Investigation into the circumstances surrounding the death of a man at HMP Manchester in October 2010

Report by the Prisons and Probation Ombudsman for England and Wales

July 2011

This is the report of an investigation into the death from apparent natural causes of a man at HMP Manchester in October 2010. He was 72 years old.

I extend my condolences to the man's family and friends and all those affected by his loss. I also apologise for the delay in issuing this report and for any additional distress this may have caused.

A clinical review of the man's care and treatment was carried out by a clinical reviewer on behalf of the local Primary Care Trust. I am grateful to her for her review. I would also like to thank the Governor of HMP Manchester and his staff for their co-operation.

The man had been in Manchester since May 2006. He had a complex medical history and his treatment necessitated frequent referrals to outside NHS hospitals in the last years of his life. His cause of death appears to have been multi-organ failure and septicaemia. Staff at Manchester appeared to have cared well for him and this report makes no recommendations.

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.

Thea Walton
Acting Deputy Ombudsman **July 2011**

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SUMMARY

The man arrived at HMP Manchester on 9 May 2006 as a remand prisoner charged with a number of serious offences that had occurred many years previously. He was subsequently convicted and sentenced to 15 years imprisonment. At that time he was 67 years old.

During initial health screening at Manchester the man reported a number of chronic clinical conditions. These included hypertension (high blood pressure), an enlarged liver, arthritis, anaemia, osteoporosis (decreased bone density) and asthma. He took various medications to control these conditions and had regular contact with healthcare staff for ongoing monitoring and treatment.

In addition to his healthcare consultations for chronic disease management, the man had many other consultations as further clinical conditions developed. His treatment for these conditions included referral to outside NHS hospitals for both out-patient and in-patient care. Amongst others, some of these new conditions included problems with his teeth and the bones in his jaw. He was also found to have bowel polyps during a colonoscopy investigation for the cause of his anaemia. Unfortunately, he sustained a bowel perforation during this procedure leading to him remaining in hospital for a number of weeks while the perforation healed.

The man became unwell on the morning of 30 September 2010 and was taken to the local accident and emergency department. At hospital, his condition continued to deteriorate and he was taken into intensive care. Hospital staff were still unclear about his diagnosis at that stage. Shortly after midnight, prison escort staff were told that he was unlikely to survive the night and he died a few hours later.

The man had not provided family contact details when he arrived in Manchester and this led to the family hearing the news by telephone through a third party. When Manchester obtained the contact details family liaison staff visited without delay and the chaplaincy team took charge of the funeral arrangements.

Following a post mortem, the pathologist attributed the man's death to multi-organ failure and septicaemia. The clinical reviewer found that the man received appropriate and comprehensive treatment for his various conditions and was referred to outside hospitals in an appropriate and timely manner as and when necessary. This report makes no recommendations.

THE INVESTIGATION PROCESS

1. The investigator first visited HMP Manchester on 18 October 2010. He spoke with one of Manchester's healthcare nurses and with one of Manchester's Family Liaison Officers (FLOs). Notices were posted informing staff and prisoners about the investigation. No members of staff or prisoners asked to contribute to this investigation.

2. A clinical reviewer was appointed by the local PCT to carry out a review of the man's clinical care and treatment. Her investigation included interviews with staff. I rely heavily on her findings in arriving at my own findings and conclusions.

3. The investigator contacted HM Coroner for City of Manchester to inform him of the nature and scope of the investigation. Upon completion, a copy of my report will be sent to the Coroner to assist his enquiries into the man's death.

4. One of the Ombudsman's FLOs wrote to the man's family and spoke to one of his daughters-in-law. She raised no specific concerns or questions on behalf of the family but did ask to receive a copy of my report.

HMP MANCHESTER

5. HMP Manchester is a category A (high security estate) prison located in the centre of the city. In addition to its function as a category A prison, Manchester also operates as a local prison serving the courts of the Greater Manchester area. It holds up to 1,269 adult male prisoners on remand, convicted and sentenced.

6. The National Offender Management Service (NOMS) publishes quarterly performance ratings of prisons in England and Wales, with each prison being assessed across a number of set indicators. Throughout the 2009/2010 operational year Manchester's performance was deemed "good" (this is the second highest possible rating).

7. Healthcare at HMP Manchester is commissioned by the Manchester Primary Care Trust. The prison has 24 hour nursing care and the healthcare centre includes an in-patient unit. Primary care services include access to a range of in-house and visiting specialist clinics.

8. HM Chief Inspector of Prisons (HMCIP) last carried out a full announced inspection of Manchester in July 2009. The Chief Inspector made a number of recommendations relating to older prisoners and vulnerable prisoners (vulnerable prisoners are those whose offences put them at potential risk from other prisoners). The man fell into both of these categories. Recommendations relative to prisoners in these groups included a recommendation about establishing a forum for older prisoners and a recommendation about the need for an investigation into prisoner perceptions about the safety of the vulnerable prisoner wings.

9. Each prison in England and Wales has an Independent Monitoring Board (IMB). IMB members are volunteers from the local community who monitor day-to-day life in the prison to help ensure proper standards of care and decency are maintained. The latest report published by the IMB at Manchester for the year ended February 2010 recognised the work of the prison staff in maintaining standards despite the ongoing need for efficiency savings. The IMB also made a positive comment about the appointment of a specialist nurse for "older prisoners".

10. Since my office took over responsibility for investigating all deaths in prison custody in 2004, there had been 13 deaths through natural causes at Manchester prior to that of the man. None of the issues identified in those cases were of significance to the circumstances surrounding this death.

KEY EVENTS

11. The man was born in June 1938 and raised in Stalybridge in Lancashire. He was the eldest of four siblings. He left school at the age of 15 with no formal qualifications and obtained work in a factory. He later joined the army to undertake national service, after which he carried out several different jobs including installation of heating and air conditioning units. He married in 1962 and had two sons. He and his wife subsequently separated and later divorced.

12. On 9 May 2006, the man was arrested and charged in connection with a number of very serious offences that had occurred many years previously. He was remanded into HMP Manchester whilst awaiting trial.

13. The man was subsequently convicted at Crown Court and on 7 July was sentenced to fifteen years imprisonment. It seems that he had anticipated receiving a non-custodial sentence and was shocked at the length of his sentence. He was provided with support at Manchester to help him deal with this, after which he soon began to settle.

14. Throughout his time in custody the man refused to engage in any offender treatment programmes. Such programmes are designed to help prisoners address their offending behaviour and the impact their offences will have had on their victims. The ultimate aim is to help reduce re-offending. The offender manager recorded many times the man's consistent denial of committing any offences against one of his victims. With the other two victims he said that he was sorry for what he had done and prayed every day for forgiveness. He said that he would never commit such offences again so there was no need for him to participate in treatment programmes.

15. The man participated in other activities however. He attended education classes, gaining many qualifications. He also enjoyed art and received prison art awards for his work. He was compliant with prison rules and he achieved enhanced status within the prison's Incentives and Earned Privileges scheme (a scheme designed to encourage good and compliant behaviour and performance at work or in education through granting more privileges than those at lower levels in the scheme).

16. The man suffered from a number of chronic, largely age-related, clinical conditions: hypertension (high blood pressure), an enlarged liver, arthritis, anaemia (abnormally low red blood cell count), osteoporosis (loss of bone density) and asthma. He was taking a number of prescribed medications for these various conditions. In addition, he attended healthcare frequently, in particular for chronic disease management and for services for older prisoners. He was compliant with his medication and attended all appointments booked for him.

17. The man continued to be seen regularly by prison healthcare staff for chronic disease management during 2007. He was also sent to outside hospital for treatment of other conditions arising during the year. One related to treatment for a tooth extraction site that had not healed. He was found to be suffering

from osteonecrosis (bone death resulting from poor blood supply to an area of bone). His treatment included debridement (removal of dead or dying tissue) and oxygen therapy to aid healing. The man was also suffering with pain from another tooth, however his consultant decided against extraction as that could lead to other problems. He was content to manage the pain with basic analgesia. He also developed a painful skin lesion on his scalp during the year resulting in a referral to a consultant dermatologist.

18. The man suffered further health problems in 2008. The problems included several episodes of cellulites (bacterial infection below the skin). With one episode he spent several nights in outside hospital where he was treated with intravenous antibiotics.

19. In March 2009, the man attended the gastroenterology department at hospital for a colonoscopy and gastroscopy (examinations of the colon and stomach using a fibre optic camera). He had been found to be anaemic and these investigations were to try to determine the cause. Findings from the investigations included the presence of a polyp (a growth) in the colon. A sample of tissue for taken for examination and this showed the tumour to be benign (non-cancerous).

20. In late August the man returned to hospital for follow up through a further colonoscopy. A number of polyps were identified in his colon and these were removed. During the procedure his bowel was perforated and he therefore stayed in hospital for some weeks as an inpatient. The perforation healed itself with the help of antibiotics and rest and without the need for surgery.

21. In early November the man was rushed to Accident and Emergency as he was suffering from abdominal pain and diarrhoea and he also appeared dehydrated and sweaty. It seems that he was suspected to have food poisoning. His condition improved at hospital and he was discharged back to Manchester the same day.

22. The man attended a hospital outpatient appointment at the end of November to follow up his progress following his colonoscopy in August. In a summary letter to the prison a hospital doctor wrote:

    > "On reviewing today he remains well. He suffers from intermittent abdominal pain particularly worse after eating although I think this is an incidental finding. His bowels are open regularly with no diarrhoea or constipation … He does not report any symptoms of being systematically unwell."

23. During the first half of 2010, the man had further regular contact with healthcare staff. His consultations were for minor matters such as a knee problem, for minor injuries and for reviews of his general health and reviews of his medication.

24. In early July, one of Manchester's doctors made a note in the man's clinical record about his long standing anaemia. The doctor recorded that he had no rectal bleeding and that his stools were not dark (dark stools can be indicative

of bleeding into the stomach). The man had not lost weight and he reported having a good appetite. The doctor referred him to the gastroenterology department at the hospital for follow up of the investigations of the previous year. The consultant gastroenterologist at the hospital wrote back to Manchester in due course to say that in view of the perforation to the bowel that he suffered the previous year he would be arrange to review him at one of his clinics.

25. The man consulted healthcare staff many more times through the months of July, August and September reporting a variety of conditions such as headaches, neck ache and feeling generally unwell. He was noted to be taking a high dose of tramadol (an opiate pain relief for moderate pain) and was also taking paracetamol regularly. A prison doctor advised him to lower his dose of tramadol and to only take paracetamol when really needed. It seems that his headaches settled after taking this advice.

26. On 29 September, the man was sent to outside hospital for the extraction of a wisdom tooth. This was carried out as a day procedure. On his return to Manchester he was prescribed paracetamol for discomfort following the extraction. His blood pressure was noted to be high, but the reading appeared to be in keeping with what was usual for him.

27. At 8.00am on the next morning, a nurse was asked by wing staff to attend the man's cell as he was complaining of a sore hand. On examination she found that his right arm was swollen and was hot to the touch. He said that he had cut his hand on his cell chair a few days previously, but had not told anyone. She assisted him in taking his medication and told him that when the doctor arrived she would ask him to visit.

28. The prison doctor along with a nurse went to see the man at 10.20am. He was on his bed. He said that he was having trouble breathing and was feeling unwell. He said he had not been feeling well for a few days and his stomach was swollen. The doctor found his blood pressure to be low and his breathing rapid. An ambulance was called and in the meantime he was given oxygen and intravenous saline.

29. The ambulance arrived shortly afterwards. The paramedics assessed the man and decided to take him to hospital. A standard risk assessment was carried out to determine the potential risk that he might pose to the public and the security measures that should be put in place to deal with that. It was judged that he should be accompanied by two officers and that his hands should be cuffed together with one wrist being cuffed to an officer with a long escort chain. (Similar arrangements had been put in place on the previous occasions that he was sent to outside hospital.)

30. On examination at hospital the man's blood pressure was found to be very low, his pulse very high and his temperature low. A chest x-ray revealed a pleural effusion (fluid on the lung) and an abdominal x-ray showed enlarged loops of the small bowel. It was thought that he might be suffering from septicaemia (blood poisoning) following his tooth extraction or to have suffered perforation of

an abdominal organ. Blood tests showed that he was in renal (kidney) failure. Following a discussion between the duty Governor and a hospital consultant, his cuffs were removed at 3.30pm. The escorting officers remained with him however.

31. At just before 5.00pm a prison doctor spoke by telephone to one of the doctors treating the man at hospital. The prison doctor noted that hospital staff were still unsure of the problem, but one possibility was sepsis (sepsis is an illness caused by the body over-reacting to an infection. In severe form, the functioning of the vital organs can be affected). The man was treated with intravenous antibiotics. He was moved into intensive care at just before midnight.

32. An hour later a hospital doctor informed one of the escorting officers that the man might only have a few hours left to live and his next of kin should be informed. The officer telephoned Manchester to pass on this message. He was told that an earlier search to establish any next of kin had been unsuccessful and that further enquiries would have to be made the following day.

33. The man continued to deteriorate and he died at just after 2.00am.

After the man's death

34. A hot debrief was held at 4.00am in the command suite at Manchester. Staff were given the opportunity to talk about their roles and to raise any issues or concerns they might have had. Staff were told of the support available through the care team if needed.

35. No next of kin were listed on the man's electronic prison records and an entry made by the prison's offender management unit noted that he had "lost all contact with his immediate family". Further checking through other of his records revealed contact details of a support service for one of the family members. One of Manchester's family liaison officers telephoned the service to tell them that he had died and she asked for contact details of the family member. The officer's intention once she had the information was to visit the family to break the news in person. (Breaking the news in person of a death in custody is the practice advised in Prison Service Order 2710 'Follow up to Death in Custody'.) In this case, however, the support service telephoned the home of the family direct to inform them of the news.

36. When the officer discovered that the family had been notified by telephone by a third party she nevertheless made arrangements to visit to pass on information and to answer any questions or concerns. The officer, accompanied by another member of the family liaison team, a chaplain, visited that afternoon.

37. The team explained the processes that follow after a death in custody. They explained that the man had made prior arrangements to pay for his own funeral. The chaplain said that the family could make their own funeral arrangements if they wished, or Manchester could make the arrangements on their behalf and

the chaplain could conduct the service. The family asked Manchester to take charge as offered.

38. The family liaison team visited the family again several days later to return the man's property and to confirm the arrangements for the funeral service.

The man's cause of death

39. The consultant forensic pathologist who conducted the man's post mortem examination identified presence of extensive disease. Following a lengthy discussion of his various conditions the pathologist explained:

> "In summary, [the man] had a combination of long standing disease processes all of which, to at least some extent, would have contributed to his death. From a purely pathological perspective it is difficult to determine the relative contribution hypertension, ischaemic heart disease, anaemia, vasculitis, myelodysplasia, chronic duodenal ulceration and ischaemic bowel made to his death. However, the clinical evidence in the case indicated that he had septicaemia and multi-organ failure which, given his abdominal symptoms, was almost certainly due to his duodenal ulcer and ischaemic bowel. Therefore taking into account both the pathological findings and clinical history in this case, in my opinion he died from multi-organ failure and septicaemia as a consequence of an acute on chronic duodenal ulceration and ischaemic bowel. In my opinion, hypertension, ischaemic heart disease, anaemia, leucocytoclastic vasculitis and myelodysplasia were contributory factors to his death."

ISSUES

Treatment of the man's complex medical problems

40. The man had complex medical needs. He had existing diagnoses of a number of chronic conditions when he first arrived in Manchester and other conditions developed during his time in custody there. The clinical reviewer has found that when various conditions were identified or as they developed appropriate referrals were made to relevant specialists at outside hospitals and that these referrals were made in a timely manner

41. The clinical reviewer has also found that the man's ongoing care in Manchester was comprehensive and thorough. He received appropriate monitoring and treatment for his various conditions which included provision of appropriate medication.

42. When the man's condition began to deteriorate on the morning of 30 September he was transferred to outside hospital in a timely manner. At hospital; his condition continued to deteriorate and he died in the early hours of 1 October. The clinical reviewer has said that the clinical staff at Manchester could not have anticipated or prevented his death.

43. The clinical reviewer found that the care that the man received was equivalent to that which he could have expected to receive in the wider community.

Use of restraints in hospital

44. When the man was sent to outside hospital on 30 September a risk assessment was carried out to determine the security arrangements that needed to be put in place. Similar arrangements were made on all the previous occasions that he went to outside hospitals. He was assessed as requiring two escort officers and he was double cuffed to reduce the opportunity to escape or re-offend. The assessment noted that the restraints were only to be removed in an emergency and with authorisation from the duty Governor. When it became apparent on 30 September that he was in a critical condition, the duty Governor authorised removal of the restraints to enable hospital staff to give treatment without restriction. The escort officers remained at the hospital. I consider these decisions to have been appropriate and respectful.

Notification to the man's family about his death

45. Prison Service Order 2710 contains advice to prisons on the notification to a family of a death in custody. Prisons are advised that for various reasons the recommended option is for the news to be delivered to the family face to face as soon as possible after the death. It was Manchester's intention to deliver the news this way, although when the man's records were checked no family contacts were listed. Indeed he had reported losing contact with his family. However contact details were found for a service supporting one of his family members and they were telephoned and asked for contact details for the family.

46. Before Manchester was able to visit the family they discovered that the support service had already telephoned and broken the news. It is possible that Manchester had not been sufficiently clear in its communication with the support service that its intention had been to visit the family itself to break the news. Of course the support service already had a relationship with the family member and might have considered that it would be more appropriate for the family member to hear the news from one of its staff rather than from an unknown party. I can certainly say that the man's family has not complained to my office about the unusual way in which they received the news. I am aware that the family liaison team at Manchester understand the way in which news about a death in custody should be delivered and so I make no recommendation.

47. When family liaison staff from Manchester visited the family they seem to have dealt with the family with sensitivity and compassion. They offered to take charge of the funeral arrangements and the family accepted the offer. One of Manchester's chaplains conducted the service.

CONCLUSION

48. When the man arrived in Manchester in May 2006 he was 67 years old and already had a great many pre-existing chronic health conditions. During the course of the following four years he experienced further health problems. The clinical reviewer has found that he was found to be unwell on the morning of 30 September 2010 and he was admitted to outside hospital. At hospital his condition worsened and he died just over 12 hours later. His cause of death appears to have been multi-organ failure and septicaemia.

49. The clinical reviewer has found that the man received appropriate care and treatment for his various and complex clinical conditions. She also found that he was referred to outside hospitals for advice and treatment as other conditions developed and when he later became acutely unwell. Finally, the clinical reviewer found that medical and nursing staff at Manchester could not have anticipated or prevented his death and that he received care equivalent to that which he would have received in the wider community.