was provided in writing to the Governor on 20 September 2011.

8. The clinical reviewer interviewed some witnesses jointly with the investigator. Her review was received on 22 January 2012.

9. The investigator contacted Her Majesty's Coroner for City of Manchester District to inform him of the investigation and request a copy of the post mortem report. The investigation report will be sent to the Coroner to assist his enquiries.

10. One of the office's family liaison officers (FLOs) wrote to the man's sister in Poland. She was nominated as the family's preferred point of contact. The FLO informed the man's sister about the investigation. During the consultation period, the man's sister received a copy of the draft report. She explained that her brother had been a cheerful and sociable person as well as being a good scholar. Her last contact with him had been in March 2011 when he telephoned to say he had been feeling unwell since being hit by a car and losing consciousness. After this the family did not hear from him again and after two weeks they grew concerned and made efforts to trace him through friends and the Polish Consulate. In late May or early June they heard from the Consulate that he was alive, but they explained that it was for him to decide whether he wished to contact his family.

11. The man's sister said that when she heard that he brother had died she visited Manchester. A prison representative explained about his behaviour in prison which was unlike how he had ever previously behaved. When she viewed his body she saw that he was emaciated. The man's sister said that she could not understand why her brother was not transferred to a mental health hospital. Nor could she understand why the prison did not think he was at risk of harming himself and why he was allowed to keep his shoelaces.

HMP MANCHESTER

12. HMP Manchester is a large high security local prison, holding 1,269 prisoners. It houses category A prisoners and also acts as a local prison for the Greater Manchester area. It consists of two Victorian blocks, one with four wings and one with five wings and mainly has double cells. There is a segregation unit, which is used for those prisoners whose behaviour is challenging and a separate healthcare centre which incorporates both in and out patients facilities. Healthcare is commissioned by Manchester Primary Care Trust (PCT) and the Mental Health In-reach Team (MHIT) is provided by Manchester Mental Health and Social Care Trust.

HM Inspectorate of Prisons

13. HM Chief Inspector of Prisons most recent inspection of Manchester was in September 2011. The Chief Inspector's comments on the prison's healthcare unit included:

> "We observed professional and good natured interactions between patients and staff, and uniformed officers in healthcare were respectful …
>
> "All inpatients had care plans on SystmOne. The nursing team briefed uniformed officers each day at shift handovers so they were aware of care objectives ...
>
> "Patients in the inpatient unit who required transfer to external mental health care waited excessive amounts of time. Average waiting times for a sample of 14 cases since December 2010 were 57 days, ranging from 0 to 157 days following acceptance. Only two out of 14 had been transferred within offender health transfer target times, which was unacceptable."

14. Overall the Chief Inspector was very positive about the prison but was concerned about the high level of self-inflicted deaths. He commented that more could be done to learn lessons from previous cases, at Manchester and nationally. Despite this he found that the prison's health department had a good approach to investigating to serious incidents, near misses and deaths in custody which the rest of the prison could build on.

Independent Monitoring Board

15. Each prison has an Independent Monitoring Board (IMB) whose members are appointed by the Secretary of State for Justice from members of the community. Their role is to satisfy themselves that the prisoners are treated humanely and justly. In their annual report for the period 1 March 2010 to 28 February 2011, the IMB made the following comments in respect of the transfer of prisoners to secure hospital accommodation:

”The delay in transfer of prisoners with severe mental health problems to secure hospital accommodation is a cause of extreme concern. The board continues to be concerned by the length of time it takes to get prisoners resident in in-patients with severe mental health problems, transferred to secure hospital accommodation. The Bradley Report recommends that once a patient has been assessed as needing to be transferred to a secure mental unit, then that transfer be made within 14 days. This does not happen and patients can sometimes wait for a few months for a suitable bed.”

Previous deaths in custody at Manchester

16. There were seven self inflicted deaths at Manchester in the three years preceding the man’s death. The investigator reviewed the Ombudsman’s reports into these deaths and found no obvious similarities between the earlier deaths and that of the man.

KEY EVENTS

17. The man was born in Poland. He moved to the UK in recent years and, before coming into custody, lived in the Leeds area. He registered with a GP in Leeds in February 2011. In February and March he visited health services, both his GP and the local accident and emergency department, on a number of occasions, although no serious problems were identified and he often left without being seen. On 3 March, he visited a hospital and complained of excessive thirst, saying that he drank 15 litres of fluid a day[1] . He had low sodium when this was tested. The sodium test was repeated and the result improved. He was advised to restrict his fluid intake to two litres per day.

18. On 4 April, he was arrested in Salford in Greater Manchester. He appeared at Salford Magistrates' Court on 6 April and was remanded into custody at HMP Manchester. During the reception process he was noted as being uncooperative and the person escort record (PER)[2] alerted staff that he might have mental health issues.

19. The man underwent an initial healthscreen on arrival in the prison. It was recorded in his electronic medical notes by a healthcare support worker (HCSW), that the man should be referred for a mental health assessment as he was "agitated not very compliant". His blood pressure was recorded as 121/100. (A blood pressure reading consists of two numbers or levels. The first number is the systolic pressure. This is the highest level the pressure reaches when the heart beats. The second number is the diastolic pressure and is the lowest level the pressure reaches as the heart relaxes between beats. A diastolic pressure of 100, as in the man's case, is classed as high blood pressure.) The man's pulse was 74 beats per minute (normal range is between 60 – 80 bpm). His weight was 79.3kg (12st 7lb) and his height was 1.87m (6' 2"). The man disclosed that he was on medication for his liver, but no other details were given. He was unable to provide details of his GP in the community. He was removed from the reception area and put into the segregation unit, due to his aggressive actions. He was due to be seen by the prison doctor the following day, but he was not examined as he was bailed following a court appearance.

20. On 23 April, the man was arrested once more, again in Salford. He was charged for possession of class B drugs (cannabis). He appeared at Salford Magistrates' Court on 25 April, and was remanded into custody. On his return to Manchester prison, he was described as "very uncooperative" during the reception process. He refused to answer questions although, after some persuasion, he told the officer conducting the interview (the name was not recorded on the induction documents) that: "The man

[1] Excessive fluid intake is seen in some patients with mental illnesses such as schizophrenia.
[2] This is a form that accompanies prisoners on all journeys from and between the different agencies involved, such as prisons, police and court. It serves as a communication tool about the risks a prisoner poses on escort or transfer. It also provides a chronological record of the escort including such information as the times meals were served and the times the journeys started and ended.

became talkative enough to tell me that he has no thoughts of self harm and is in court tomorrow". The note in the medical record said that his English was understandable. He did not volunteer information about his GP in the community.

21. Later in the induction documents, it was recorded that "the man was very obstructive and refused to answer any questions". He also refused to cooperate with healthcare staff but was referred to the mental health in reach team (MHIT), as staff noticed a referral had been indicated from his previous time at Manchester at the beginning of April. A cell sharing risk assessment (CSRA)[3] was completed and the man was assessed as high risk. This assessment was based on information provided by the agency that escorted him to and from court, indicating possible mental health problems and uncooperative behaviour. He was located overnight on H wing.

22. The following day, the man was due to appear in court. He became obstructive and violent while he waited to be discharged to court. He was placed under restraint and he calmed down and was taken to court. He was remanded into custody again by the court and kicked the cell door at court and shouted abuse at staff.

23. During his journey back to Manchester, he soiled the escort van. He was restrained on arrival at the prison and taken to the segregation unit at 5.55pm. At 6.20pm, he was given a shower, clean clothes and it was recorded that he became more compliant.

24. When someone is segregated, various processes need to be undertaken to ensure they are able to cope with a period of segregation. This includes completion of a safety algorithm to assess the person's mental health. The man's medical records shows that a segregation safety algorithm was completed which found that he would be able to cope with a period of segregation.

25. The man soiled his cell in the segregation unit the following day. On the same day, a nurse from the MHIT went to see the man to carry out a secondary health care review. She was accompanied by a Polish speaking healthcare assistant. The man refused to engage with the healthcare staff and the nurse noted in his medical record that:

> "… [The man] did not talk to myself or the healthcare assistant. [A governor] attempted to engage with him to with the healthcare assistance but again, although it was clear he could hear and understand what was being said he did not respond".

26. The man remained in the segregation unit and continued to be uncooperative with staff. He was placed on the basic regime as part of the

[3] A CSRA is undertaken to ascertain the level of risk a prisoner presents in sharing a cell. It is based on evidence from previous offences and behaviour, and information from the prisoner involved. It is completed by officers and healthcare staff.

incentives and earned privileges scheme (IEP)[4] on 28 April because of failure to comply with the regime, abusive behaviour, and poor personal hygiene. He was later reviewed by a nurse who noted that the man would still not engage with her but did appear "more settled in mood".

27. On 29 April, another nurse reviewed the man as part of the daily segregation checks and recorded that he had suffered from diarrhoea for a few days and had some abdominal pain. She referred him to the prison doctor. The doctor examined the man the same morning. The man said he had been unwell for two days and the doctor noted:

> "Dehydrated, very dry mouth and tongue, acute hard painful abdomen, bruise on the chest, back and abdomen due to accident? [patient will] not say why he has these bruises, chest clear, [nothing abnormal detected]"

28. The man's blood pressure was recorded by the doctor as 136/82 (within normal range), pulse 115 (high) and he was urgently referred to hospital. He was admitted to North Manchester General Hospital on 29 April where he remained until 9 May.

29. During this time he was given intravenous antibiotics, although no diagnosis had been made. On 3 May, following further tests it was recorded that the man's had signs of an infection. He was treated with a high dose of antibiotics for a possible central nervous system (CNS) infection.

30. On 5 May, the man's behaviour in hospital was recorded in the medical file by the outpatient manager at Manchester, as "bizarre and aggressive". He sometimes refused to allow the antibiotics to be administered. Further tests were required to determine if he had encephalitis (inflammation of brain tissue caused either by infection or by conditions that cause the immune system to malfunction and attack healthy tissue).

31. A prison psychiatrist requested an urgent referral for a psychiatric assessment from North Manchester General Hospital and lumber puncture (a procedure used to check the cerebrospinal fluid that surrounds the brain and spinal cord. It is most often used to help diagnose medical conditions that affect the brain and spinal cord). The man was seen by a hospital psychiatrist who decided he did not have the mental capacity to withhold consent for investigations or treatment. Medical investigations were normal and, following an assessment by another psychiatrist who stated that the man was not suffering from mental illness, he was discharged back to Manchester with an assessment of having purely behavioural problems.

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[4] The Incentives and Earned Privileges scheme, or IEP scheme, is used to encourage and reward good behaviour in prisons. Prisoners move between Basic, Standard and Enhanced levels according to their behaviour and performance. The key earnable privileges/incentives are: extra and improved visits, eligibility to earn higher rates of pay, access to in-cell television, opportunity to wear own clothes, more private cash to spend and time out of cell for association.

32. When he arrived back at Manchester, the man was polite to staff although he was subject to a 'level 2'[5] unlock due to his previous behaviour towards staff. (The records show that the man was both unpredictable and uncooperative.). He was assessed by a nurse and was admitted to the healthcare centre for observation. The man was advised of the level of behaviour expected of him and of the available support. Over the next few days, his behaviour was settled. He complied with the healthcare regime and attended exercise and association with other prisoners.

33. On 12 May, the man was examined by the prison psychiatrist. He said that he did not have any mental health issues but "his only problem is his stomach and he gets headaches since kick in the head four weeks ago". (There is no evidence to corroborate that the man had received a kick to his head.) The psychiatrist recorded that the man's mood was stable with no evidence of mental ill health. He was assessed as fit to return to a general wing.

34. Over the next few days, the man remained in the healthcare centre and was generally settled, although he refused to shower or clean his cell. On 15 May, a nurse recorded that:

> "[The man] has taken to lying on the floor beneath his bed despite staff trying to encourage him to lie on his bed. However polite at present when speaking to him although will not engage in conversation at length. States he is okay at present and no concerns expressed".

35. This behaviour continued until 18 May. When he was given his dinner, the man became aggressive and attempted to grab the arm of a member of staff. The man was reminded about his behaviour and he was noted to have settled after that.

36. On 20 May, the man was taken to the segregation unit under restraint for threatening behaviour. He remained subject to a level 2 unlock until his behaviour became more acceptable. He was seen daily by MHIT staff while in the segregation unit. On 23 May, the Nurse Manager recorded:

> "[The man] spoke to me and said he needed to talk to someone. I spoke to him at length and he speaks English well and his understanding is good too. He appeared vague and repeated himself many times. He does not remember any of his violent episodes or arrest, but his memory is very vague about lots of other things too. He is very paranoid about the officers and he also appeared to be responding to external stimuli while I was talking to him."

37. The Nurse Manager discussed her concerns with the prison psychiatrist and a prison doctor. The following day, 24 May, the man left the segregation unit and returned to the healthcare centre for further

[5] Level 2 unlock means that three members of staff are required to be present when a cell is unlocked.

observation and assessment of his confusion and paranoia. Over the next few days, staff encouraged the man to engage with them and continue taking fluids.

38. On 26 May, the man's behaviour continued to be challenging and unpredictable. An officer issued him with clean clothes and bedding but, when threatened by the man, the officer shut the cell door. The man threw his bedding out of the window.

39. The same day, a prison doctor and the prison psychiatrist assessed the man in the healthcare centre through his door observation panel, as there were not enough staff to unlock the door. The doctor recorded that the man made good eye contact and there was no evidence of thought disorder. However, he noted that the man did express some paranoid thoughts about officers hating him, but there was no evidence of clear psychosis. (Psychosis is a symptom or feature of mental illness typically characterised by radical changes in personality, impaired functioning, and a distorted or nonexistent sense of objective reality.) He was observed to be in pain as he held his stomach, and he was referred to a prison doctor. The doctor examined the man and recorded that his stomach felt normal. He was prescribed paracetamol for pain relief.

40. The CSRA was reviewed by a multi-disciplinary team on 27 May and the man remained high risk due to continued violent behaviour and lack of engagement with staff. He also remained level 2 unlock. This assessment was authorised by the Safer Prisons Manager.

41. Over the next few days, the man's behaviour remained unchanged. He had little engagement with staff, refused to shower, declined exercise and association and often refused food. On 31 May, two prison psychiatrists went to assess the man who observed that the man appeared to vomit. The man told the psychiatrists that he thought something was being done to his food as it was upsetting his stomach and that he did not like the officers, but did not say why. He engaged in conversation with the psychiatrists but was easily distracted by looking at the officers outside. The psychiatrists concluded that the man's presentation was "compatible with a paranoid psychosis in the absence of another explanation". However, they recorded that further assessment and observation was necessary.

42. The man went to Salford Magistrates' Court on 1 June where he was remanded back into custody again. No problems were recorded at court or during the journey. He returned to the healthcare centre and, other than continuing to ignore staff and refusing to shower, he was generally stable. A prison doctor and a mental health nurse went to assess the man on 6 June. He refused to engage with them. Two days later, the doctor again tried to assess the man but he refused to engage.

43. On 9 June, the man was asked to move to a different cell in healthcare, due to the poor hygienic condition of his room. Initially, the man refused to move and would not shower, although he did eventually do so. Later the

same day, he banged his cell door and asked to move back to his old cell. He eventually settled and over the next few days his behaviour remained unchanged.

44. A doctor reviewed the man on 16 June and diagnosed possible psychosis as the man was distracted, suspicious of the officers and appeared vague. The doctor noted that there was a limited response to questions, although the men did say he was not eating well as the food was a problem. He said he did not hear voices and did not express any thoughts of harming himself.

45. The records indicate that the doctor decided to refer the man to Meadowbrook (a low secure psychiatric unit in Manchester Hospital) for further assessment and admission although there is no referral document in the man's file. The doctor also recorded "he [the man] didn't express any self-harm or suicidal ideation".

46. On 21 June, a nurse recorded that the man "remains bizarre in his behaviour and appears paranoid when interacting with staff". The man was referred to Meadowbrook the same day.

47. Another nurse recorded that, on 26 June, the man continued to refuse to engage with staff and threw objects at his cell door in an attempt to hit staff. This behaviour continued the following day. He refused to shower and made rude gestures towards staff.

48. The man appeared at Manchester Crown Court on 28 June. No problems were recorded during this visit. The next day, a doctor went to speak to the man but, due to a lack of available staff to unlock him, he had to speak to him through the observation panel in his cell door. The doctor observed the man holding his stomach, but he would not say what was wrong. The doctor recorded:

> "He [the man] remained paranoid and suspicious, and had ear plugs in his ears, denied any hallucinations, refused to try any medication"

49. The prison psychiatrist was asked by a prison doctor to review the man with a view to contacting Edenfield (a medium secure psychiatric unit based at Prestwick Hospital) for assessment, as there were security concerns about the man going to Meadowbrook. The prison psychiatrist explained during his interview with the investigator:

> "… the offences [committed by the man] were not serious enough to [warrant admission] to the medium secure unit but precautionary unlock [and the severity of his behavioural problems] would make it very difficult for local service to take him. So I spoke to the consultant at Meadowbrook … who … had grave concerns because of the unlock … Dr B … then liaised with … Edenfield saying he [needed a medium secure setting]. My hope was that … he might have had a brief admission to Edenfield for a period of assessment [and] might have overcome the need … for the precautionary unlock when he would have

become well enough to maybe transfer back to local service. But subsequently we … found out that he … had a GP elsewhere so we went round in … circles. So … the referral process to a hospital was not straightforward [due to] homelessness … and … his behaviour and the nature of his offences and the fact which we learnt he had a GP elsewhere."

50. On 30 June, the man's situation was discussed at a case conference. A prison doctor discussed with the consultant from Edenfield what would be the most suitable location for the man given his recent behaviour and unpredictable nature. It was noted that it was doubtful he would be suitable for a low security environment. Following a review on 1 July by a multi-disciplinary team within the prison, the level of staff required for unlocking the man was reduced to two (level 1 unlock) to try to promote more therapeutic interactions with staff.

51. A nurse recorded on 2 July that the man complained of stomach pains during the night and was given paracetamol. The man later told a healthcare worker that he thought his food was being tampered with. She tried to reassure him that this was not the case.

52. The man constantly pressed his cell bell through the afternoon of 4 July but, when staff responded, he either ignored them or was verbally hostile and made derogatory gestures. He threw his plate of food at an officer following the evening meal and, due to concerns about him not eating, one of the nurses discussed the matter with a prison doctor. In response, the doctor prescribed Fortisip drinks (a nutritional supplement). The following day, he refused to say what he wanted to eat and was seen sitting on his bed laughing.

53. On 7 July, another doctor went to healthcare to review the man. The doctor noted that there were an insufficient number of officers available for the cell to be unlocked. The doctor also noted that the man was lying under his bed and refused to acknowledge him. At a case conference that afternoon it was confirmed that the referral to Meadowbrook (the low secure unit) had been passed to Edenfield (the medium secure unit).

54. A report from one of the prison nurses made in the early morning of 12 July referred to the man having had a settled night. The nurse also noted an opinion that the man was losing weight and that he had been given a Fortisip drink as directed. The man appeared at Manchester Crown Court later that day. It was recorded in the PER that he initially resisted being put on the van to return to Manchester.

55. A nurse recorded on 13 July that the man continued to refuse to engage with staff and would not see a doctor or psychiatrist. She noted that healthcare staff attempted to monitor his food and fluid intake, but were unclear when and how much he was eating. She added that he might be admitted to a secure hospital under the Mental Health Act.

56. On 18 July, the prison received a letter dated 14 July, from the referrals coordinator at Edenfield Centre, which stated:

> "Unfortunately we are unable to assess patients who do not fall within our Primary Care Trust boundaries. As the man's GP and home address is in Leeds, it is the Primary Care Trust in Yorkshire who will be responsible for assessing and funding his care."

57. The same day, a prison doctor sent a fax to Bellebrooke Surgery in Leeds to enquire if the man was a registered patient with them and asking them to fax a reply to Manchester. The doctor reviewed the man later the same day, and observed him holding his stomach. He noted that there was a bad smell in the man's cell. The man complained that staff did not allow him out of his cell to collect food and the doctor noted that this was not true.

58. On 19 July, a nurse recorded that the man continually pressed his cell bell during the evening but, when staff attended, he refused to speak to them. Over the next two days, he often refused food, which made it difficult for staff to monitor his fluid and dietary intake and he continued to ignore staff and refused to have a shower.

59. On 21 July, another nurse recorded that another case conference was held. It was noted that, as the man's GP had been confirmed as a Leeds practice, he had been allocated to Leeds services and the appropriate referral would be submitted by the prison.

Events on the day of the man's death

60. A nurse recorded at 4.47 am that the man:

> "… spent the first part of [last] evening continually pressing his cell bell. however, he refused to engage with staff when spoken to. He eventually settled to sleep, no new concerns expressed at time of report."

61. An officer working an early shift on the day of the man's death arrived at the healthcare centre at 6.40am and checked the roll (that all prisoners were in their cells and accounted for). The officer said that due to building works, some of the healthcare cells, including the man's, were quite dark. When the officer looked into the man's cell, he saw him in silhouette standing by the window. The officer said "alright" but got no response. The officer told the investigator that he had carried out a lot of morning roll checks and the man was always standing by the window.

62. Each morning, prisoners in healthcare are asked their meal choices for that day. At around 8.15am, an officer went to the man's cell to ask him for his choices. The officer opened the observation hatch and saw the man by the window, but in a slumped position with a ligature around his neck. The ligature had been made from shoe laces. The officer shouted for assistance from another officer and, at the same time, opened the door and went into the cell. He cut the ligature with his anti-ligature knife.

63. The officers laid the man on the floor and checked for signs of life. There were no signs of pulse or breathing so one officer started chest compressions. Another officer attempted to give rescue breaths, but she was unable to open the man's mouth.

64. Two other members of staff, also responded to the shout for assistance. One pressed one of the healthcare alarm buttons to raise a general alarm. More staff, including nursing staff, responded to the general alarm. The control room was contacted to notify a medical emergency. The emergency response nurse was summoned and an emergency ambulance was called three minutes after the time of the general alarm.

65. A nurse inserted an airway through the man's nose and used an ambu-bag[6] to ventilate the man while chest compressions continued to be given. A defibrillator[7] was attached to the man, but it advised that no shock be given and that CPR should continue instead. A second nurse took over giving chest compressions. The ambulance arrived at the prison at 8.25am and the paramedics reached the man at 8.28am. They examined the man and noted that rigor mortis (stiffness in the body) was evident which indicated that the man had been dead for some time.

Support for staff

66. The head of healthcare, held a hot debrief with all the staff involved in the attempted resuscitation of the man. This meeting provided an opportunity for staff involved in the attempted resuscitation of the man to discuss the events and support each other. Support from the prison was immediately made available to the staff involved by the care team. During interviews with the investigator, all staff said that they were contacted by a member of the care team and were aware that, if they chose to, they could contact them at any point for ongoing support.

Support for prisoners

67. A notice to prisoners was issued by the Governor the same day letting them know of the man's death and expressing condolences. This notice reminded prisoners of the available support, via wing staff, the prison chaplaincy and the Listeners (prisoners trained by the Samaritans to offer confidential support to their peers). Checks were made on prisoners subject to ACCT procedures.

Contact with the man's family

68. The man had not provided the name of his next of kin when he arrived in Manchester. Following his death, Manchester contacted the Polish

[6] An ambu bag is a medical device used to provide assisted ventilation to people who not breathing or are having trouble breathing. The bag is compressed to force a volume of air into the lungs.
[7] A defibrillator measures electrical activity in the heart and gives audible instructions on management of the patient such as whether or not an electrical shock should be given.

Consulate to seek assistance in tracing the man's family. The Consulate was able to identify that his mother and sister lived in Wroclaw and notified his family of his death. The man's sister subsequently came to the United Kingdom and met a member of Manchester's family liaison team. Manchester paid for the repatriation of his body and for the funeral costs.

Post-mortem

69. A post mortem examination was undertaken at the Royal Oldham Hospital. It was concluded that the cause of death was hanging. There was no natural disease in the man's body which would have caused his death and the toxicology showed there were no illicit substances or alcohol in his blood.

ISSUES

Clinical review

70. A clinical review was commissioned to review the medical care that the man received while in prison custody. Her clinical review looks at the care and treatment he received at Manchester and considers whether it was appropriate and comparable to that which is available in the community. The clinical reviewer obtained a specialist opinion from a consultant forensic psychiatrist, which is contained within her review. Comments and quotes from the clinical review are described as from the clinical reviewer, and those from the consultant forensic psychiatrist are described as from the specialist clinical reviewer.

Physical health

Seeking community records at the first healthscreen on 25 April

71. At the reception healthscreen assessment on 25 April, no records were taken of the man's GP in the community. This made it impossible for staff to check his medical history at that point. The clinical reviewer writes of this matter:

> "The health care staff could not identify the man's General practitioner as the man was unable to tell staff the name and address of his GP. Therefore they were unable to request his GP records. Not having the name and address of his GP later led to a delay in identifying the correct secure commissioners."

72. This matter is returned to in the mental health section of this report.

Physical health problems

73. The man complained of abdominal pain and diarrhoea following his entry into custody. Following his review by a doctor, he was transferred to hospital on 29 April. The clinical reviewer, comments on this aspect of his care:

> "The man presented with physical symptoms which were investigated and he was transferred to the local acute hospital in a timely manner for his physical problems to be investigated and treated."

74. When the man was discharged from hospital his stomach problems remained undiagnosed. There is no discharge record from the hospital and he continued to have bouts of diarrhoea, complained of stomach pains and was observed to vomit. On his return from hospital, he was placed in the healthcare centre. The specialist clinical reviewer comments: "Again this was an appropriate response and management intervention following his return from outside hospital."

75. One of the prison doctors said in interview with the investigator:

> "The psychiatrists did tell us that they wondered if his physical symptoms were related to his mental state. I think there's probably a strong likelihood that that's the case, or was the case, in that abdominal discomfort or pain is a common symptom for anybody who may be distressed, mentally distressed for any reason."

76. This opinion was never verified and the cause of the man's stomach problems remains unclear. Furthermore, it was recorded by the prison psychiatrist on 12 May that the man disclosed that he had been kicked in the head four weeks earlier. There is no information to corroborate whether he had received such an injury and, if so, when and where this occurred. No follow up was made to establish any further information about this. We would have expected this to happen.

77. Throughout his time in custody, healthcare staff were concerned about the man's food and fluid intake. The man would often decline food but then request food at unsuitable times. However, an officer said in interview:

> "I honestly think he did eat but my own opinion is he may have been making himself sick as well. Because I have seen him take bread and things and when you went in [the] morning and looked in the cell there were empty sandwich packets, there were remnants of food on the plate but there was nothing in the toilet and I went outside and looked outside his window there was nothing thrown outside his window either."

78. Nursing staff made many entries in the man's records about the difficulties in monitoring his food and fluid intake. This led to a discussion on 4 July between a nurse and a doctor. The doctor agreed to prescribe fortisip nutritional drinks. One of the prison nurses noted on 12 July that, in his opinion, the man was losing weight. However, none of the other staff noticed any weight loss and he was not weighed again after his reception.

79. The post mortem revealed that the man then weighed 64kg, meaning that he lost 15kg (2st 6lb) from the time of his arrival at Manchester (he was there for three and a half months). However, the post mortem also records his height as 6'. This results in a body mass index (BMI) of 19.1. The NHS calculator deems a BMI of 19.1 to be within the 'healthy' range, albeit at the very lowest of the healthy range. In terms of weight for height it is in the low range. While the man's lack of interaction with staff made things difficult, we are very surprised that such a weight loss in such a short time was not was not identified. Such a loss should have been investigated further when noted by the nurse on 12 July. As nothing was done to identify or investigate such a significant weight loss it is hard to be satisfied that his physical health care was always to an appropriate standard.

The Head of Healthcare should ensure that perceived significant weight loss in prisoners is investigated and monitored.

Mental Health

80. The man's behaviour throughout his time in custody raised concerns about his mental health. He was uncooperative and at times aggressive. His behaviour led to him being segregated on a number of occasions. The clinical reviewer comments on how concerns with his mental health were identified while he was in the segregation unit:

> "When on the segregation unit the mental health in-reach nurse raised concerns with the psychiatrist about the man's mental health status. He was transferred to the in-patient health unit in a timely manner to allow the medical staff to observe and monitor his mental health."

Difficulties in assessing the man

81. The man was reviewed on a number of occasions by mental health staff and prison psychiatrics. However, some of the assessments were made more difficult by the security restrictions requiring three officers to be present when his cell was unlocked. This was a precautionary measure to prevent him assaulting staff although there is no clear evidence of how much a risk he actually posed. Unpredictability seemed to be the problem. The clinical reviewer identifies the difficulties this restriction caused: "The health care staff were not always able to assess the man on a face to face consultation due to the number of staff required when his cell was unlocked." The specialist clinical reviewer also comments on this issue:

> " … conducting a mental state examination of a disturbed prisoner was, in his case, complicated by (apparently) not enough staff to unlock him and the interview had to be conducted through (for safety purposes) the hatch of his cell."

82. The difficulties that clinical staff faced in attempting to engage with the man are well documented. Whether he would have engaged with staff had they entered his cell is another matter, however it would clearly have offered medical staff greater opportunity to engage with him. It is unacceptable that doctors were forced to attempt to hold complex clinical consultations with a prisoner through the observation hatch in a cell door because there were insufficient officers available to unlock the cell. This should have been resolved through better organisation and planning. We also consider that the doctors involved should have insisted that staff were provided before attempting to conduct their assessments.

    The Governor should ensure that, when necessary, sufficient staff are available to facilitate clinical consultations in a prisoner's cell.

Treating the man's mental health problems

83. Despite the man's, at times, aggressive and bizarre behaviour, he was never formally diagnosed with any mental illness. However, staff were

clearly concerned that his behaviour might be caused by mental health problems of some kind. The specialist clinical reviewer writes:

> "By [16 June 2011] it appears to the author [that] health professionals, both nursing and medical had concluded a likely explanation for his behaviours was the presence of psychosis (mental illness)."

84. The prison doctors believed the man needed to be assessed in a specialist unit. There was some difficulty identifying a suitable mental health unit, due to the varying level of risk that the man posed at different points of his time in custody. Initially, he was referred to a low secure unit (Meadowbrook). However, staff at Meadowbrook indicated that they would be unlikely to accept him as the prison believed he was sufficiently dangerous to require three officers to be present when he was unlocked.

85. Due to this, staff discussed the possibility of referring the man to a medium secure unit (Edenfield). Following the referral to Edenfield, it was discovered that the man was registered with a GP in Leeds, and therefore fell outside the area for referral to this unit. The failure to establish his GP details at an early stage meant that he was referred to an inappropriate service. The specialist clinical reviewer writes of this issue:

> "The author would advise those investigating that this matter could have been clarified earlier, ie: it could have been determined through either discussion with the man or other sources as to his last address that would then likely inform those involved in his care as to the location of his general practitioner. The location of the latter almost always then determines where the patient is referred in the event they need assessment with a view to transfer to outside psychiatric hospital."

86. The post mortem report states that the man had been admitted to Leeds Hospital in March 2011 suffering from psychogenic polydipsia (the consumption of excess of fluid that affects functioning which can be exhibited by those with mental illness.) If the GP had been identified earlier, his mental health history and his health service area would have been known at the start of his time in custody. Such knowledge would have enabled the prison to act quickly when they became worried about his mental health. Without it, delays occurred and the man was never transferred to a psychiatric institution before he died. While we accept that he was a challenging prisoner and uncooperative at times, we agree with the specialist clinical reviewer that his GP details should have been sought as a priority. Efforts should have continued to have been made even if, at first, he was unwilling or unable to provide details.

The Head of Healthcare should ensure that on arrival prisoners' GP details are sought and recorded as a priority and that particular efforts are made where there are health issues to resolve.

Assessment, Care-in-Custody and Teamwork (ACCT)

87. Assessment, Care-in-Custody and Teamwork (ACCT) procedures aim to monitor and support prisoners at risk of harming themselves. Once subject to ACCT procedures, the prisoner is supervised at regular intervals according to the perceived level of risk, and is involved in regular case reviews.

88. The man displayed a number of behaviours that can, in certain circumstances, indicate an increase in their potential risk of self harm. Such behaviours include refusal of meals, poor personal hygiene and withdrawal from everyday activities. The man displayed all these behaviours at Manchester but staff tended to regard them as part of his usual behaviour. He never actively harmed himself while in the prison and, during times when he did communicate with staff, never expressed any thoughts of harming himself. Nevertheless, his erratic eating habits and food refusal were damaging behaviours which could have been interpreted as a form of self-harm

89. During his interview with the investigator, the Safer Prisons manager, confirmed that his team were never asked for guidance or advice from staff with regards to opening an ACCT. However, all staff who have contact with prisoners are trained in ACCT procedures, and might not have needed a further opinion to feel confident that the man did not require ACCT procedures. He went on to say:

> "I don't think there was a need to open an ACCT in this instance. The man never … displayed any self-harm behaviour and … was being managed in healthcare because of his mental health issues."

90. Figures published by the Ministry of Justice in February 2012 indicate that around 70% of prisoners suffer from two or more mental disorders. It does not follow that those displaying symptoms of, or diagnosed with a mental illness necessarily pose a risk to themselves. However, men with mental illnesses are statistically more likely to kill themselves. To that extent the man should have been regarded as at some degree of heightened risk even though there had been no formal diagnosis. The lack of engagement with health professionals and others made it difficult to assess his risk but that in itself was a further risk factor as isolation from others exacerbates the risk as does impulsivity – an identified characteristic of the man. Essentially an assessment of his risk was made very difficult because of the lack of a thorough mental health assessment.

91. Even with prisoners who appear to be substantially unwell such as the man, ACCT procedures are not necessary unless staff have concerns that they are at risk to themselves. In the man's case, he had not harmed himself while in custody and gave no indication that he was likely to do so. With hindsight it is possible to say that a more cautious approach should have been adopted, but we accept this was a difficult judgement. The very fact that so little seem to have been known about the man would suggest that, at least as a precaution, some benefit might have been gained by monitoring him under ACCT procedures. We acknowledge that his case

was reviewed at regular healthcare case conferences but, whether through ACCT procedures or not, it is hard to avoid commenting that an active multi-disciplinary care plan to help manage and provide appropriate support for the man would have been helpful.

The discovery of the man's death in July

92. An officer carried out a roll check of prisoners in healthcare at 6.40am that morning. He recalled seeing the man standing by the window, but did not get a response from him when he asked if he was "alright". This was not unusual as the man did not generally engage with staff. When the officer next checked the man at 8.15am, he was found to be hanging from a ligature tied to the window bars. The officer acknowledged that the man was in much the same position as he had been at the time of the roll check 90 minutes earlier. This raises the possibility that the man was already hanging at that time.

93. Had the man been subject to ACCT monitoring, one might have expected the officer to have switched on the in-cell night light to observe the man better. However, the man was not subject to ACCT procedures and the officer had no reason to suppose that anything untoward might have occurred. The purpose of such morning roll checks is usually primarily one of security – to establish that the correct number of prisoners are present rather than to check on their well being. We have examined Manchester's local instructions about this which are rather confusing and say "Staff must …satisfy themselves that the prisoner is actually there. A verbal response is not sufficient. If it is necessary to wake a prisoner in order to get an accurate roll check then this will be done." National instructions are also not explicit about the level of interaction, if any, is required, although a national Security Alert issued to all governors in 2008, said about roll checks that staff should "gain a response from prisoners in some manner to ensure that the prisoner is present."

94. We accept that the purpose of the early morning roll check in prisons is primarily for security. But we have considered that in this case the man was a patient in the prison's inpatient unit. All the men in the unit are there for a reason – either they have mental or physical health problems. We consider a higher standard of care and intervention than that which applies on a general prison wing must be expected. Just as we would have expected the officer conducting the roll check to have interacted further with the man if he had been on an open ACCT, we would also expect an increased level of interaction and check on an inpatient unit where all the prisoners are assumed to be ill. We do not criticise the officer conducting the check that morning as this was not the understanding at Manchester at the time.

The Governor and Head of Healthcare should ensure that staff conducting roll checks in the inpatient unit assure themselves of the safety of all prisoners.

95. We are also concerned that the man used the window bars of his cell in the in-patient unit to hang himself. We know that it is very difficult indeed to provide environments free of ligature points, but it is a concern that such an obvious means of taking ones own life was available to prisoners in Manchester's healthcare in-patient unit, most of whom, like the man, will have some form of mental health problem. We understand that this is a matter that the Manchester coroner has raised on a number of occasions. We would have made a recommendation accordingly, but we are informed that all the windows in cells in healthcare at Manchester are now fitted with safer cell windows, which means they have reduced ligature points. In addition a bid has been submitted to NOMS to convert the cells to safer cells. The Governor of Manchester has suggested that this would be detrimental to the facilities available for prisoners with disabilities and those requiring palliative care at the end of their lives. We do not think that such an outcome is necessary if a proportionate and risk assessed approach is taken.

96. During the hot debrief[8], one officer G stated that, during his response to the discovery of the man, he could not locate the general alarm bell in the healthcare centre, as he did not usually work in that area of the prison. (It was another officer who activated the alarm.) Manchester dealt with this issues quickly by advising all staff working there to familiarise themselves with the position of alarms in healthcare. The investigator has also been told that, from 15 April 2012, the healthcare department uses a fixed group of prison officers, which ensures that the staff are familiar with the environment.

97. We note that staff used the general alarm, rather than a radio call to the control room to announce an emergency alarm which would request attendance by the emergency response nurse. In this case this was not an issue as the man was located in healthcare, and nursing staff were on hand to respond very quickly to the general alarm.

Record keeping

98. There were a number of incidents when the man would not engage with doctors. During his interview with the investigator, one of the doctors disclosed that he did not always record the occasions when he had been unable to see the man due to his behaviour, but has now started doing this with other prisoners. A change in a prisoner's behaviour could have impact on their health and it would be helpful for other healthcare staff to be aware of it.

The Head of Healthcare should ensure that healthcare staff record when they are unable to meet prisoners due to their behaviour.

[8] Hot debriefs should be held as soon as possible following a death in custody. Among other matters, a hot debrief should identify any immediate learning points arising from the incident.

CONCLUSION

99. The man had been at Manchester for three months by the time of his death on 22 July 2011. He had been held in the prison's healthcare unit during most of that time as staff were concerned about his mental health. Sometimes doctors inappropriately made assessments through his door hatch rather than in a face to face consultation. Efforts were made to refer him to two local mental health units for assessment of his mental health problems, but the referrals were declined as he was not registered with a general practitioner in the catchment area served by the mental health units. It was eventually established that he was registered with a general practitioner in Leeds, and arrangements were put in place to refer him to a mental health unit in that area. The man took his life before the referral was pursued.

100. Despite many manifestations of mental illness, the man never threatened or carried out any acts of self-harm and support and monitoring through the ACCT process to mitigate against any such risks was not put in place. We accept this was a difficult judgement but this meant that there was a lack of active multi-disciplinary care planning to help manage and support the man. We consider that more strenuous efforts should have been made to identify the man's home area and thus the appropriate mental health unit to which he could have been referred, but that it would have been difficult for the prison to have anticipated his apparent intention to kill himself.

RECOMMENDATIONS

The following recommendations were made in the draft report. The Service responses are included in italics following each recommendation:

1. The Head of Healthcare should ensure that perceived significant weight loss in prisoners is investigated and monitored.

   Recommendation accepted
   The prison has now purchased further digital scales for weighing patients. They are located in all treatment rooms and relevant clinical areas. All staff will be reminded to adhere to the Manchester Mental Health and Social Care Trust Nutritional Policy and this will be available on the intranet. Completion will be in September 2012.

2. The Governor should ensure that, when necessary, sufficient staff are available to facilitate clinical consultations in a prisoner's cell.

   Recommendation accepted
   If there is a clinical need / requirement for a prisoner to be assessed in his cell either due to his ill health or behaviour then staff will be provided to facilitate this. There is, however, the issue of patient confidentiality and HCC being able to conduct consultations with sufficient privacy whilst also not putting themselves at risk. Any such requests for cell based consultations should initially go through the wing manager and then ultimately the orderly officer / duty governor. Completion will be in September 2012.

3. The Head of Healthcare should ensure that on arrival prisoners' GP details are sought and recorded as a priority and that particular efforts are made where there are health issues to resolve.

   Recommendation partially accepted
   Staff are still reliant on patients informing them of their GP details to enable them to request information. The prison has now introduced Smartcard usage within the prison to allow access to the NHS spine. This will enable staff to identify if a patient is registered with a GP and request significant clinical data. Completion will be in September 2012.

4. The Governor and Head of Healthcare should ensure that staff conducting roll checks in the inpatient unit assure themselves of the safety of all prisoners.

   Recommendation accepted
   Staff should not continue with a physical head count until such times as they have satisfied themselves that the prisoner is alive and present in the cell. Guidance to this effect will be issued to ensure compliance. Completion will be in September 2012.

5. The head of healthcare should ensure that healthcare staff record when they are unable to meet prisoners due to their behaviour.

Recommendation accepted

Guidance will be sent to clinicians regarding record keeping from their overseeing regulatory bodies to ensure that issues arising from a patient's behaviour are monitored. Completion will be in September 2012.