Investigation into the circumstances surrounding the death of a man at HMP Manchester in September 2008

Report by the Prisons and Probation Ombudsman for England and Wales

July 2009

This is the report of an investigation into the circumstances surrounding the death of a man at HMP Manchester. The man died in September 2008 at a hospital local to the prison, having been taken ill in a prison workshop two days earlier. The man had been in custody for just three weeks when he died.

The cause of death, established after a post mortem, was a stroke caused by a blockage in the blood supply to the brain.

I offer my sincere sympathy and condolences to the man's family and to all of those affected by his loss. The family had a number of concerns regarding the circumstances of the man's death and I hope that my report helps provide answers.

The investigation was carried out on my behalf by my colleague. In addition, 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 the clinical reviewer for her assistance.

I would also like to thank the Governor and staff of Manchester for their full and ready co-operation. My particular thanks go to the deputy safer prison co-ordinator for her work in liaising with my investigator.

I find that the man was treated appropriately by staff at Manchester, and my report includes just one recommendation. The clinical reviewer has made several additional recommendations in the clinical review that have been addressed separately to the local Primary Care Trust.

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.

Stephen Shaw CBE
Prisons and Probation Ombudsman **July 2009**

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SUMMARY

The man was remanded to HMP Manchester in September 2008. (He had previously spent a week on remand there in June.) Having been seen banging his head against a wall whilst at court, he was admitted to the inpatients unit for observation on arrival at Manchester. An ACCT form (the document used by the Prison Service to monitor and support persons deemed to be at risk of suicide or self-harm) was also opened. The man told staff that he was a heavy drinker. He therefore began an alcohol detoxification programme.

Despite these early concerns, the man settled well into prison life. He had some difficulty sleeping, but was reported to be getting on well with staff and helping out his elderly cell mate. On 16 September, he was prescribed a course of diclofenac (an anti-inflammatory drug used as pain relief) for a finger injury. Later that night, however, he had an allergic reaction to the drug. His eyes and face were red and swollen and he said that he was itching all over his body. He was given an antihistamine (a drug used to control the symptoms of an allergic reaction) that night and again the following morning. He was subsequently put on a three day course of steroids to reduce the swelling.

On 17 September, the man moved from the healthcare centre to a cell on D wing. He settled well on the wing and was reported to be getting on well with his new cell mate and wing staff. After a case review on 23 September, the ACCT form was closed.

At around 5.00am on 25 September, the man fell from his bunk bed. After a short period of recovery, he got back into bed and went to sleep. He did not call for the assistance of staff. In the morning, the man told his cell mate that his head was “banging” and, at around 8.00am, he saw a nurse about this. The nurse booked an appointment for him to see a prison doctor that afternoon.

Around two hours later, the man was taken ill in the workshop where he was taking a course in industrial cleaning. Shortly afterwards, he vomited and collapsed and an emergency response nurse was called to the workshop. The nurse asked for an emergency ambulance and administered oxygen whilst they awaited its arrival. The man was admitted to North Manchester General Hospital shortly afterwards. Tests undertaken at hospital revealed that he had suffered a significant stroke. He did not recover and died on the afternoon of 27 September. His family were present at his bedside.

The clinical reviewer concludes that the man’s death could not have been anticipated or prevented by staff at the prison. She has made six recommendations, which I have addressed separately in a letter to the local Primary Care Trust. (These recommendations mostly involve improvements to recording practice in healthcare.) My own investigation finds that the man was treated appropriately during his time at Manchester. I make one recommendation, relating to the recording of details of prisoners’ next of kin.

THE INVESTIGATION PROCESS

1. The investigation was opened on 1 October 2008 when my investigator issued notices announcing the investigation to staff and to prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known to my investigator. No prisoners came forward as a result.

2. An independent clinical review of the man's health needs whilst he was in custody was carried out by the clinical reviewer on behalf of the local Primary Care Trust.

3. My investigator was given access to the man's prison files, including the medical record. He visited Manchester on 6 and 25 November 2008 and interviewed six members of staff and one prisoner, the man's cell mate.

4. My former senior family liaison officer telephoned the man's mother on 22 October 2008 to inform her of the investigation. On behalf of her family, the man's mother raised the following issues:

    - The man's girlfriend went to visit him on the Tuesday before he died. Whilst waiting in the visits hall she was told that he was unfit for the visit. Apparently, his head was swollen and his eyes were bulging and bloodshot. The man's mother said that the family would like to know more about this occasion.

    - The man's mother said that she would like to know how long it was until the man received medical attention when he collapsed in the workshop, and how long it took for the ambulance to arrive.

    - On either the Monday or the Tuesday before he died, the man apparently spoke to his cell mate and asked if he could stay awake and watch him while he slept. The man was apparently scared that something might happen to him in his sleep.

    - The man's mother said that the most distressing aspect was that she understood that the man was taken to hospital at 11.45am on 25 September, but she was not notified until the evening. On her arrival at hospital that night, the man was in a coma. The man's mother was told that he had been slipping in and out of consciousness that afternoon. She felt that, if she had been told of his collapse sooner, she might have been able to speak to him while he was conscious.

5. The man's mother spoke to my former senior family liaison officer again on 5 January 2009. She said that the man had developed a bald patch at the back of his head and had been complaining of headaches. She queried whether this may have been related to a blood clot. The man's mother added that the man's hands had been hurting him for a while and would go white and be freezing cold to touch.

HMP MANCHESTER

6. HMP Manchester is a local prison which takes people who are remanded into custody from courts in the Greater Manchester area. It has been part of the Prison Service's 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. After an initial stay as an inpatient in the prison's healthcare centre, the man was housed in a double cell on D wing.

7. Healthcare at Manchester is commissioned 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 report of the prison's Independent Monitoring Board report for 2007-08 notes that a number of the beds in healthcare 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, the form used by the Prison Service to monitor and support persons deemed to be at risk of suicide or self-harm) forms are housed in healthcare.

8. Manchester was last inspected by HM Chief Inspector of Prisons in May 2007. The Chief Inspector also found that a number of prisoners were being inappropriately admitted to the inpatient unit. She recommended that admission to the inpatient unit should be on the basis of clinical needs alone.

9. The man's death was the 21st to have occurred at Manchester since April 2004 when I began investigating all deaths in prison custody in England and Wales. Six of the previous 20 deaths were due to natural causes. There have subsequently been a further four deaths at Manchester, one of which was due to natural causes.

10. One of my previous investigations involved the death of a prisoner who collapsed after a short time at Manchester. This man was also treated for alcohol addiction during his time at the prison. Other than this, however, there are few similarities between the cases.

KEY FINDINGS

11. The man was remanded into custody at HMP Manchester on 6 June 2008. Whilst in a cell at court he was observed by a member of the escort service to be slicing his neck with a sharp object. The man was subsequently placed in an observation cell at court, where he was noted to be head-butting the wall. A suicide/self-harm warning form was therefore completed by the escort service and handed to a Senior Officer (SO) in reception at the prison.

12. Following his arrival at Manchester, the man was seen by a reception nurse. On account of his behaviour at court the reception nurse opened an ACCT form. During his interview with the reception nurse, the man said that for a long period of time he had been cutting himself to release anxiety. He also said that he had attempted to hang himself within the last two years. The reception nurse established that the man had been prescribed benzodiazepines (sedative medication to ease anxiety) for some time and that he was asthmatic. The man also said that he was a regular user of amphetamines and a very heavy drinker. The reception nurse referred him to a prison doctor regarding both his physical health and substance use.

13. At around 6.20pm that evening, the man was seen by a locum doctor at the prison. The doctor noted that the man's account of his drug and alcohol intake was not consistent with what he had told the reception nurse. He recommended that the man be observed for signs of alcohol withdrawal and reviewed if required.

14. After seeing the locum doctor, the man had an ACCT assessment interview with a second SO. The man said that he cut himself in order to relieve tension. He went on to say that he had attempted suicide in the past, using a variety of methods. The SO noted that the man was in good spirits, but had said that if he were to feel tension he might harm himself.

15. The following morning, the man was seen by a doctor specialising in alcohol detoxification. The doctor noted the man's history of alcohol and drug use. He also spoke to the man about his recent self-harm. The man said that he had been hearing voices telling him to self-harm, but had no thoughts of doing so at present. In contrast to the previous day, the man now denied having had suicidal thoughts in previous years. The doctor prescribed chlordiazepoxide (a benzodiazepine used to control alcohol withdrawal symptoms), thiamine (to replace the natural vitamin B1 that can be reduced by alcoholism) and carbamazepine (for bipolar disorder, whereby patients experience manic and depressive moods, usually separated by periods of 'normal' mood). He also prescribed a salbutamol inhaler for the man's asthma.

16. That afternoon, the man had an ACCT case review with a Principal Officer (PO), the manager of the induction wing, the SO he had seen the previous day and a prison officer. It was noted that the man had made remarkable

progress since his arrival. The PO said that he remembered the man from his last time in custody and that the man was now much more like the person he was then. Nevertheless, the review panel decided to keep the man's ACCT document open whilst he completed his detoxification programme.

17. At a review with a nurse on 8 June, the man said that he was feeling "okay". It was noted that he had a family history of cardiovascular disease (affecting the heart or blood vessels). This was confirmed the following day when the man's medical records were received from his doctor in the community.

18. On 11 June, the man had a second ACCT case review, this time with two SOs. It was noted that the man was very positive during his review and had had a constructive week. As he was due in court on 13 June, the panel decided to keep the form open until his next review, which was scheduled for four days later. I believe this was the correct action.

19. The man was released on bail after his court appearance on 13 June. However, he was arrested again by Greater Manchester Police on 2 September. Whilst in police custody, the man was prescribed chlordiazepoxide by a police doctor. After a night in a police cell, the man appeared in court on 3 September and was again remanded into custody.

20. Whilst in a cell at court, the man was seen to be banging his head against a wall. A community psychiatric nurse was asked to assess him. The man told the psychiatric nurse that he was hearing voices. She noted that he became more agitated as the interview progressed. The psychiatric nurse completed the relevant suicide/self-harm warning form, and sent a fax to HMP Manchester asking that the man be placed on the healthcare inpatients wing for further observation.

21. Following his arrival at Manchester, the man was seen by a Healthcare Officer (HCO) for a reception health screen (a routine health screen for all new arrivals into prison). The HCO noted that the man was a heavy drinker and had used amphetamines recently. The psychiatric nurse's assessment was available to him, and the HCO noted in addition that the man appeared to be in a distressed state and had thoughts of self-harm. He therefore opened an ACCT document and referred the man to the duty doctor and mental health in-reach team. In addition, the man was admitted to the inpatients wing for observation. Later that afternoon he was seen by a prison doctor. The man was prescribed a course of chlordiazepoxide for alcohol detoxification, and the first dose was given to him by the HCO. An 'alcohol detox protocol' was completed, consisting of brief questions and medical observations to determine the level of treatment required. The result was that the man should start on a 30mg dose of chlordiazepoxide, which would be reduced to zero in seven to ten days.

22. The following morning, the man was assessed by a doctor on the detoxification unit who is employed by Manchester Drug Services. The doctor on the detoxification unit decided to continue with the dose of chlordiazepoxide prescribed by the prison doctor the previous evening. He also prescribed a course of thiamine, an additional vitamin B tablet and ascorbic acid (vitamin C). The man said that he had a broken finger. The doctor therefore gave him some painkillers, and noted that he had a doctor's appointment regarding his finger later that day.

23. Later that morning, the man had an ACCT assessment interview with an ACCT assessor. The man told the officer that he felt depressed because he was back in custody, but that he would be better in a few days after his detox programme. He went on to say that he would not attempt to harm himself. The ACCT assessor noted that the man was communicating well and that they could consider closing the ACCT at his next review.

24. The man saw a locum doctor, that afternoon regarding his finger. The locum doctor noted that the man had pain in his right little finger, although there was no swelling. He made a referral for an x-ray and prescribed a course of co-codamol (a painkiller).

25. The following afternoon, the man was seen by a psychiatrist at Manchester. The psychiatrist noted that the man was very vague about the voices inside his head and that he was fully rational and coherent. The man's main concern was lack of sleep and he asked for sleeping tablets. The psychiatrist thought that the man showed signs of an anxiety disorder (in which the patient becomes overly anxious on account of a particular event). He therefore prescribed a course of zopiclone (a sleeping tablet) and citalopram (an antidepressant).

26. On the same day, it was noted that the man could not remember his girlfriend's telephone number. A member of staff contacted the man's mother to obtain a mobile number for his girlfriend. The man's girlfriend had two visits booked in the next three days.

27. Over the following days, the man settled into life at Manchester. No further concerns were raised. He attended court on 10 September and hoped to get bail, but was refused. On his return to prison, the man continued to live on the inpatients wing of the healthcare centre. An ACCT review was held, led by the nurse manager at Manchester. The man said that he was feeling a little down as he had not got bail and was still having difficulty sleeping. He went on to say that he had built good relationships with staff and was getting on well with his cell mate. The review panel decided to keep the ACCT form open until his next review in two weeks time.

28. On 11 September, the man was assessed again by the psychiatrist. It was noted that the man was feeling up and down and was unhappy that he had not got bail. The man said that the voices he heard were now less intensive. The psychiatrist later attended a review meeting with a

consultant psychiatrist at Manchester and a nurse in the mental health in-reach team. They concluded that the man was fit to live on a normal prison wing and that he would be assessed by the psychiatrist the following day to confirm this.

29. The psychiatrist saw the man on the afternoon of 12 September, with a mental health nurse. The found that the man showed no evidence of mental illness or of harming himself and agreed that he was fit to live on a prison wing. The psychiatrist prescribed a reduced dose of citalopram, plus a course of trifluoperazine (an antipsychotic drug used to treat patients with anxiety). The man would continue to live in the healthcare inpatients unit until there was a space available for him on a wing. He was noted over the following days to be pleasant and talkative, and helpful to his cell mate who was an older prisoner struggling to cope.

30. The man attended the local hospital for an x-ray on his finger on the morning of 16 September. He was seen in the afternoon by a prison doctor after complaining of pain in his forearm and finger. The man told the prison doctor that he had hurt his finger whilst being restrained by escort staff at court on 3 September. The prison doctor prescribed a course of diclofenac (an anti-inflammatory drug used as pain relief).

31. At around 10.00pm a nurse was called to the man's cell as he said that he was having an allergic reaction. The nurse assessed the man and noted that his eyes and face were red and swollen. The man also said that he was itching all over his body. The nurse noted that the man had recently begun a course of diclofenac and wondered whether this might have caused the reaction. She gave the man some cetirizine tablets (an antihistamine, used to control the symptoms of an allergic reaction).

32. Half an hour later, the nurse returned to check on the man. She noted that his symptoms were improving, although his face and eyes remained red. The nurse instructed that the man should not be given diclofenac in the morning as a precaution. She returned at around 6.30am and observed that the man's eyes and face were still red, although his itching had improved. The man was given some more cetirizine.

33. Around three hours later, the man was seen by the nurse manager at Manchester. She noted that the swelling was very noticeable on his face and feet and that the man complained of itchy eyes, face and feet. The nurse manager gave the man a course of chlorphenamine (an antihistamine) and some Gaviscon tablets, as he had also complained of heartburn. Later that morning, the nurse manager discussed the man's symptoms with the prison doctor. A three day course of prednisolone (a steroid used to reduce swelling) was added to his medications.

34. That afternoon, the man moved to a cell on D wing. An ACCT review was held prior to his discharge from healthcare. It was noted that the man had no problem about moving to D wing and was coping well at the time.

35. The man settled well on D wing and was reported to get on with his cell mate and wing staff. An ACCT case review was held on 23 September at which it was noted that the man's depression was well managed. The man said that he had no thoughts of harming himself. The panel, led by the wing SO, decided that the man's ACCT form could be closed.

36. At around 5.00am on 25 September, the man fell from his bed, the top bunk. His cell mate woke up, and said in interview that the man was not moving at first but came round quickly. The man said that he was "okay" when his cell mate asked if he should press the bell to summon assistance. His cell mate did not therefore call for help. The man then got back into bed and went to sleep.

37. The man's cell mate recalled that, in the morning, the man had blood on his face from a cut above his eyebrow. The man also said that his head was "banging". At around 8.00am, he went to the wing treatments hatch to see the nurse who had brought the prisoners' medication to the wing. He told the nurse that he had fallen out of bed. An appointment was booked for the man to see a doctor that afternoon. When he returned to his cell, the man told his cell mate that he had been told that he was "okay" to go to work.

38. Since the start of the week, the man had been taking a course in industrial cleaning in one of the prison workshops. On his arrival on the morning of 25 September, he told the workshop instructor that he was ill and asked to be sent back to his cell. The man did not specify his symptoms. Although the workshop instructor could not remember whether the man looked well, he told my investigator that he had no reason to be concerned about the man. The workshop instructor said that he was not allowed to release the man as the prison procedure is that only a senior officer can keep a prisoner off work.

39. At around 9.40am, a prisoner came into the workshop office and told the workshop instructor that the man was looking ill. The workshop instructor and his colleague went to see him. The workshop instructor described the man's condition as follows:

> "He really did look ill. He was sat on a chair with another chair in front of him and he was lent on it with his chin on his hands and he really did look ill, all pale."

40. The workshop instructor asked the man how he was feeling, and he replied that he did not feel well. The workshop instructor therefore called in two prison officers who were supporting the workshops that day. Whilst one prison officer was attempting to ask the man how he was feeling, the man vomited and collapsed. The two officers placed the man into the recovery position, before one of them made a radio call for a response nurse to attend the workshop. The time was now around 9.55am.

41. On receiving the call for assistance, the response nurse asked for further information and was told that the man was having a fit. The workshop is some distance from healthcare and it took the response nurse around five minutes to make her way there. On her arrival at the workshop, the man was just coming round. She asked the man if he had any pain and he replied that he did not. The response nurse asked the man to squeeze her hand, and noticed that there was a weakness in his right hand. She therefore concluded that he had suffered a stroke and asked for one of the officers to call for an emergency ambulance.

42. Whilst awaiting the arrival of the paramedics, the response nurse kept the man in the recovery position and gave him oxygen from an emergency bag that she had requested from healthcare. During this time, the man was drifting in and out of consciousness. The paramedics arrived at the prison at around 10.25am and at the workshop around three minutes later. After assessing the man, the paramedics took him to North Manchester General Hospital at around 10.45am.

43. The man was accompanied at the hospital by three officers, and was cuffed to one of them by means of an escort chain (a long chain with handcuffs at each end). At around 4.00pm, it was noted that the man asked one of the nurses to remove the escort chain. The man had experienced further fits at the hospital and a sister on the ward had apparently told the escorting officers that he had been faking them. Around five minutes later, the escorting officers were informed by a nurse that the man had been drinking 'hooch'. An hour later, at 5.00pm, the man was re-assessed and the nursing staff now believed that he was not faking his fits. At 5.45pm, following advice from a doctor about the serious nature of the man's illness, the escort chain was removed. At around the same time, and because of his condition, the duty chaplaincy worker was asked to contact the man's family.

44. The duty chaplaincy worker searched the Local Inmate Database System (LIDS, a prison based computer system used to record various details about individual prisoners) for details of the man's next of kin. She found a partially completed address for his mother, with no telephone number. The duty chaplaincy worker found no further details in the man's paper record, and she was unable to access the list of telephone numbers that the man was permitted to call as no staff work in that area of the prison in the evening. Fortunately, the duty chaplaincy worker spoke to a Roman Catholic chaplain, who was able to identify the full address of the man's mother thanks to his knowledge of the area. He agreed to visit the man's mother that evening. At 7.45pm, the chaplain telephoned the prison to say that he had spoken to the man's mother, girlfriend, brother and sister-in-law.

45. At around 12.30am on 26 September, the man was visited by his mother and other family members. The man continued to experience fits during the day and, that evening, the results of a scan confirmed that he had suffered a significant stroke. He deteriorated significantly later in the

evening and did not recover. After discussions with the man's family, hospital staff began the process of switching off the man's life support at 3.10pm the following afternoon. At 3.37pm on 27 September, the man was pronounced dead.

46. The cause of death, established after a post mortem, was given as cerebellar/brain stem infarction (a stroke) due to right vertebral artery thrombosis (a blood clot in the artery that carries blood from the heart to the neck and brain) and right vertebral artery atheroma (build up of fatty deposits in the same artery).

47. The man's funeral was held on 13 October. My investigator found that the prison's contribution to the funeral arrangements was in accordance with PSO 2710 (the Prison Service Order that sets out the actions to be taken following a death in custody).

ISSUES

Reception to Manchester on 3 September 2008

48. The clinical reviewer considers that reception staff acted appropriately in admitting the man to the inpatients unit. She goes on to say, and I agree, that the ACCT document was opened appropriately by the HCO and that all concerns were properly addressed.

49. As is normal practice, the man was seen for a reception health screen following his arrival at Manchester. The screen was carried out by an HCO. The clinical reviewer notes, however, that:

> "It is the practice of HMP Manchester for this process to be supervised by a registered nurse who will have either carried out the screening him/herself, or supervised the action of a healthcare support worker."

50. The man's reception screen was not signed off by a registered nurse. The clinical reviewer recommends that the head of healthcare develop a protocol to ensure that the supervising registered nurse is able to sign off reception screens. She notes that the following action has been taken at Manchester:

> "I am aware this recommendation has been addressed by the head of healthcare who has developed a 'Protocol for Reception Screen' which confirms that the registered nurse must make an entry on EMIS [an electronic system for recording medical information] to confirm that all necessary actions have been taken by the healthcare assistant."

51. During the reception process, the HCO gained the man's consent to contact his doctor in the community to obtain his previous medical records. The man subsequently signed the relevant consent form. The consent form is on the same sheet as the 'In-Possession Medication Rules' (guidelines to patients who will hold their own medication in prison) and the signature given covers both areas. However, there is no space on the form for the prisoner's name and number, nor is there a space for the countersigning nurse to print their signature. The clinical reviewer considers the form to be inadequate.

52. The man was admitted as an inpatient to the healthcare centre because of concerns about his mental health. The clinical reviewer notes that there is "no documented evidence that a nursing assessment or care plan had been completed on his admission to the healthcare unit". She considers that such action would have been appropriate.

53. Around two to three days after a prisoner's arrival at Manchester, a secondary health screen is usually carried out. This is a follow up to the reception health screen and provides an opportunity for gathering further health information and checking on how the patient is settling into prison life. The secondary health screen is an integral part of the induction

process to prison. Prison Service Order (PSO) 3050, regarding the continuity of healthcare for prisoners, instructs that the screen must take place in the week following first reception.

54. There is no evidence to suggest that a secondary health screen was carried out in the man's case. The clinical reviewer considers that it was not appropriate to carry out the screen within Manchester's usual three day timescale, on account of the man's distressed state at the time. However, it does not appear that a screen was arranged for a later date.

Alcohol detoxification programme

55. At his reception screen, the man was identified as a heavy drinker and suitable for an alcohol detoxification programme. An 'alcohol detox protocol' was carried out, consisting of brief questions and observations to determine the treatment plan to follow. The clinical reviewer considers that the protocol was appropriately completed. However, she goes on to say that the protocol documentation does not contain essential information such as the date of completion or name and signature of the person who completed the assessment.

56. A 'detox regime treatment card' is held for each patient on a chlordiazepoxide programme. The card is signed each time the patient collects a dose of medication. Although he did take the full detoxification course, the man's card was discontinued after the morning dose on 4 September and there is no evidence of a second card being completed.

57. The results of the detoxification protocol of 3 September and subsequent prescription of chlordiazepoxide were not recorded on EMIS. The man was seen by a detoxification specialist the following day, who decided to continue with the dose prescribed the previous evening. Again, this decision was not recorded on EMIS.

The man's health during a visit shortly before his death

58. The man's mother told my former senior family liaison officer that his girlfriend had visited him on the Tuesday before he died. Whilst waiting in the visits hall she was told that the man was unfit for the visit. Staff told her that the man's head was swollen and his eyes were bulging and bloodshot. The man's mother said that the family would like to know more about what happened on this occasion.

59. The visits record shows that the man was visited on nine occasions by his girlfriend following his arrival at Manchester on 3 September. This includes 23 September, which was the Tuesday before he died. An ACCT review was held that morning at which it was noted that the man had settled well on D wing. The ACCT form was closed at the review, with no mention made of the man experiencing any physical symptoms. There were no significant entries in his medical record on 23 September.

60. The symptoms that the man's mother referred to are very similar to those he experienced on 17 September. On this occasion it was reported that the man's eyes and face were red and swollen after he had an allergic reaction to a painkiller. The record indicates that the man's girlfriend visited on 17 September. It is probable that this is the visit about which his mother spoke to my senior family liaison.

61. The events of 16-17 September are described in paragraphs 32-35 of my report. In her clinical review the clinical reviewer concludes that "healthcare staff acted in an appropriate and timely manner to [the man's] physical symptoms." I agree.

The man's conversations with his cell mate

62. The man's mother told my former senior family liaison officer that, on the Monday or Tuesday before he died, he asked his cell mate to stay awake and watch him as he was scared that something might happen. My investigator spoke to the man's cell mate during the course of the investigation. He told my investigator that the man had a lot of headaches and often asked him for paracetamol, but made no mention of the man asking him to watch over him at night.

63. The man's cell mate said that he was not sure if the man reported any of his headaches to staff. There is no evidence in his prison record that he did so. The man did see a nurse on the morning of 25 September after falling out of bed during the night. On this occasion, he told his cell mate that his head was "banging". The prison nurse made the man an appointment to see a prison doctor that afternoon.

64. In her clinical review, the clinical reviewer concludes that the actions of the prison nurse on the morning of 25 September were appropriate. She goes on to say that there was "no information to suggest that it should have been an emergency appointment".

Emergency response on 25 September 2008

65. According to prison logs a prison officer made a response call for emergency medical assistance at 9.55am on 25 September when the man vomited and collapsed in the workshop. It is not exactly clear how much time had elapsed at this stage since the man was first taken ill. In his statement to the Governor, the prison officer said that he and a second prison officer were called in to the workshop at around 9.40am. The second prison officer said in his statement that this happened at 10.40am, although this is presumably an error. The workshop instructor told my investigator that the man vomited and collapsed around two or three minutes after he was first informed that the man was unwell. He went on to say that the officers then put the man into the recovery position before calling for emergency medical assistance.

66. In her clinical review, the clinical reviewer concludes that "the workshop staff acted quickly and appropriately by putting [the man] in the recovery position and summoning assistance." She adds that "the nurse who answered the call assessed the situation and acted quickly and appropriately by requesting an emergency ambulance."

67. After arriving at the workshop and assessing the man, the response nurse asked for an emergency bag to be brought from the healthcare centre so that she could give the man oxygen. She had initially been told by the workshop staff that they thought that the man was having an epileptic fit. The clinical reviewer considers that the response nurse "took the appropriate equipment given the information she had received".

68. Given the distance between the workshop and healthcare, it took several minutes for the bag to be brought over. Some time prior to 25 September, the head of healthcare had placed an order for an emergency bag to be stored in the workshop area. This was because of the distance of the workshops from healthcare. At the time of the man's collapse the order had not been delivered. I understand that an emergency bag is now in place.

Cuffing in hospital

69. The man was initially accompanied by three officers whilst in hospital and cuffed to one of them by an escort chain. At around 4.00pm on the afternoon of 25 September, the man was reported to have asked one of the nurses to remove the handcuffs. It was recorded by the escort officer at the same time that a sister on the ward had told him that the man was faking his fits. Shortly afterwards, the escort staff were advised that it was believed that the man had been drinking 'hooch'. Around an hour later, the escort officer recorded that the man had been re-assessed and the nurses now believed that he was not faking the fits. At 5.45pm, following advice from a doctor about the serious nature of the man's illness, and after consultation with the duty governor, the escort chain was removed.

70. Over the course of the next two days, it became clear that the man had suffered a significant stroke. Given his condition on the afternoon of 25 September and with the presence of three escorting staff, it is unlikely that he constituted a significant risk of escape. However, given that the escorting staff were told that he was faking his fits and had recently been drinking illicit alcohol, it was entirely understandable that he was still restrained. Once they were told the serious nature of the man's illness, the cuffs were promptly removed. However, I am bound to say that this episode does not reflect well on the local hospital.

Time taken to inform the man's family of his collapse

71. The man's mother told my former colleague that she was not notified that he had been admitted to hospital until the evening of 25 September. When she visited him that night the man was in a coma. She felt that, had

she been told of his admission earlier, she might have been able to visit in the afternoon when she understood he had been slipping in and out of consciousness.

72. Whilst the precise nature of the man's condition on the afternoon of 25 September cannot be ascertained from the bedwatch records, it is clear that he was conscious at some point. At 4.00pm, he apparently asked a nurse to remove his handcuffs. It is also reported that he experienced some fits in the afternoon.

73. The duty governor (the on call senior manager at the prison) on 25 September told my investigator that the diagnosis of a patient's illness would determine whether it was suitable to inform the next of kin of a hospital admission. He added that, if they were aware that a patient's condition was life threatening, they would attempt to inform the next of kin as soon as possible.

74. As I have noted above, the seriousness of the man's condition did not fully emerge until late in the afternoon of 25 September. Following advice from a hospital doctor at around 5.45pm, the man's handcuffs were removed. At around the same time, the duty chaplain was asked by the duty governor to contact the man's family to inform them of his condition. The duty chaplain was unable to find a full address or telephone number on LIDS or in the man's paper records. Fortunately, her colleague, the Roman Catholic chaplain, recognised the name of the block where the man's mother lived and was able to identify its exact location. He agreed to visit the man's mother to tell her of her son's admission to hospital. At 7.45pm, the chaplain telephoned the prison to say that he had left the man's mother's house after having broken the news.

75. It is apparent to me that the duty governor asked the chaplaincy team to contact the man's next of kin as soon as it became clear how serious his condition was. There was then a short delay to contacting the man's mother, as the prison did not hold a full address or accessible telephone number for her. Due to the time of night, the duty chaplain had been unable to obtain a telephone number from the list of numbers that the man was permitted to call.

76. Prison Service Order (PSO) 500 provides the following instruction to reception staff:

> "Staff must ask prisoners for the name, address and telephone number of their next of kin and accurately record the information, including 'nil' entries, on page 2 of the F2050 [a paper record of information relating to individual prisoners] and LIDS. Obtaining and recording a prisoner's next of kin is extremely important. Staff should not be left in a position where, in the event of an emergency, or needing to obtain particular support for a prisoner, the appropriate contact details are not available. Staff must also request and record the details (again on page 2 of the F2050 and LIDS) of any other person to be notified in an emergency. "

77. It is not clear why a telephone number for his next of kin was not recorded when the man was seen in reception on 3 September. It is possible that he could not remember it at the time, although two days later a member of staff telephoned his mother on the man's behalf to obtain his girlfriend's number. It is also possible that he was not asked by reception staff. I note that the man was in an agitated state on the afternoon of 3 September, which might have prevented staff from obtaining his full details.

    The Governor should remind reception staff to record the full address and telephone number of the next of kin for all new receptions into prison. If it is not possible to attain accurate details on reception, efforts should be made to obtain and record them as soon as possible thereafter.

Whether the man's stroke have been predicted or prevented

78. The man's mother said that he had developed a bald patch on the back of his head and had been complaining of headaches. She queried whether this might have been related to a blood clot. She also mentioned that the man's hands had been hurting him for some time and would go white and cold to the touch.

79. There is no evidence to suggest that the man reported headaches (other than on the morning of 25 September) or cold hands to healthcare staff at Manchester. In her clinical review, the clinical reviewer says that "there were no concerns documented on EMIS or in the ACCT that were not properly addressed." She goes on to say that the man was "treated in Manchester's healthcare system in an appropriate and timely manner." The clinical reviewer concludes by saying that "[the man's] untimely death could not have been anticipated or prevented by the healthcare staff in HMP Manchester." I agree with her judgement.

RECOMMENDATIONS

1. The Governor should remind reception staff to record the full address and telephone number of the next of kin for all new receptions into prison. If it is not possible to attain accurate details on reception, efforts should be made to obtain and record them as soon as possible thereafter.

   Accepted – currently in reception the prisoner is asked who their next of kin is and it is explained to them why it is necessary to have this information. The current induction interview booklet will be updated and in the Safer Custody section an additional question will be added that asks the prisoner again who their next of kin is. In addition to this, for those prisoners this applies to, as part of the ACCT assessment, the prisoner will be asked to give details of their next of kin.