

**Investigation into the circumstances surrounding the  
death of a man in August 2011 in outside hospital  
while in the custody of HMP Manchester**

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

**October 2012**

This is the report of an investigation into the death of a man while in the custody of HMP Manchester. He suffered a stroke during a night in August 2011 and died in outside hospital the following morning. He was 78 years old. I offer my condolences to the man's friends and family.

The investigation was carried out by one of my colleagues. Manchester Primary Care Trust (PCT) commissioned a clinical reviewer to undertake a review of the man's clinical care. Staff at HMP Manchester cooperated with this investigation. I apologise for the delay in publishing this report.

The man was elderly and had suffered some health problems in the past. On reception into prison, his medical history was noted, and he had ongoing contact with healthcare throughout his sentence. On a night in August, he collapsed in his cell. His cellmate called staff and he was taken to hospital by ambulance. Tests showed that he had suffered a stroke, and the hospital were unable to do anything for him beyond making him comfortable. He died the following morning.

The man received good quality healthcare while in custody which was equal to that he could have expected in the community. Nevertheless, the report does identify some learning from the man's case. Thus the clinical reviewer considers that Manchester should review the monitoring of the blood pressure of hypertensive prisoners, particularly when they present consistent headaches. The report also repeats a number of recommendations that we have made previously to the prison as a result of other investigations. First, it is of considerable concern that, for reasons which have not been satisfactorily explained, restraints were applied to a very sick and unconscious patient for a period of his time in hospital. Second, there remains a need to ensure early communication with families if a prisoner becomes seriously ill. Finally, we repeat the need for the prison to ensure staff are properly debriefed following a death.

I am pleased to see that the National Offender Management Service have accepted the recommendations in this report. The man's family have also responded, and their comments are reflected below.

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.

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**Prisons and Probation Ombudsman**

**October 2012**

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## SUMMARY

1. The man was 78 years old and serving a sentence of five years imprisonment. He had suffered from multiple health problems and, in the past, had had heart bypass surgery. Shortly before coming into prison, he suffered a stroke.
2. When he came into prison his medical history was noted. He had regular contact with healthcare services, and his medication was subject to review and assessment. In addition to prescribed medicines, the man frequently used Gaviscon (an over-the-counter treatment for indigestion and heartburn).
3. During July and August 2011, the man complained of headaches on several occasions. He was given paracetamol and ibuprofen. No concerns were recorded.
4. Shortly before 9.00pm on an evening in August, the man collapsed. He was a Muslim. His collapse occurred during Ramadan but, although he had been fasting previously, he had not been that day. His cellmate called for assistance, and staff attended. The man was still breathing, so staff put him into the recovery position and called for medical staff. An ambulance was called and he was transferred to hospital. He was not subject to any physical restraints, and was accompanied by two prison officers.
5. Once in hospital, the man was assessed. Doctors found that he had suffered a haemorrhagic stroke (which involves bleeding in the brain), and were unable to do anything for him but make him comfortable. They recommended that his family were contacted and staff at the prison did so. At this stage, an escort chain was applied to the man. This seems to have been due to a misunderstanding between prison staff, rather than an assessment that it was necessary.
6. The man's family arrived, and asked if the chain could be removed. Permission was sought from the prison and the chain was subsequently removed. Following a request from the hospital consultant, the prison officers escorting the man moved to wait outside the room, to leave him alone with his family. At 8.32am the following morning, the man died. Staff returned to the prison and, although they were spoken to by the staff care team, a debrief was not held.
7. The clinical reviewer notes that the care the man received in Manchester was equal to that which he could have expected in the community. She makes a recommendation about monitoring prisoners with high blood pressure, which we endorse. In addition, we make further recommendations concerning informing prisoners' families when they are seriously unwell, security assessments for prisoners in outside hospital, and debriefs for staff in light of a death in custody.

## THE INVESTIGATION PROCESS

8. This office was informed of the man's death on 18 August 2011. HMP Manchester provided the Ombudsman's investigator with the man's prison record. The investigator also obtained the man's medical records from the prison. He visited Manchester and spoke to staff who knew the man.
9. Notices were issued to staff and prisoners informing them of the investigation and inviting anyone with relevant information to contact the investigator. No replies were received.
10. Greater Manchester Police conducted an investigation into the circumstances surrounding the man's death. No charges were subsequently brought.
11. Manchester Primary Care Trust (PCT) commissioned a clinical review of the man's care and treatment. The investigator discussed the investigation with the clinical reviewer, and they conducted joint interviews.
12. The investigator interviewed five members of staff, and those interviews were recorded. The investigator provided feedback to the Governor at Manchester during the investigation.
13. The investigator wrote to HM Coroner to inform him of the nature and scope of this investigation and to request a copy of the post mortem report. This report will be sent to the Coroner to assist his enquiries.
14. One of our family liaison officers contacted the man's daughter to explain the investigation process and offer his family the opportunity to raise any issues or questions. The family asked:
  - What medications and dosages their relative was receiving and whether regular checks were made to monitor him,
  - Why the family were not contacted until two hours after their relative was taken ill,
  - Why the family were unable to contact anyone at the prison on the telephone number given or on the general prison number.
15. The man's family received a copy of the draft version of this report. They replied that they would look to address the issues they had during the inquest process. They were unhappy with the use of restraints. They also remained angry at the prison for providing a telephone number that went to an automated system. The man's family also explained that they strongly disagreed with the findings in the report which stated that the care their relative received while in custody was equal to what he would have expected in the community"
16. There were some issues around the man's healthcare which required further investigation, and this has delayed the publication of this report. We apologise for this delay.

## **HMP MANCHESTER**

17. Open since 1868, HMP Manchester was rebuilt following a major disturbance in 1990. It now forms part of the High Security prison estate, but also acts as a local prison, taking both remand and sentenced prisoners from courts from the North West. It is one of the largest prisons in the country. The healthcare centre contains a 20 bed inpatient unit. Healthcare is commissioned by NHS Manchester and provided by Manchester Mental Health and Social Care Trust.

### **Previous deaths at Manchester**

18. Since this office took over responsibility for investigating deaths in prison custody in 2004, 16 prisoners have died at HMP Manchester of natural causes. There have been a further three deaths of prisoners from apparent natural causes since this man's death. We have previously made recommendations about informing families when prisoners are taken to hospital, and regarding restraints of prisoners in hospital. We have also raised the issue of holding debriefs after a death in custody. It is disappointing, therefore, that we need to raise these issues again.

### **Her Majesty's Inspectorate of Prisons' report**

19. The last report published on HMP Manchester by HM Chief Inspector of Prisons was of a follow-up inspection in September 2011. Regarding the prison's healthcare department, the report said:

“Health care was generally very good and we identified a number of points of good practice. In particular, the emphasis on improvement and good staff-prisoner relationships created the conditions for good quality care.”

### **Independent Monitoring Board (IMB) report**

20. Each prison in England and Wales has an Independent Monitoring Board, made up of unpaid volunteers from the community who are appointed by the Secretary of State for Justice. They are responsible for monitoring day-to-day life in the prison and to ensure that proper standards of care and decency are maintained. The last report published by the IMB for Manchester in February 2011 and commented on the provision of a specialist nurse for older prisoners:

“Prisoners who would not make the effort to visit the Healthcare centre are seen approximately once a month by the specialist nurse who can assess their needs within their own environment. Any medical needs she finds can then be addressed. The nurse involved has told us that she feels that it is an important service to the older prisoner as their needs could be so easily overlooked in a busy and bustling high security environment.”

## KEY EVENTS

21. Having been sentenced to five years in prison, the man arrived at HMP Manchester on 23 April 2010. He was seen in reception by a nurse. The nurse noted that the man had undergone a triple coronary artery bypass in 2009 and suffered from atrial fibrillation (an irregular heartbeat). He also suffered from anaemia, kidney problems, high cholesterol, and prostate problems. The man said he had been monitored by a consultant urologist for signs of cancer in the prostate gland, but in January of that year the consultant said no treatment was required other than monitoring.
22. The nurse noted that the man was on a number of medications, including aspirin, atenolol (used to treat heart problems and high blood pressure), simvastatin (used to treat high cholesterol), lansoprazole (used to treat stomach problems), tamsulosin (used to treat prostate problems), warfarin (a blood-thinning agent), and fluoxetine (an antidepressant). He also noted that he was a smoker, had a hearing impairment for which he used hearing aids, and used a walking stick to help mobility. He was referred to the healthcare centre for further assessment of his needs. The man then saw a prison doctor, who prescribed his medication. He was then admitted to healthcare for further assessment, and to see if he could be housed on an ordinary prison wing. The cell-sharing risk assessment (CSRA) showed that, although he presented a low risk to any potential cellmate, he might have problems sharing due to his age and health.
23. The following day, the man saw the Imam. He told the Imam that he had been in prison before. He said that he had no thoughts of harming himself, and was aware of the support systems in place if he felt he needed them.
24. On 27 April, one of the prison doctors assessed whether the man would be suitable to be housed on a normal wing. The doctor noted that he was able to care for himself, was mobile, and had no specific care needs. Being on normal location would make it easier for him to take part in association (free time when prisoners can socialise with each other), and the doctor recommended that he was suitable for a move out of healthcare. The following day, the man moved to C wing.
25. The man seemed to settle on the wing without problems. An entry on his case notes on 2 May show that a carer was to be appointed because of his limited mobility. On 4 May, the diversity manager and the disability liaison officer made some recommendations about the man's care. This included the provision of grab rails for his toilet and shower, making a wheelchair available for Friday prayers and visits, and being located on the ground floor. He was also scheduled for appointments with the optician, and the audiologist. A personal emergency evacuation plan assessment was completed.
26. The recommendations were reviewed on 7 May. The man reported that he did not need grab rails in his cell. Furthermore, he was able to move

unaided around the wing, including walking to Friday prayers, and did not want to use a wheelchair. If he needed assistance collecting his meals, his cellmate was helping him. He had been assessed by the audiologist and given a new hearing aid. He also had an appointment with the optician.

27. A note on the man's medical file shows that, on 16 June, he told one of the prison doctors of increased pain in his knees when walking. He said that he had had problems since his stroke. The doctor gave advice on exercises, how best to use painkillers, and gave him paracetamol.
28. During the evening of 20 June, the man was sick. On the following day he saw one of the prison doctors. He told the doctor that he had only been sick once. He had not had any chest pain, palpitations or shortness of breath (which might have indicated a problem with his heart). The doctor examined him and found no abnormalities with his chest, his blood pressure, or his nervous system. He said that the man should be reviewed the following week. He subsequently saw a further doctor on 28 June. The doctor noted the man's bronchitis, but found on assessment that he was coping well. He was prescribed amoxicillin, an antibiotic, plus some medication to help him sleep.
29. The man continued to have contact with healthcare services. More broadly, he associated mostly with other Muslim prisoners, and did not have any problems beyond those with his health. During November and December, he spent just over a month in HMP Wymott to enable him to attend a court hearing, and continued to be monitored by healthcare staff there. He saw the prison doctor on 1 December, who noted that he was not suffering from any acute medical problems. Shortly before he left Wymott, it was discovered that he had missed four days of his warfarin prescription. Although records do not indicate why this might have been, the clinical reviewer notes that this did not have a detrimental effect on his health.
30. On 15 December, the man attended court and was told that, under the terms of the Proceeds of Crime Act, he had to make a significant repayment. It is not clear from the records how he reacted to this news. Upon leaving court, he was taken back to Manchester and initially located on G wing. He moved back to C wing on 6 January 2011.
31. The medical file notes that, on 2 February 2011, the man suffered from dyspepsia (discomfort in the upper abdomen). He had frequently been taking Gaviscon (a non-prescription treatment for heartburn). On 15 February, he complained of testicular pain and blood in his urine. He saw a prison doctor and was prescribed painkillers (co-codamol) and antibiotics (ciprofloxacin). The doctor also made a hospital referral. The man saw one of the prison doctors on 22 February and said that his testes were still painful and swollen. He was prescribed a further three-week course of antibiotics (ciproxin), as well as tramadol (a strong painkiller).

32. Following concerns from his daughter over his care, the man's solicitors wrote to the prison. The care manager replied on 1 March, saying that his medical treatment had been timely and appropriate, and further investigative tests were pending.
33. The man had an appointment at an outside hospital on 8 March. He had a cystoscopy (examination of the bladder), which showed that he had an inflamed bladder and some enlargement of his prostate. He still complained of enlargement to his left testicle, so blood tests were also taken. The hospital arranged for scans using both ultrasound (imaging of the internal organs) and computed tomography (CT - a specialised X-ray test to give clear pictures of the inside of the body, particularly of the soft tissues). He was also placed on the waiting list for a bladder biopsy (removal of a sample of tissue from the body for examination) and for a further cystoscopy under general anaesthetic. He went back to hospital for the ultrasound scan on 15 March, but further tests scheduled for 23 March had to be cancelled because he was still taking warfarin. The appointment was rescheduled.
34. Healthcare staff continued to monitor the man. A note on his medical file dated 1 April recorded that he often used Gaviscon in addition to his antibiotics. On 6 April the man's renal profile (performance of his kidneys) was noted to be borderline. A further test was scheduled. On 13 April, results of blood tests were received and one of the prison doctors sought advice from outside hospital. The man was subsequently advised to stop taking warfarin for five days, prior to a biopsy. On 15 April, however, he told a prison doctor that he refused to have the scheduled cystoscopy and biopsy. He said that he did not want to go to hospital in handcuffs. He also said that he did not want to stop his warfarin because when he last did so he suffered a stroke, and he did not want to run the risk. The doctor arranged for the appointment to be cancelled. He also told the man that he would arrange for his prostate-specific antigen (PSA) levels to be monitored. (Antigens are a substance which produces antibodies.) If they were to rise, the doctor advised him that he should reconsider his decision not to have the tests. The man accepted this.
35. The medical file shows that, on 17 April, a nurse saw the man. He had not had warfarin for two days, and the nurse was unable to clarify from the record whether this was in line with his prescription or not. She spoke to the healthcare manager and they agreed that, without instructions from a doctor, they would not give him warfarin that evening but that the correct status should be clarified the following day. He was told that his blood coagulation levels (the tendency for clotting) would also be checked the following day.
36. A prison doctor assessed the man on 18 April. He continued to suffer symptoms of indigestion and took Gaviscon for relief. He also said that his angina (chest pain, usually caused by a narrowing of the arteries) had returned: although he had had a bypass two years previously he was no

longer under review by a cardiologist. He told the doctor that he was looking into the legal process to apply for “discharge on medical grounds”. He asked if there was a wing for elderly prisoners where he could be housed, as he disliked being locked up. The doctor re-prescribed warfarin and a glyceryl trinitrate spray (GTN, commonly used to ease angina pains). He also referred the man to the cardiology department at an outside hospital.

37. On 25 May, the man told the healthcare department’s outpatient manager that he was not willing to go to hospital wearing handcuffs. He said that he would attend any further medical appointments when he was released. He signed a disclaimer to that effect. The outpatient manager noted that there remained an outstanding videolink appointment for the man with the cardiology department. There are no further details in the records about this appointment. On 15 June, a prison doctor noted on the medical file that a doctor from outside hospital had advised that the man should be referred to the hospital, but that he had declined further outside hospital appointments.
38. On 2 and 18 July, the man was given paracetamol for headaches. On 18 July he saw a prison doctor in relation to some stomach problems. On 19, 20, 24, 25, 26, 27, 29 July and 6 August the man complained of headaches and was given paracetamol. On a date between 6 and 10 August (the date on the file is obscured) he was given ibuprofen for a headache, and then given more on 10 August.
39. A prison doctor was asked to assess the man on 15 August. He had told one of the nurses that he had noticed some short-term memory impairment since his stroke, and the doctor gave him a memory screening. The results were good, but the man said that he had had a headache for three weeks. It was more severe in the afternoons and worsened when he coughed, although the ibuprofen had helped. The doctor reassured him, and issued paracetamol and ibuprofen.
40. The same day, the prison received a letter from the man’s solicitors. They outlined his medical conditions and concerns over his health. They asked that release on compassionate grounds be considered. If that was not possible, they asked whether he could be transferred to a prison with a lower security category.
41. On 16 August, the man saw the dental officer, complaining of a loose tooth. After discussing his options, the man said that he would leave it for the time being. He also mentioned to the dental officer that he had a headache.
42. On the morning of 17 August, the man saw a nurse. She gave him 10ml of Gaviscon. The man did not have any further interaction with healthcare staff that day.

43. As a Muslim, the man had been fasting during Ramadan. His cellmate later said that the man had not, however, been fasting the day before he died.
44. Shortly before 9.00pm, prisoners were locked in their cells for the night and staff on C wing were changing from day to night shifts. An officer was coming off duty and, as he was leaving the office on the second landing, the cell call bell for cell C1-20 was activated. This was the man's cell. The officer opened the observation panel, and found the man's cellmate in some distress. He said that the man had slumped on his chair while praying, then collapsed onto the floor. As he was just about to go off duty, the officer had passed his radio to a member of the night staff. He therefore shouted to the office for an officer to ask for someone from healthcare to attend. She did so, also informing the principal officer (PO). By this point another officer had joined the officer at the door. They opened it and went in. Their colleague joined them.
45. The man was lying on his side at the back of the cell. One of the officers is a trained first-aider, and went to help. The man was having difficulty breathing, so the officer put him into the recovery position (which allows an unconscious person to breathe more easily) and tried to get a verbal response from him, without success. He noted that the man had some liquid around his mouth. He was not completely still, but was twitching slightly. Knowing that healthcare had been asked to attend, the officer continued to monitor the man's breathing pending their arrival. His colleague moved furniture from the cell, and took the man's cellmate to a different cell.
46. Having been made aware of the situation, the principal officer asked the communications office to call an ambulance. Her request was made at 9.00pm, and the ambulance was requested at 9.01pm. A further principal officer had also been asked to attend C wing
47. The healthcare officer with responsibility for responding to emergency calls having been asked to attend C wing, he made his way there and arrived at the man's cell between two and four minutes after the two officers had entered. He assessed the man, and checked his vital signs. He confirmed that an ambulance was on its way. He noted that there were no visible injuries, and continued to monitor the man until paramedics arrived.
48. The ambulance arrived at the prison at 9.08pm. Paramedics arrived at the man's cell at approximately 9.10pm. The emergency response nurse briefed the paramedics, and they took over providing medical aid to the man. After working for some time, they transferred him to the ambulance and, at 9.45pm, left the prison to take him to outside hospital.
49. When a prisoner is required to go to outside hospital, his security arrangements must be assessed. This will include how many members of staff should accompany the prisoner, and whether he should be subject to

physical restraint. Prisoners may either be in handcuffs themselves, cuffed to a prison officer using a longer chain known as an escort chain, or double-cuffed, which is both of these.

50. It was agreed that two members of staff should accompany the man. Two officers volunteered to do so. The risk assessment marked all risks as low, apart from risk of escape which was marked as medium because of the insecure location. The principal officer who was asked to attend C wing advised that no physical restraints were required, though if the man's condition stabilised then restraints should be used. The ambulance arrived at the hospital at 9.55pm.
51. At 10.35pm the man was taken for a brain scan. This confirmed that he had suffered a stroke. Nursing staff told the escorting officers that they were monitoring him but not providing treatment, only making him comfortable. They advised that his family should be contacted.
52. At 11.30pm one of the escorting officers contacted the principal officer and asked for the man's family to be contacted. The communications room was asked to facilitate this and, at 11.41pm, a senior officer telephoned the man's daughter. His family were in Leeds, and left to travel to Manchester.
53. The log kept by the escorting officers indicates at this point, that they received a message that the duty governor had given instructions that an escort chain should be applied to the man. The principal officer informed the escorting officers that the family were on their way, and the escort chain was applied. In interview, however, the duty governor said that he did not recall giving this instruction.
54. The man's family arrived at 12.56am that morning. His daughter asked the officers if the escort chain could be removed. One of the officers telephoned the principal officer and passed on the request. He said that the family were not causing problems, but were distressed about the situation. The principal officer contacted the duty governor and he agreed that the chain could be removed.
55. At 2.10am, the man was moved to a private room. At 2.25am the consultant in charge of his care asked whether the staff could leave the man alone with his family. This was agreed by the prison and the officers moved to a position outside the room. At 8.32am it was confirmed that he had died.
56. The prison Iman had been informed and travelled to the hospital. Another member of the prison chaplaincy, a trained family liaison officer, also attended and spoke to the man's family.

## **Debrief**

57. Prison Service policy requires that, following the death of a prisoner, a hot debrief (as soon as possible) is held with staff involved in his or her care. This is to ensure that staff have an opportunity to discuss any issues arising, and for support to be made available.
58. Although the officers who escorted the man to hospital were spoken to by members of the staff care team on their return to the prison, they did not attend a formal debrief
59. Staff on the man's wing were informed of his death by wing managers. Support was made available if required.

## **Informing and supporting prisoners**

60. Prisoners on the man's wing were told of his death by staff. They were reminded of the different support mechanisms available should they feel that they needed them. To inform prisoners beyond the man's wing, notices were posted around the prison. In line with prison service policy, all prisoners subject to monitoring under suicide and self-harm prevention measures were reviewed.

## **Post Mortem**

61. A post mortem was carried out on 19 August 2011 at outside hospital. The doctor concluded that the man's death was due to:
  - 1a Cerebral infarction (haemorrhagic stroke)
  - 2 Generalised atherosclerosis  
Ischaemic heart disease
62. In layman's terms, the man had a stroke. The effects of this were more serious because he had heart disease caused by a reduced blood supply through congested arteries. His heart was weakened from a previous heart attack. The doctor noted no evidence of any assault. She gave the opinion that the man died of natural causes and notes that his condition was clearly inoperable
63. The report noted that the man had a long history of ischaemic heart disease and had an irregular heart rhythm. He had suffered from a previous stroke, which had affected his eyesight, and also suffered from problems with his prostate gland. He had previously suffered heart attacks and a coronary bypass, and his weakened heart would have made him less able to withstand a stroke.
64. The man was taking warfarin. The report noted that a high level of this can lead to an increased risk of intracerebral haemorrhage (bleeding in the brain), but that he had regular checks of the effectiveness of his warfarin. The last check was on 17 August 2011, when the levels were

reasonable. The post mortem report noted that a haemorrhage would be unlikely to be caused by warfarin, though once the haemorrhage had begun it might have made it worse.

### **Funeral**

65. The man's funeral took place on 23 August 2011. In line with national guidance, Manchester offered to assist with the costs and, with the family's permission, were represented at the funeral.

## **ISSUES**

### **Reception health screening**

66. The man was given a reception health screening on arrival in Manchester. The clinical reviewer notes that having seen a nurse, he was referred to a doctor. He was then admitted to the healthcare centre for observation. In her view, this was appropriate. He did not have his blood pressure or pulse recorded in reception, but this had no adverse effect on his care as he was fully monitored on the healthcare unit. Similarly, being on the unit was more than adequate cover for him not having a secondary screening.

### **The man's medical care in Manchester**

67. Having been admitted to the healthcare unit, the man was assessed for suitability for transfer to an ordinary wing and was subsequently moved. Once on the wing, he was assessed by the disability liaison officer and recommendations were made. Although he declined some of the recommended provisions, all were properly addressed. A carer was identified to provide any day-to-day help he might need.
68. The clinical reviewer notes that the man's general health was stable and unremarkable. He was referred to the doctor when required and, when suffering from any specific illness, he was treated appropriately and in good time. The effects of his warfarin were properly monitored and his medication amended wherever necessary.
69. When referred to outside hospital to see a cardiology specialist, the man refused to attend and signed a disclaimer. Staff explained the consequences, and the clinical reviewer writes that he had the mental capacity to understand and to make the decision not to attend.
70. It is noted in the medical record that the man made frequent use of Gaviscon, and the appropriateness of this has been considered. The clinical reviewer notes that he was seen by a nurse and a prison doctor for his frequent indigestion, and does not consider that the amount given was excessive. The doctor reviewed his digestive problems and identified no cause for concern.
71. The post mortem report says that the kind of stroke which killed the man is most common in people with hypertension (high blood pressure). He had been diagnosed with hypertension and was started on treatment before he came into prison. The clinical reviewer states that the prison were aware of this and his treatment with a beta-blocker was continued. The clinical reviewer confirms that the man's blood pressure was monitored regularly throughout his detention, and did not give cause for concern. She notes that once someone's blood pressure is stabilised the National Institute for Health and Clinical Excellence (NICE) advise that blood pressure is checked annually (the man's was checked more

frequently). Had he been living in the community, his blood pressure would probably have been checked every six months at most.

72. In the weeks leading up to his death, the man frequently complained of headaches. He was given paracetamol and, later, ibuprofen to help with the pain. He saw the prison doctor on 15 August, when the man again mentioned his headaches. The medical notes state that the doctor examined him and found nothing abnormal and so reassured him. The clinical reviewer notes that the medication given to him for his headaches was not excessive and there could have been numerous reasons for his headaches. However, given his previous history of hypertension, the clinical reviewer suggests that it would have been prudent for the man's blood pressure to be checked at this stage to ensure his treatment for hypertension was still working effectively. She makes a recommendation about the policy for monitoring prisoners' blood pressure. We endorse her recommendation:

**The Head of Healthcare should review the policy for monitoring hypertensive prisoners' blood pressure, particularly in relation to consistent headaches.**

73. The clinical reviewer writes that the man was seen more frequently by healthcare staff in prison than would have been usual in the community. This also meant that the provision of medications such as paracetamol and Gaviscon were monitored, which they would not have been had he been out of prison and buying these himself. His chronic conditions were also monitored more closely. Healthcare staff were fully aware that he had suffered a stroke before coming into prison, and he was assessed and monitored throughout his time in prison. The clinical reviewer concludes that the care the man received in prison was equal to that which he would have expected in the community.

### **Informing the man's family**

74. The man's family asked why they were not informed that he was in hospital until the two hours after he was admitted. He left the prison in an ambulance at 9.45pm, arriving at 9.55pm. He was taken for a scan at 10.35pm, and records do not indicate when he was brought back from that scan. The escorting officer says that it was in light of the scan that they were advised that the man's family should be informed. The request to contact the family was passed to the prison's control room at 11.30pm, and the call to the family was made at 11.41pm.
75. Policy at the prison is that informing prisoners' families that they have been taken to hospital depends on the prisoner's condition. If he is in a life-threatening condition contacting the family is at the discretion of the security manager. Contact is usually made via the prison chaplaincy. If prisoners are capable of responding, they should be asked if they want someone to be informed.

76. The man's family were contacted once nursing staff at the hospital told the escorting officers that they thought it advisable. Prison Rules state that:

"If a prisoner dies, becomes seriously ill, sustains any severe injury or is removed to hospital on account of mental disorder, the governor shall, if he knows his or her address, at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed."

77. When the man collapsed, the non-medical staff involved thought that he might be suffering from a fit. The note on the man's medical record from the nurse who attended the cell, however, notes that he had suffered a major cerebral incident (relating to the brain). The duty governor's log of events contains a note at 9.08pm that he had "suffered a Stroke/Heart Attack and possible Brain Seizure" and that an ambulance was in attendance. This clearly indicates that the prison knew that the man was seriously ill. While accepting that he collapsed during the night, when the prison had fewer staff on duty than during the day, the prison should have considered contacting the man's family at an earlier stage. Prison Service Instruction 64/2011, which is now in force, says:

"Where prisoners have suffered sudden life-threatening harm, the prisoners' wishes on who they would like to be contacted must be obtained where possible.

In any event where the prisoner is unable to communicate their wishes, the prison must contact the next of kin or a nominated person who must be given an accurate account of what has happened, including treatment given, whether the prisoner is in hospital, and information about visiting the prisoner".

78. Also the man's family were unable to contact the hospital on the number provided by the prison. When the family tried to call the prison back, they could only reach an automated system. In such a distressing circumstance, the family should have been provided with a telephone number on which they could speak to a member of staff.

**The Governor should issue clear guidance on when prisoners' families should be notified that a prisoner is seriously ill (in line with PSI 64/2011) and that they be provided with a contact telephone number where they will be able to speak to a member of staff.**

### **Use of restraints**

79. When prisoners are taken to hospital, they are still subject to security. What level of security this should be is assessed at the time. When the man left in the ambulance, he was not conscious. The security assessment noted that risk factors were all low, with the exception of

“prisoner’s escape potential”, which was marked as medium due to the insecure location. The security assessment was that he should be accompanied by two members of staff but that he did not need to be physically restrained by handcuffs. He was unconscious and extremely unwell, and we are pleased that he was not restrained.

80. This assessment also stated that if the man’s condition stabilised or he regained consciousness, restraints should then be used. We understand that once in hospital he remained unconscious but an escort chain (length of chain attached to the prisoner one end and the officer the other end) was applied. The escorting officers told our investigator this was because the man was reassessed once in hospital and the duty governor requested that the chain be applied. This is surprising, it is all the more disturbing to hear that this happened once the man’s family had been informed he was seriously ill and were on their way to the hospital. The family were understandably very distressed to find him restrained and asked that they be removed. It is small comfort that the escorting staff acted swiftly and contacted the duty governor, who agreed they could be removed. Restraints should not have been applied to an unconscious and very sick man.
81. In interview, the duty governor said that he had no recollection of making the request to apply the restraints, only agreeing to their removal. The duty governor’s log does not contain any reference to restraints beyond the agreement at 1.40am on the day of the man’s death and the family’s request to remove the restraints. However, the risk assessment showed that restraints should be used if he regained consciousness or became stable, and the Person Escort Record shows that the message the escorting officers received was that the duty governor had instructed a closing chain to be applied once the family were on their way. The duty governor told the investigator that he did not think that restraints were required in the situation, and could not think that he would have requested them to be applied.
82. There was a process in place to assess the security requirements. A security assessment was made, and the man was taken to hospital without physical restraints. Security needs were re-assessed while he was in hospital. From the duty governor’s assertion that he did not require the man to be handcuffed and the escorting officer’s statement that the instruction came through for an escort chain to be applied, it would appear that there was a breakdown in communication rather than an overly-stringent application of security procedures. Finding the man subject to a security chain while he was unconscious was distressing for his family and not acceptable.
83. The concordat between the National Offender Management Service (NOMS) and the National Health Service (NHS) states:

“Levels of restraint used on prisoners must at all times be proportionate to the perceived security risks and be balanced by

considerations of care and decency for the prisoner. Using handcuffs or other restraints on terminally or seriously ill prisoners is considered inhumane by the courts unless justified by security considerations”.

84. The Governor should ensure that the security assessment processes for prisoners in outside hospital are absolutely clear to escorting staff and duty governors.

**The Governor should ensure that staff fully understand the policy on applying restraints to prisoners attending outside hospital. Managers should ensure that risk assessments fully take into account individual circumstances and are based on the actual risk a prisoner presents.**

85. When the hospital consultant asked whether prison staff could leave the man with his family, this was agreed. Escort staff carried out their security duties outside the room, allowing the man to spend his last hours alone with his family. We are pleased that the prison agreed to this request and he was allowed to die with dignity.

### **Debrief**

86. Staff who were escorting the man to hospital were spoken to by members of the staff care team when they returned to the prison. A formal debrief, however, was not held. It is important that a hot debrief is held as soon as possible following the incident so that staff can discuss what happened and any lessons to be learned in a supportive environment.
87. The requirement for a hot debrief is set out in PSI 64/2011 (which replaced PSO 2710) and clearly states:

“... a ‘Hot Debrief’ must be held immediately after the all deaths in custody. A senior member of staff must act as the debriefer and a member of the care team must attend. All staff directly involved in the incident, including Healthcare staff, should be invited”.

**The Governor should ensure that debrief sessions and support arrangements following a death in custody are carried out in accordance with current prison service instructions, and involve all affected staff across disciplines.**

## CONCLUSION

88. The man was elderly with a number of health problems. These were noted on his reception into prison. He had regular contact with healthcare services for various issues around his health.
89. The man's needs were assessed by the disability liaison officer, and a care plan was formulated. The action points identified were followed up, with the man's input and his wishes taken into consideration. Although he continued to suffer problems with his health, prison healthcare services provided ongoing care. The clinical reviewer notes that his general health was stable, and that he was treated in a timely and appropriate manner when suffering from acute illness.
90. The man was taken to hospital without any physical restraints, which we believe was the correct decision. His family were not informed that he was in prison until hospital staff asked that they should be. When his family were on their way to the prison, an apparent breakdown in communication meant that a security chain was applied to the man. After his family requested the removal of the chain, this was agreed and the chain was removed quickly. However this oversight caused considerable distress to the man's family.
91. We agree with the clinical reviewer, that overall, the man received a good level of care from Manchester. This report makes four recommendations. The first is to the Head of Healthcare about the policy for monitoring hypertensive prisoners' blood pressure. The remainder are to the Governor and concern informing families when a prisoner is taken to hospital, security assessments, and debriefs for staff in light of a death in custody.

## RECOMMENDATIONS

1. The Head of Healthcare should review the policy for monitoring hypertensive prisoners' blood pressure, particularly in relation to consistent headaches.

This recommendation has been accepted. The National Offender Management Service (NOMS) commented:

“The policy for monitoring hypertensive prisoners' blood pressure will be reviewed, particularly in relation to consistent headaches, taking into consideration the National Institute for Health and Clinical Excellence Guidelines that are currently in consultation.”

2. The Governor should issue clear guidance on when prisoners' families should be notified that a prisoner is seriously ill (in line with PSI 64/2011) and that they be provided with a contact telephone number where they will be able to speak to a member of staff.

This recommendation has been accepted with the comment:

“Next of kin details are routinely recorded and unless there are security concerns then arrangements should be put in place to ensure that families are contacted following guidance from clinical staff and with the prisoner's permission.

Family members will be given a contact number for the ward of the hospital where their relative is located for any clinical queries. They may also be given a day time contact number for a relevant department within the establishment in order to discuss procedural issues, and they will be provided with the number for the establishment switchboard so that there is a method of contacting the prison at night.”

3. The Governor should ensure that guidance on risk assessing prisoners in outside hospital clearly set out in what circumstances restraints should not be applied, taking into account the NOMs and NHS concordat.

This recommendation was accepted. NOMS commented:

“This routinely happens via a collaborative risk assessment process which involves consideration of both health needs and potential security risks. Once a prisoner is discharged to hospital these arrangements are regularly reviewed.

NSF (National Security Framework) guidelines on the use of restraints are being issued to all managers who sign off risk assessments.”

4. The Governor should ensure that debrief sessions and support arrangements following a death in custody are carried out in

accordance with current prison service instructions, and involve all affected staff across disciplines.

This recommendation was also accepted. NOMS gave the following comments:

“A reminder is being sent to all Duty Governors to confirm that if a prisoner has died in outside hospital, a hot debrief needs to take place when the staff arrive back at the establishment. Staff are also supported through the care team and via management support. This support is also extended through to the inquest stage of a death in custody. The establishment also has access to counselling services whose contact details are made widely available to staff.”