

**INVESTIGATION INTO THE DEATH OF A MAN AT HMP MANCHESTER,
ON 9 MARCH 2005**

**REPORT BY THE PRISONS AND PROBATION OMBUDSMAN FOR
ENGLAND AND WALES**

JUNE 2005

This is the report of an investigation into the death of a man who died from natural causes in North Manchester General Hospital on 9 March 2005, having been taken ill two days earlier.

The man had been convicted on 25 March 2003 and sentenced to six years imprisonment. It was his first conviction and his first experience of prison life. He was held at HMP Manchester and it was there that he was taken ill on 7 March 2005.

This investigation has been undertaken by one of my investigators. I would like to thank the Governor of Manchester Prison, and his staff for their participation in the investigation. A doctor of North Manchester Primary Care Trust was commissioned to undertake a review of the man's medical care, and I appreciate his assistance.

The man's clinical care was found to be appropriate and his transfer to hospital timely. However, I do have concerns about the failure to notify the man's family of his admission to hospital in a timely manner. I have made a specific recommendation to HMP Manchester on this matter, but this is an issue that could sensibly be the subject of further guidance from the National Offender Management Service (NOMS) Safer Custody Unit.

The loss of a loved one is always distressing. I would like to add my condolences to those already expressed to the man's family by my Family Liaison Officer.

Stephen Shaw CBE
Prisons and Probation Ombudsman

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Summary

1. The man was born in 1934 and was 70 years old when he died from natural causes on Wednesday 9 March 2005.
2. The man arrived at HMP Manchester on 25 March 2003. At his First Reception health screen it was noted that he had a number of health problems including diabetes.
3. On 3 March 2005, the man complained of feeling unwell. He was feeling hot and cold, and suffering from dizziness and nausea. He was examined by a prison doctor who requested further tests to be carried out. During the afternoon of Monday 7 March, he remained unwell and it was decided that he should be transferred to North Manchester General Hospital.
4. Whilst he was an in-patient at the hospital, a bedwatch was carried out by prison officers. Due to the nature of his offences he was initially handcuffed, but when his condition deteriorated, a closeting (escort) chain was used until shortly before his death. The man died in hospital two days later.
5. The clinical review carried out by the reviewer concludes that the man's care whilst in prison was appropriate and of a good standard. The reviewer also considers that the man's referral to North Manchester General Hospital was appropriate and timely following a thorough examination.
6. On 3 May 2005, one of my Family Liaison Officers contacted the man's family. They expressed their concern about the failure of the prison to notify them when he was first admitted to hospital and also about the care and treatment given to him by the prison.

Background

7. The Probation Service prepared a comprehensive assessment on the man before he was sentenced, which described him as having poor health including diabetes which was controlled by diet.

HMP Manchester

8. HMP Manchester was first opened in 1868. It was comprehensively re-modelled following the serious disturbance of 1990. There are nine wings and a supporting infrastructure including kitchens, extensive workshops and a healthcare centre. There is a weekly GP clinic for men in the vulnerable prisoners unit, but there are no clinics for chronic disease management.
9. Her Majesty's Chief Inspectorate of Prisons (HMCIP) carried out an unannounced inspection of Manchester in July 2004. The inspectors described a safer prison than when they had last visited three years earlier. However, the report did state that the quality of healthcare had deteriorated since the previous inspection and that although 'individual staff were motivated, this was undermined by chronic nursing shortages and the lack of infrastructure and robust systems'.
10. The prison responded to the findings of the inspection report and has taken positive steps to improve its healthcare provision.

Conduct of the investigation

11. My investigator studied all relevant prison records relating to the man. These included his main prison record, Inmate Medical Record and the Bedwatch Logs covering the period spent at North Manchester General Hospital between 7 and 9 March. My investigator also studied instructions at Manchester on the arrangements to be followed when prisoners are escorted outside the prison, including the use of restraints.
12. A Clinical Review was commissioned from North Manchester Primary Care Trust. I am very grateful to the PEC Chair for undertaking this review in a prompt and timely manner.
13. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the Post Mortem report. Upon completion, this report will be sent to the Coroner to assist him in his enquiries into the man's death.
14. One of my Family Liaison Officers contacted the man's family and was told their concerns about his care at HMP Manchester. The families' concerns included the use of mechanical restraints, the delay in notification of the man's transfer to hospital and questions about whether his previous medical care had impacted upon his health.
15. My investigator visited Manchester and discussed aspects of the man's treatment with staff and discussed the issues raised by his family. I hope this report provides them with answers to their concerns. The Primary Care Trust found that the man's clinical care was appropriate and his transfer to hospital was timely. However, I do have concerns about the timeliness of informing the next of kin of admission to hospital and have made a recommendation concerning this.

Key Findings

16. When the man first arrived in Manchester, it was decided that he should be given Vulnerable Prisoner status because of his age and the nature of his offence. The First Reception health screen was carried out on 25 March 2003 and this stated that he had a number of health problems including diabetes.
17. On 18 November, the man was admitted to Manchester Royal Infirmary for knee replacement surgery. Just over a year later, he was admitted to Manchester Royal Infirmary for an operation to replace an aortic valve in his heart.
18. On 3 March 2005, the man complained of feeling unwell as he had a temperature, dizziness and nausea. He told the prison doctor that he had suffered from dizzy spells since the previous week, when he had fallen and hit his head. The prison doctor examined him and asked for further tests to be carried out. Blood samples were taken for testing the following day.
19. During the afternoon of 7 March, the man was still feeling unwell. He attended the GP clinic and was seen again by the prison doctor. The doctor thought that there was a possibility of endocarditis (the inflammation of the lining, valves and muscle of the heart), and he decided to refer him to North Manchester General Hospital. The man was escorted in handcuffs from the prison to the hospital.
20. Once he was settled on the ward in the hospital, the nursing staff requested that a closeting (escort) chain be used instead of handcuffs. This enabled the nursing staff to have easier access to the man when they carried out their duties. The request was granted.
21. On 8 March, the nursing staff carried out further tests and administered medication. During the evening of the same day the doctor attending the man told the officers that he had an infection and would be unwell until the medication started to have an effect. The doctor also told the officers that he expected him to be in hospital for about a week.
22. At 8:30am on 9 March, The man was taken for an electrocardiogram (ECG). While the nurse attempted to carry out the ECG, the needle, which was administering drugs intravenously, came out of his arm. The officer escorting the man removed the closeting chain to facilitate the re-attachment of the needle. The chain was replaced, but a little later it was removed again to enable him to have a shower following the earlier blood spillage.

23. At 1:05pm, after the man was seen by the doctor, hospital staff were asked by a Senior Officer to telephone his next of kin to inform them that he was in hospital and tell them to contact the prison about visiting arrangements. The man's sister had been visiting the hospital since 7 March to see her daughter, who was also an in-patient, but was not informed about her brother's situation until the evening on 9 March. The man's sister was able to visit him immediately after she was informed, but by this time he had already passed away.
24. At 4:15pm, the man was moved to the Intensive Care Unit (ICU) and at 6:10pm the ICU Consultant, informed the Senior Officer that the man's condition had deteriorated to such an extent that it necessitated the removal of the closting chain. This was to enable nursing staff to have instant access for defibrillation and on health and safety grounds. The doctors prognosis was poor, as he had found that the man had suffered heart failure. Permission was given by the Governor to remove the closting chain.
25. At 6:20pm, the man's condition deteriorated and the officers on bedwatch duty withdrew to enable clinical staff to carry out the necessary medical interventions. At 7:00pm, the doctor informed the Senior Officer that the man had died.
26. The duty governor was immediately informed of the man's death. A member of the prison chaplaincy, maintained contact with the family and assisted with the funeral arrangements. The prison also provided financial assistance with the funeral costs and the Governor represented the prison at the man's funeral.
27. The post mortem report states that the cause of death was due to natural causes as a consequence of endocarditis of the aortic valve and tight aortic stenosis (the narrowing of the aortic valve).
28. The Clinical Reviewer concluded that the man's care while he was in prison was of a good standard and that medical issues were dealt with in a timely manner.
29. I share the concern of the man's next of kin that they were not informed in a timely manner of his admission to hospital. In his comments on the bedwatch logs, the Senior Officer stated that he asked the hospital to inform the man's next of kin about his admission to the hospital and to tell them to contact the prison to arrange when they could visit him.

30. In my view, the prison itself should have informed the man's family about his admission to hospital as soon as it occurred. This was especially important because of his age and his medical condition, and it would have enabled his family to visit him at an earlier stage. It is particularly sad that the man's sister, who visited another patient on the Monday, Tuesday and Wednesday, could have seen her brother when he was still alive, if she had been notified in a timely manner.
31. My investigator considered the use of mechanical restraints and I am satisfied that the decision to remove the man's restraints was taken at the earliest opportunity.

Recommendations

Operational

The Governor should remind staff that next of kin should be informed when a prisoner is admitted as an in-patient to hospital at the earliest opportunity. Should a prisoner be insistent that their next of kin is not informed, this should be appropriately recorded in the bedwatch log.