PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent investigations

Investigation into the circumstances surrounding the death of a man at HMP Manchester in May 2011

Report by the Prisons and Probation Ombudsman for England and Wales

July 2012

This is the report of an investigation into the death of a man who was a prisoner at HMP Manchester. He was 49 years old. In May 2011, he was found in a chair in his cell at 5.30am. He was declared dead at 6.00am. The post-mortem report found that he died of chronic liver failure resulting from methadone toxicity. I offer my condolences to his family and friends.

My colleague was appointed to carry out the investigation. A review of the man's healthcare was commissioned by the local Primary Care Trust (PCT). A clinical reviewer carried out the review. I am grateful to the Governor of HMP Manchester for his co-operation during this investigation. I apologise for the delay in the publication of this report.

The man was remanded to Manchester in April 2010. He was prescribed a high dose of methadone as the healthcare team were worried about the consequences of stopping the medication on his wellbeing. Although his liver problems grew worse, he was sufficiently well to remain in his own cell and walk around the wing. Towards the end of his life, the substance misuse team told him he would need to stop taking methadone in order to be considered for a liver transplant. However, he died shortly afterwards.

The investigation explored the appropriateness of prescribing methadone to prisoners on long sentences for an extended period of time, rather than putting them on a detoxification programme. The man also suffered from severe liver failure which had to be taken into consideration in terms of the physical effects of the medication and the potential impact of withdrawing methadone to his mental state. While certain checks could have been improved, the investigation found that the care provided to him was, overall, appropriate and equivalent to what he would have received had he been in the community.

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 **July 2012**

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SUMMARY

1. The man was remanded to Manchester on 17 April 2010, charged with serious offences. Upon his arrival, he told staff of his alcohol and substance misuse history and explained that he was prescribed methadone in the community. Staff began an alcohol detoxification programme, and prescribed him a low dose of methadone to start his course, in accordance with agreed protocols. He completed his alcohol detoxification treatment and, by June 2010, his methadone prescription had increased to the same dose he had previously received in the community.

2. The man entered prison with significant health concerns. He had a number of scans in outside hospitals and, in summer 2010, there was concern about the possibility that he had liver cancer.

3. The methadone prescription was increased to 80ml in October 2010 as a prison doctor felt that the man's level of physical and mental distress warranted it. However, the doctor warned him that, due to prison protocols, the dose would not be increased any further. In the meantime, he continued to have a number of tests and hospital visits.

4. The man was sentenced to ten years' imprisonment in November 2010 which shocked him. He became more unwell and, in January 2011, staff were worried that he could no longer care for himself in his cell. However, he did not want to move to the healthcare centre and he remained in his own cell.

5. In February 2011, the doctor discussed decreasing and ultimately ending the man's methadone prescription but he was resistant to such a decision. Due to the serious condition of his liver, he was assessed for a liver transplant. However, his continued methadone maintenance threatened his eligibility for this emergency procedure. Accordingly, the doctor reduced his prescription from 80ml to 78ml on 21 April. However, he was very unhappy with the decision. His liver continued to worsen throughout May, although he was still able to move around the wing by himself.

6. An officer saw the man in the chair in his cell at 7.00pm in May when she undertook her evening roll check. He was in the same position when she did her morning check at 5.30am, and the officer was concerned because he was normally in bed at that time. She summoned assistance and entered the cell. However, he had already died.

7. The man was found to have died from chronic liver failure. His acute liver disease together with methadone toxicity caused his death. Despite this, the investigation found his prescription of being methadone was appropriate. This report makes one recommendation.

THE INVESTIGATION PROCESS

8. The investigator visited HMP Manchester on 8 June to open the investigation. He met senior prison managers and took copies of the documentation relating to the man. Notices of the investigation were issued to staff and prisoners, inviting those who wished to provide information regarding his death to make themselves known to the investigator. No-one came forward with regard to the notices.

9. The investigator wrote to the Chief Executive of the local Primary Care Trust (PCT) to commission a clinical review. Manchester PCT asked a clinical reviewer to carry out a review of the care received by the man whilst at HMP Manchester. She received a copy of the relevant medical documents upon which she based her findings. She commissioned a further expert review into his methadone prescription conducted by a doctor. However, delays in receiving this report meant that the clinical review was not received into the office until 1 February 2012. It was not possible to publish this report without the clinical review due to the medical aspects of the case so this caused the late publication of this report.

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

11. The investigator returned to Manchester on 19 July, 19 August and 15 September to interview staff.

12. One of the Ombudsman's family liaison officers contacted the man's family at the beginning of the investigation. He informed them of the investigation and offered them the opportunity to raise any questions or concerns they would like addressed during the investigation. The family raised the following issues:

- Was he on a special diet and had he been referred for a liver transplant?
- In what position had he been found in and had he been observed in the same position at earlier checks?
- What medication was he receiving?
- Why was he not in hospital?
- When was the last time he had been seen alive and how often had he been checked through the night?
- Why was he not located in healthcare?

13. It is hoped that the report provides information on these matters, and gives the family greater understanding of his time in custody.

14. Following the publication of the draft report, the office received responses from the National Offender Management Service (NOMS) and the man's family. The response from NOMS to the recommendation is included. The family asked some further questions regarding the care provided to him. The

investigator contacted the clinical reviewer and received further information on the matters raised. This has been included in the report where appropriate.

HMP MANCHESTER

15. HMP Manchester is a category A prison located in the centre of the city. (A category A prison holds prisoners who would be highly dangerous to the public, police or national security if they were to escape. In addition to holding some category A prisoners, Manchester also operates as a local prison serving the courts of the Greater Manchester area. It holds up to 1,269 adult male remand, convicted and sentenced prisoners.

16. Healthcare at HMP Manchester is commissioned by Manchester Mental Health and Social 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.

Methadone prescription at Manchester

17. Methadone is used to treat people entering prison with a dependence on opiates, such as heroin. Any prisoners requiring a methadone prescription need to provide evidence of opiate use, (a urine sample or evidence of withdrawal or both). If it is unclear what amount they were using in the community the methadone dose would be gradually increased until they reached a level they could be safely maintained on. However, if the prison can confirm that the prisoner was taking a certain amount in the community they could be prescribed that amount. (They would confirm this by contacting the pharmacist in the community who has to verify that the individual was on observed consumption and that the last dose was within the previous 72 hours.) They would be reviewed at 13 weeks and, unless there are specific reasons such as being on remand, on a short sentence or health reasons, they would gradually be detoxified. The 'Guidelines for the use of methadone in HMP Manchester' note: "The standard maximum dose in the secure environments is 40ml daily, but can be titrated up to 80ml (or rarely to higher doses) according to the discretion of a drug treatment doctor."

Incentives and Earned Privileges scheme

18. The IEP system is intended to encourage and reward good behaviour in prison. Prison Service Order (PSO) 4000 describes it as follows:

> "The IEP scheme complements the discipline system by rewarding good behaviour. In addition to any local aims, it is intended to encourage prisoners and YOs [young offenders] to behave responsibly, to participate in constructive activity, and to progress through the system. This will foster a more disciplined and controlled, and therefore safer environment for prisoners and staff. It should also contribute to the reduction of re-offending by encouraging prisoners to lead law-abiding, productive and healthy lives."

19. Prisoners are able to move up a level (basic, standard or enhanced) and earn various privileges. Poor behaviour can result in moving down a level or losing privileges. Privileges include association time and extra visits.

Her Majesty's Chief Inspector of Prisons

20. HM Chief Inspector of Prisons' (HMCIP) last inspection of Manchester before the man's death was in July 2009. Following that inspection, HMCIP stated that:

> "Manchester is a complex and large prison, which needs to manage a varied population, including those involved in gang activity. It is commendable that it has managed to retain its local prison focus, and to provide purposeful activity for a large number of prisoners … The focus and direction of its resettlement work needs attention: in particular, the services for drug and alcohol users."

21. HMCIP reported that within healthcare there was evidence of strong support from Manchester PCT. The primary care services had improved and there was access to a range of in-house and visiting specialist clinics. The introduction of Telemedicine (the use of communications technology to diagnose, evaluate and treat patients remotely), which had significantly reduced the number of prisoners going out of the prison for National Health Service (NHS) assessment. The application system within healthcare was not sufficiently robust and there was an absence of, assessment, referral, advice and throughcare services (CARATs). prisoner focus groups, which meant that prisoners were unaware of significant changes in healthcare delivery. The management of external NHS appointments was efficient, and inpatient health provision satisfactory.

22. At the time of the inspection, Manchester was preparing to implement the integrated drug treatment system (IDTS), a national initiative aimed at improving clinical services for drug treatment in prison. [This was subsequently introduced on 1 April 2010.] HMCIP found the current clinical management safe, but treatment options were limited. Drug and alcohol dependent prisoners were located on dedicated units and received a good level of care, but this had not been fully integrated with counselling.

Independent Monitoring Board (IMB)

23. 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 ending February 2010 recognised the work of the prison staff in maintaining standards despite the ongoing need for efficiency savings.

Previous deaths at Manchester

24. Since this office took over responsibility for investigating all deaths in prison custody in 2004, there had been 15 deaths through natural causes at

Manchester prior to that of the man. Another death a few months earlier was also related to drug toxicity. Although his particular circumstances are not similar to that of the other death, the prison will want to consider the findings of each report in this context.

KEY EVENTS

25. The man was born in 1961. He was placed in care aged 16. While in care, his alcohol consumption significantly increased and he did not complete mainstream education. However, at 18, he enrolled in college and gained five O levels and two A levels. While in college he began to use illicit substances, particularly heroin. This drug use was the cause of a lot of his interactions with the criminal justice system. While serving a previous custodial sentence, he completed a significant part of an Open University degree and achieved a diploma in pure mathematics. Following the birth of his son in 2005, he engaged with the community drugs team and continued to do so for the five years prior to imprisonment. He complied with his methadone prescription while in the community.

26. The man appeared at Crown Court on 15 April 2010, charged with serious offences. While in police custody he was prescribed diazepam and dihydrocodeine. (Diazepam can be used to relieve a wide range of conditions including anxiety, and dihydrocodeine is used for pain relief.)

27. The man was remanded into HMP Manchester on 17 April. He underwent a first reception health screen with a nurse. (All prisoners are given a first reception health screen when entering prison. The aim of the screen is to identify any needs or health concerns that the prisoner might have. It includes identifying a prisoner's past medical history.) He discussed his drug use and his current methadone and diazepam prescription in the community. He was then examined by a doctor, who noted his previous interaction with a community drugs team and that he consumed a large amount of alcohol daily. He tested positive for methadone, heroin and benzodiazepines. The doctor prescribed him methadone and benzodiazepines to prevent any withdrawal effects. (Benzodiazepines can be used to treat anxiety and insomnia, among other conditions.) The doctor noted that he did not have any other health problems and referred him to the detoxification team.

28. The man went to "I" wing as a detoxification prisoner. During his first night induction he stated there were no medical conditions staff needed to be aware of and he was given 10ml methadone and 10mg diazepam. (Methadone prescriptions start at a low level if the prison cannot be assured of the amount taken in the community. This is to reduce the chance of an overdose.)

29. The following day, he had a secondary health screen where his basic observations were taken, such as his weight and height. He was also examined by a detoxification doctor who noted in his medical record that he was withdrawing from alcohol and had no history of seizures (although his medical record indicates he was prescribed anti-convulsion drugs in 2008). The doctor confirmed that he had been on a planned methadone prescription in the community. The doctor prescribed alcohol withdrawal drugs, methadone and vitamin supplements.

30. The man engaged with Counselling, Assessment, Referral, Advice and Throughcare services (CARATs), a drug treatment service, and was assessed by a drugs worker on 19 April. The drugs worker recorded that he had hepatitis C (an infectious liver disease) and had an appointment at hospital on 20 April with the hospital consultant overseeing his care. He said methadone helped him with daily life and alcohol helped him shut off. He also told the drugs worker he had liver problems.

31. On 21 April, the man had a joint review with integrated drug treatment system (IDTS) nurse and a member of the CARATs team. (IDTS is a treatment regime aimed to provide prisoners the same treatment options available in the community.) The nurse noted in his medical record that it was his five day review and he was awaiting stability on the methadone programme. He was prescribed 40ml at that point after being gradually increased from 10ml. He was to be reviewed again in two days.

32. A doctor examined the man again the following day. He noted that he was comfortable with his alcohol detoxification, but he experienced drug withdrawal symptoms around midnight and subsequently had trouble sleeping, was restless and twitchy. He requested an increase in his methadone, to which the doctor agreed. His methadone prescription was increased to 50ml for two days and then to 60ml. He had been prescribed 70ml in the community.

33. The man had his seven day detoxification review on 23 April with a detox nurse. She noted that he was doing well on his withdrawal treatment programmes and there were no problems at that time. He completed his alcohol detoxification on 25 April. The following day, a doctor continued his methadone prescription at 60ml. On 29 April, he progressed to “H” wing, where prisoners participate in group work to address substance misuse once their withdrawal symptoms have been controlled. He stayed there for a couple of weeks before being moved to a wing that holds unsentenced prisoners.

34. The man attended an appointment with hepatitis specialist nurse on 13 May. He told the nurse that he had undergone an ultrasound scan the previous month, which she said she would chase up. (Ultrasound scans are a means of visualising the soft tissues of the body to check potential problems.) She made a note that she would also contact the nurse he had seen in the community about his hepatitis. No further medical history was given by him, although he gave his consent for the nurse to contact his doctor in the community.

35. The man had a 28 day detoxification review on 19 May with a nurse and a worker from the CARATs team. He asked to see the detoxification doctor as he felt that 60ml of methadone was not sufficient to control his withdrawal symptoms. He said he still felt pain in his arms and had been on 70ml of methadone in the community. He was advised to put an application in to see the doctor. No other problems were observed or reported.

36. The hepatitis specialist nurse wrote to another prison doctor following an appointment with the man on 20 May. She informed him that, having reviewed his records, she found that liver cirrhosis (scarring of the liver and poor liver function) had been confirmed by an ultrasound scan. The ultrasound also showed that the vein which carries the blood from the bowel and spleen to the liver was enlarged. She said that his hospital consultant felt it was important to do an endoscopy examination to rule out varices (enlarged veins) or to provide appropriate treatment. (An endoscopy is a diagnostic procedure used to examine the inside of a person's body using a thin, long, flexible tube that has a light source and a video camera at one end.) He also had an enlarged bile duct between the liver and the pancreas. The nurse said that she had discussed this with him and he understood his condition and accepted the information.

37. A detoxification doctor assessed the man on 25 May regarding the pain in his arms and insomnia. He said that he wanted to increase his dosage of methadone to match what he had received in the community (70ml) as he felt that would be sufficient to control his withdrawal symptoms. He mentioned he had a court appearance in five weeks time and hoped to be released. If he was, he said he would maintain the dose through the community drugs team that he had engaged with prior to custody. The doctor agreed to increase his methadone prescription to bring it in line with his previous prescription in the community.

38. The man attended an outpatient appointment with the consultant at hospital on 18 June. The consultant noted that he had severe scarring on liver and an increase in the blood pressure in the portal vein. He wrote to HMP Manchester healthcare centre explaining that he was concerned that the man had cancer of the liver and advised that he should be tested further to confirm or deny this.

39. A doctor summarised his appointment with the man on 10 July in his medical record. He made a note of his enlarged portal vein (between the intestines and the liver) and cirrhosis of the liver. The doctor felt that if he were treated, he would need 72 weeks of therapy and would need careful monitoring, with support for his low blood count. He thought that he would need beta-blockers to help manage his enlarged portal vein, as well as an endoscopy. (Certain beta-blockers can be used to lower blood pressure in the portal vein.) The doctor said that he would review him in four to six weeks when he had received further test results. It was his view that he was not ready for treatment as his condition was too risky. He told him that if he were released following his court appearance, he needed to abstain from drugs and alcohol and visit a hospital urgently to start treatment.

40. On 13 July, the man attended court and was sentenced to 12 weeks for common assault. Later that month, he had a CT scan (a computerised tomography scan is a particular type of x-ray to show images of the body) and a MRI scan (magnetic resonance imaging scan is a medical imaging technique to reveal internal body structures) at hospital. The doctor made an entry in his medical record on 29 July that the scan results confirmed

cirrhosis of the liver, with multiple nodules and suspicion of cancer of the liver. (A nodule is a general term for a small growth of tissue.) He noted that portal hypertension had also been confirmed and he needed to take beta-blockers. Further tests were arranged for him to evaluate the extent of his condition.

41. The doctor made a further entry that day saying that the man was upset about the condition of his liver. Given his distress, he was to remain on his current dose of methadone, despite being at the 13 week review stage. (The 'Guidelines for the use of methadone in HMP Manchester' note: "Maintenance may be continued beyond the review whenever detoxification would be likely to cause substantial harm to the physical or mental health of the patient.") She explained to the investigator that he was very upset by the news of his condition:

> " … he was very upset about this finding and that it could possibly be cancer of the liver and very distressed, and that was part of the review at that point. I couldn't see, that was his persisting physical health problem that made me feel that I should not start the detox at that particular time. He was very distressed and he thought he was a terminal case … "

42. The man was said to be happy with the decision not to reduce his methadone prescription. The doctor explained that she was concerned about the effect on his mental health had she insisted on starting detoxification. She said that this did not actually change throughout the rest of his life:

> "I felt the level of his distress at that particular point was too great and it didn't actually change for him actually every time I spoke to him."

43. On 2 August, the man presented himself to the doctor as he had a lump in his left breast that he had noticed three weeks previously. He had no further symptoms and the doctor reassured him that he would review him again in two weeks' time and, if it was still the same, he would make a referral to have it examined.

44. A CARATs worker made an entry in the man's CARATs case record on 27 August that he was struggling to come to terms with his medical issues. The CARATs worker recorded that the clinical team had therefore agreed to maintain him on methadone indefinitely. Two doctors explained to the investigator that the term 'indefinitely' was not really accurate. They explained that there were no plans at that stage to start detoxifying him, but it was not the case that detoxification would never be considered.

45. Following a blood screening appointment on 2 September, the hepatitis specialist nurse wrote a letter to the doctor to say that the beta-blockers made the man feel quite unwell. He described becoming breathless when walking and suffering from hallucinations and nightmares. The doctor had a long discussion with him on 9 September and prescribed Ventolin (an inhaler used to prevent breathing difficulties) for breathlessness. The doctor noted

that he was not suitable for Hepatitis C treatment due to his liver cirrhosis and said that he would write a letter to his solicitors outlining his current condition. He noted that he would probably be admitted to hospital to enable the liver team to review him and carry out further tests.

46. The man was admitted to hospital on 10 September and remained as an inpatient for a week. He had a CT scan and an endoscopy. The doctor wrote to his solicitors while he was in hospital to inform them that he had end-stage liver disease with cirrhosis and possible cancer of the liver. The doctor said that he only had a short life expectancy if the liver team's investigations were not instigated and acted upon urgently. The doctors at the hospital assessed him fit enough to attend court, and he was discharged on 17 September for his trial. The hospital arranged that, depending on the outcome, he could either be re-admitted for further investigation or, if he was released, he could re-admit himself.

47. He was admitted to the prison's healthcare department following his discharge from hospital. He stated on arrival that he did not want to be on the unit and was uncooperative. He said that if he was placed in a single cell he would cause damage and so his television was removed for safety reasons.

48. He asked the doctor for a 10ml increment in his methadone prescription on 30 September. He presented with no withdrawal symptoms and said that the methadone "brings him alive". As he had been stable on 70ml of methadone for some time, the doctor asked him why he thought he needed an increase. He became irritable and said that he was not going to beg for it and he was content to stay on 70ml. The doctor did not alter his prescription and recorded that there was no medical need at that time.

49. The man had another methadone review with another doctor on 4 October, who observed that he was physically unwell and had lost weight. She increased the methadone prescription to 80ml per day and informed him that this was the highest dose she could prescribe. She recalled that he was content with that. She said to the investigator that "it was due to his physical distress and mental distress; he was still thinking that he was going to die from what he thought was liver cancer." The doctor explained that he may have felt like he needed an increase due to the uncomfortable symptoms of his liver disease.

50. Both doctors explained to the investigator that the intention would always be to detoxify someone when they felt it appropriate. However, the first doctor acknowledged: "Although if we'd have had a diagnosis of terminal liver cancer we might have decided it wasn't fair to force him to detox".

51. As he had not received any medical intervention over the previous two weeks, he was to be discharged from healthcare to normal location. He applied for vulnerable prisoner status as he said he was receiving threats from another prisoner on "K" wing regarding his index offence. The application was approved and he was relocated. He was moved to A wing.

A wing is split into two sections. The inner section is for vulnerable and own protection prisoners, the outer section is for sentenced prisoners (kitchen workers). He resided in the inner section. He was said to have settled well on A wing and was employed in the print shop. It was noted in his case note history that he reported to feeling a lot better. He was awarded enhanced level on the Incentives and Earned Privileges scheme, which staff described as well deserved.

52. A doctor made an entry in the man's medical record on 28 October that he was to have a repeat scan six months after the date of his last one. The doctor noted that it was likely that he did not have cancer of the liver. He was still worried about the lump in his breast, so the doctor made a note that he was to be referred to the breast consultant.

53. On 4 November, the man was sentenced to 10 years' imprisonment (this concerned a separate offence to the one he had already been sentenced for). He was shocked at the lengthy sentence.

54. On 8 November, he attended an appointment with his consultant. In a letter to the doctor following the consultation, the consultant said that he had reviewed him with another consultant and they had agreed it did not look like he had cancer of the liver. It was their view, therefore, that he did not need a transplant. Both the consultants noticed that he had significant oesophageal varices (when the veins in the throat swell) and therefore needed to be started on 20mg of beta-blockers twice a day, to be increased to 40mg for the prevention of bleeding. The consultant wrote that he and his colleague felt they should review him in the joint liver clinic and would send an appointment.

55. The man was referred to hospital by another prison doctor regarding the lump in his left breast. The lump was hard and tender and reportedly getting larger. He went to hospital on 24 November. He had an ultrasound scan which showed that the lump was not cancerous and was a secondary problem to his liver condition.

56. He was prescribed water tablets on 23 December as he had increased swelling in his ankles over the previous few weeks. (Water tablets are a diuretic drug used to reduce fluid retention.) The doctor recorded that he was due to have another scan in February following the advice of the liver consultants and that his blood needed to be monitored. (Bloods were taken and monitored monthly including a full blood profile and liver function tests. The results were monitored by both the prison GP and the visiting consultant.)

57. The swelling increased over the next week and caused his legs to become firm and tender. His water tablet prescription was increased on 29 December by a doctor.

58. The man complained of abdominal pain in the evening of 1 January 2011, stating that it was in the "liver area". A nurse examined him in his cell and found that his stomach was distended. He made an appointment for him to

see a doctor the following morning. Another nurse made an entry in the medical record that the man had had numerous call outs to the wing that day and was very uncomfortable and requested the cell door to be left open. He said that he had been given reassurance and a doctor's appointment had been made. He did not appear to be coping well on the wing and if his condition deteriorated staff decided he should be admitted to the inpatient unit.

59. A doctor examined the man the following morning. He noted his medical history and prescribed another water tablet to be combined with the water tablet he was already taking. He also prescribed a drug used to treat stomach acid conditions.

60. The man told a nurse that he did not want admission to the healthcare unit at the present time and that he would tell staff if he felt there were any major medical issues that were not addressed on the wing. He said that the staff on the wing were very helpful and he had friends for support. He was reviewed by a locum doctor on 6 January regarding his swollen legs. There was no obvious cause for the swelling and they were still painful, causing him to suffer from insomnia. The combined water tablet prescription was continued and he was also prescribed sleeping tablets.

61. He was unable to have an endoscopy procedure on 18 January as he was required not to eat or drink before the procedure, but had continued to drink tea. On 19 January, he signed a medical disclaimer stating that he declined any further outside hospital appointments and treatment. He stated he was fully aware of the implications and accepted responsibility for the consequences. He had been due to go to hospital for the endoscopy he had missed, however he drank tea again, which was against the nil by mouth policy.

62. On 20 January, a doctor noted some weight reduction which indicated some improvement in his legs. He asked for sleeping tablets again, which the doctor noted he reluctantly issued and advised him that walking would help further reduce the swelling. The doctor explained to the investigator his reasoning for the prescription of sleeping tablets:

> "I did from time to time prescribe him sleeping tablets and probably at a slightly lower threshold than a lot of other people admittedly but I took his other conditions and illnesses into account."

63. On 22 January, the man complained to a nurse that he was not able to move his left arm and that the right side of his face would not move. When he spoke, the nurse noted that his face was symmetrical and had normal movement. He refused to take his left hand out of his pocket and when the nurse asked him again to move his arm, he became abusive and walked off.

64. A doctor re-referred him to the breast consultants on 2 February as the lump on his chest had increased in size and his skin below the nipple was uneven. There was also a small lump in his right breast.

65. The doctor reviewed his methadone prescription on 3 February. She said that he had been due for a scan the previous week, but it had not taken place. He said he felt generally unwell with regard to his liver disease, although his weight remained the same. It was also noted that he was not suffering from jaundice and his recent liver function tests were only slightly abnormal. They discussed his detoxification from methadone and he stated that he was not ready to do so due to the uncertainty of his liver condition. She suggested a staged reduction, such as 5ml per week, pause for a few weeks and then a further decrease. She said she would see him in five weeks to plan the detoxification course and explained that he would not have any choice at that point due to prison protocol.

66. A nurse examined the man on 11 February as he complained about a headache and swollen legs. She found no cause for concern and encouraged him to elevate his leg to relieve the pressure. He told the nurse that he had not taken beta-blockers for the last seven weeks as they made him paranoid and his Ventolin inhaler leaflet had advised not to. Although he said he was breathless, the nurse found no evidence to suggest that he actually had any breathing difficulties.

67. A doctor reviewed the man's legs on 12 February and noted that he was only taking one of the two prescribed water tablets. The doctor encouraged him to take both. The doctor thought he was suffering from cellulitis (tissue inflammation) and prescribed appropriate medication and a moderate pain relief. On 17 February, he was examined by the locum doctor. He still had swollen legs and, as the cellulitis medication had not been effective, it was changed to an alternative type of antibiotic.

68. On 10 March, the man went to hospital for an endoscopy. The results of the procedure showed that there were two protruding varices (swollen veins) that had increased slightly in size, but were not red and bleeding. He was scheduled to have another endoscopy in a year's time. He also had an MRI scan that month, which showed that the liver cirrhosis had worsened and the spleen was also severely enlarged.

69. A nurse examined him in his cell during evening of 29 March. He complained of pain in the back of his legs and his stomach was still distended. She observed him lying uncomfortably on his bed. His legs had been elevated, with extra pillows to support the back of his legs. His stomach was very swollen. He reported that it had been like that for the last three weeks and said he had been undergoing tests for liver cancer and was awaiting the results. An appointment was booked for him to see the doctor the following day. She gave him reassurance and advised him to continue taking the water tablets that had been prescribed.

70. A doctor assessed the man's condition the next afternoon. He said that he was feeling better, but was unable to sleep. The doctor prescribed sleeping tablets.

71. On 7 April, he attended an appointment with his consultant at hospital. In a letter copied to a doctor following the consultation, the consultant asked if the man was prescribed beta-blockers. He said they made him feel claustrophobic. (Claustrophobia is the fear of being enclosed in small spaces.) The consultant asked him to try them again. He wrote that he had discussed the possibility of a transplant and he was keen to be assessed for it. The consultant planned to refer him to another hospital.

72. A doctor made an entry in the man's medical record on 18 April because his methadone prescription needed to be reviewed. She noted that he was under investigation for possible liver cancer and he was to be continued on 80ml of methadone daily for the time being. He had a drug treatment review on 21 April with the doctor. She recorded that she had discussed him with a consultant, who suggested that he should be on beta-blockers as well as a combined prescription of water tablets. He said that he felt claustrophobic on beta-blockers and was unable to take them. The consultant wrote that his recent liver investigations showed that he was suitable for a liver transplant and he was to go to another hospital in the next few weeks for an assessment. The consultant mentioned to her that the man must come off methadone, as the transplant team would be likely to want this. She recalled the conversation to the investigator:

> " … we discussed his case and he said yes, absolutely, his methadone 'we need to get him off his methadone before his transplant absolutely', if he's going to have a transplant."

73. When the doctor told him this, he became agitated and upset. He said that he did not want to come off his methadone at all and could not contemplate any sort of detoxification. She explained to him that she would reduce his prescription from 80ml to 78ml daily and she would review him in four weeks' time. She noted that at this point the man walked out of the review. The doctor described his reaction to the suggestion that he needed to come off methadone in order to get a liver transplant:

> "I discussed that with him and he couldn't, I don't think he could quite see why I should take his opiates from him. I'm sure he was, I mean he's an intelligent man and I'm sure he understood the case, but he just, he was so dependent on the opiates he sort of couldn't get his mind around the fact that he was to come down. Which I know is slightly sort of contradictory in some ways, but this is often the case with some of our clients, that whatever reasoning you're applying/give and however logical it is, they don't want to come off their opiates."

74. Another doctor reviewed the man on 27 April and assessed that his chest was clear and his heart had sounded normal. He continued his prescription of one of the water tablets and referred him for a blood test. The doctor arranged to review him again in two weeks' time and noted that he would chase a clinic letter for the hospital. He said he still suffered with pain to his nipple and had a long standing lump with no reported discharge. The doctor believed it may have been mastitis (inflammation of breast tissue) and

prescribed a pain relief and anti-inflammatory gel to be applied three times a day.

75. According to the man's medical record, his blood test result was returned on 28 April as 'abnormal'. An appointment was booked to discuss this with a doctor. (During his interview, the doctor stated that the blood tests were taken for another doctor and were to monitor the effectiveness of his treatment.)

76. The man saw a doctor on 10 May, who recorded that his abdomen was becoming more sore and bloated. He increased the prescription of water tablets from one to two per day. He said that he was not sleeping well and requested a sleeping tablet. The doctor prescribed a sleeping tablet for one night.

77. Another doctor reviewed his methadone prescription again on 16 May but did not see him in person. She recorded that he should attend a review later that week, but re-prescribed his methadone at 78ml. On 17 May, another doctor re-prescribed the beta-blockers, to be taken twice a day.

78. A doctor made another entry in the man's medical record on 19 May that he had not been seen and was not in the review book. She wrote that he needed to be seen in two weeks and she re-wrote the prescription for methadone in the meantime. (An appointment was arranged for 31 May but he died before he could attend it.)

79. The man attended hospital for further tests on 24 May 2011. He had a CT and a MRI scan and was waiting for the results. A nurse saw him in the morning, as she gave him his methadone in reception before he was taken to hospital. She said that they had a good chat and he seemed quite upbeat. She confirmed that there were no signs that he was over-sedated on that morning.

80. A doctor wrote in his medical record on 26 May that the man had been reviewed by consultants at hospital and needed to go to another hospital regarding a transplant. The doctor was unable to access any of the test results or letters and there were no clinic letters from the consultants at the hospital on his record. He wrote that he was not taking water tablets and was prescribed 78ml methadone daily.

81. On 27 May, the man wrote to Children and Family Support, with a visiting order. He said that it had been six weeks and two days since he had last seen his son and that, as his health was deteriorating, he would like to see him as soon as possible. He also wrote to his partner that day. He said that he was upset as he had not seen their son recently, but he hoped to see him the following week as he was off school and he had spoken to him the night before. He said that he had put in an application for a video link conversation with his partner and was looking forward to seeing and talking to her properly. He wrote that the longer nights depressed him, as well as being locked up over the weekends, but he was glad he was still able to have a single cell.

He said he was going to see the detoxification doctor that week so he could get his medication down. He finished writing the letter on the afternoon of 29 May, saying that he had just had his medication and was going to post the letter.

82. On 29 May, at approximately 7.00pm, an officer was on night patrol and conducted an initial roll check of "A" wing. (A roll check is when an officer ensures that all prisoners are safely in their cells.) She observed the man in his easy chair watching television. The officer told the investigator that he was alive at that time, but she could not recall if she spoke to him: "I can't say for definite that I spoke to him at the beginning of that night because I know I did speak to him but I can't really say for definite that it was that night". She wrote in her statement following the incident that, there was no reason for her to carry out further checks on him that evening.

83. The officer carried out the final roll count of her night shift at approximately 5.30am the next morning. According to the log, she arrived at his cell at approximately 5.40am. She looked into the cell and saw him in an unresponsive state, slumped to one side in his chair. She told the investigator that he was normally in bed for the morning roll check, so his position made her "take a second look". She radioed for assistance from the Night Orderly Officer (who operationally manages the prison during a night shift) and the healthcare emergency response nurse. An officer responded to the emergency call at 5.44am according to the prison records and was met by the officer who said she could not obtain a response from him. He entered the cell with her. On entering the cell, it was apparent that he had died as, according to the officer's accounts, rigor mortis had set in. Cardio pulmonary resuscitation (CPR) was not undertaken.

84. Two nurses responded to the emergency call at 5.44am, according to the prison records. When they got to the cell, they asked for paramedics to be called to confirm the man's death. The nurses cleaned his face and the paramedics arrived at approximately 5.45am. They carried out an electrocardiogram (ECG) (analysis of the electrical activity in the heart) which showed no signs of life. They pronounced his death at 6.00am. A chaplain later attended the cell and conducted a blessing.

Prisoner Support

85. The prison produced a notice to prisoners to inform them of the death of the man. Those prisoners subject to ACCT procedures were reviewed and listeners and the chaplaincy were available to any who required further support.

Staff Support

86. A hot de-brief was held in the centre office at 7.40am. (This is a meeting of all the staff who were involved in finding of the prisoner.) A summary of events was given by staff with regard to the events leading up to the man being found. The support and care teams were made available to all staff.

Liaison with the man's family

87. The man's wife was in custody at the time of his death. Staff at her prison informed her of his death, on behalf of HMP Manchester. Manchester contacted other members of the family who took his property to them. The prison also arranged and contributed to the cost of the funeral.

ISSUES

Clinical care

Overall judgement

88. The clinical reviewer writes that the man was appropriately assessed and treated when he arrived at Manchester. She writes of the overall care provided to him while in Manchester:

> "He received the appropriate care and treatment from the integrated drugs service for his substance misuse. He received appropriate and current medical treatment for his liver condition. … His level of care was equal to that he would have received in the community."

89. The substance misuse expert who contributed to the clinical review writes:

> "In a general and overall sense I am happy with the level of care provided to him with respect to his drug problem whilst in HMP Manchester. His case presented many difficult and challenging aspects."

90. The man was a physically unwell man who had depended on opiates for years. His liver condition resulted in swollen legs and enlarged veins in his throat. This meant that he was on a number of medications and needed frequent visits to hospital. His methadone prescription was a complicating factor in his health, but one that he was reluctant to give up. However, despite the complexity of his health problems, the clinical reviewer is of the view that, overall, his care was appropriate.

Methadone toxicity

91. The pathologist found that the cause of death was:

> "1a. Chronic liver failure from advanced cirrhosis precipitating methadone toxicity
>
> 2. Chronic intravenous drug abuse and alcohol abuse."

92. The post-mortem tests revealed methadone and EDDP (a methadone metabolite produced when methadone is absorbed) in the man's body. The consultant clinical biochemist who completed the tests wrote in her report:

> "Methadone is present in the blood at a concentration within the range (>1000 microg/l) frequently associated with fatalities. The methadone/EDDP concentration ratio is consistent with ingestion of a large dose of methadone shortly (after two hours) before death but a similar pattern can be found in maintenance therapy with accumulation due to impaired metabolism, either acquired as in liver disease and / or inherited."

93. The pathologist wrote in the post-mortem report:

> "Toxicological testing revealed a high level of methadone in the post mortem blood sample. It is difficult to state precisely what effect this must have had on the man, because he would have been habituated to methadone. … Assuming that the only methadone to which he had access was that which had been prescribed, it is entirely possible, if not likely, that his methadone therapy resulted in a cumulative toxic effect because his chronically damaged liver had lost the ability to metabolise methadone effectively. … Overall, in my opinion, the most likely explanation for the man's death was that his liver failure consequent upon his advanced cirrhosis had progressed to an extent that he developed unexpected toxic symptoms from his methadone maintenance therapy."

The appropriateness of the man's methadone prescription

94. The findings of the pathologist suggest that the high dose of methadone, combined with the man's serious liver condition, is likely to have caused his death. When he entered prison, he was appropriately prescribed methadone consistent with his long-term treatment in the community. The clinical reviewer sought advice from a substance misuse specialist. He writes regarding the decision to begin him on a methadone prescription:

> "Although he was admitted into custody in April 2010 he was a remand prisoner until September 2010 at which time it would appear he went to trial and was found guilty. Maintenance during this time was entirely reasonable."

95. The specialist also suggests that the increase in the man's methadone prescription from 70ml to 80ml was not significant in terms of his eventual death:

> "Although the man's methadone was increased from 70ml to 80ml, that is above the level required to stabilise him in the community, this probably would not have been significant in terms of his death and although many prisoners can settle on lower doses of methadone in prison than outside it is quite possible that the increased stress he was feeling at this time would have rendered him liable to illicit drug use or alcohol use or perhaps self-harm in prison had his methadone not been increased."

The continuation of the man's methadone prescription

96. Prisoners can be given methadone as part of a detoxification or maintenance prescription. A detoxification prescription tapers off slowly so the prisoner's dependence on opiates is slowly reduced. A maintenance prescription keeps prisoners on a steady prescription during their time in custody. This might be done for a number of reasons such as the sentence being too short to safely

detoxify, or the concern that the prisoner will use illicit drugs on release from prison. Prison Service Order 3550 (Clinical service for substance misusers) requires that prison guidelines for maintenance prescriptions include:

> "Criteria for inclusion:
> - maintenance for those on remand or with a short sentence, who have been maintained on methadone in the community and evidence if engaged in community treatment programme and who do not have evidence of using other drugs in addition.
> - pregnant women
> - HIV +ve and terminally ill who are on methadone maintenance."

97. The man, by the time of his death, did not fit any of the above criteria. (Although the post-mortem report confirms that he had liver cancer, he was not treated as terminally ill at the time of his death.) He was maintained on methadone during his time at Manchester. A doctor explained her justification for not reducing his methadone prescription during this time: "I felt the level of his distress at that particular point was too great and it didn't actually change for him actually every time I spoke to him."

98. In their 'Guidelines for the use of methadone in HMP Manchester', the prison provides the following instructions:

> "Maintenance treatment should be offered to all prisoners and a review will take place after 13 weeks. Maintenance may be continued beyond the review whenever detoxification would be likely to cause substantial harm to the physical or mental health of the patient."

99. In addition, the specialist points out that the Updated Guidance for Prison Based Opioid Maintenance Prescribing issued on 30 March 2010 says:

> "a. Prisoners should be made aware from the outset that if they go on to receive a prison sentence of more than 6 months they will be expected to work towards becoming drug free.
> b. There is a requirement that all periods of extended prescribing whether maintenance or gradual reduction regimes are reviewed every three months as a minimum.
> c. There may be occasions when prisoners on longer sentences require consideration of slower reduction regimes because it is considered that any other intervention will have an adverse effect on health. Where longer term prescribing is offered to those whose sentence exceeds 26 weeks it should be explained that at an appropriate time there will be an expectation that the prisoner works towards reducing their dose and that abstinence remains the ultimate goal."

100. The updated guidance and specific circumstances of the man's situation explain why the clinical review considers the substance misuse treatment provided by Manchester was appropriate. The clinical review sums up the

reason for his extended treatment as: “In this case further detoxification was delayed because of adverse affects on his mental health.”

101. In their response to the draft report, the man’s family expressed their view that detoxification from methadone should have been imposed on him. The investigator contacted the specialist, who provided the following further information:

> “Detoxification could theoretically have been forced on him but this would have had very significant risks as well including deliberate self-harm or even suicide or the use of illicit drugs or alcohol in the prison with risk of further liver damage (by alcohol) or accidental overdose (by drugs – because he would lose tolerance to their effects). No means of managing the man’s care would be without its significant risks then, and the usual means of treating a patient in such cases is to decide jointly with them about the best course of treatment provided (as is the case here) it is within accepted guidelines.”

102. In their response to the draft report, the man’s family enquired whether he had received a mental health assessment. The investigator contacted the specialist, who said: “I do not think he was referred for a specialist mental health assessment. This is not unreasonable as the IDTS would be capable themselves of assessing and treating most mental health issues among their patients.”

Methadone and liver disease

103. The man was prescribed methadone while suffering from liver disease. While the clinical review includes the conclusion: “He received appropriate and current medical treatment for his liver condition”, it also makes clear that further checks could have been undertaken:

> “I cannot find evidence that he had an ECG … the IDTS guidelines note that a baseline ECG should be considered in patients with evidence of liver disease. Given that liver impairment both secondary to hepatitis C and alcohol use is not uncommon in the prison population, a protocol should be devised with regard to the management of patients with drug misuse and severe liver disease.”

104. The specialist suggests that consideration should be given to monitoring the levels of serum methadone in prisoners. (This is a means of testing how well methadone is absorbed into the blood.) He suggests that a protocol should be put in place for prisoners with drug misuse and severe liver disease to include reference to responsibility for treatment amongst staff, consideration of in-patient visits, and the use of ECGs.

105. The clinical review also indicates that the hospital staff asked for the man’s urea and electrolytes to be checked daily (a way of checking the health of the kidneys), but there is no evidence that this happened. Although the clinical reviewer does not consider this to have had a detrimental effect on him, it is

important for letters received by the prison to be dealt with appropriately. The clinical reviewer argues that more robust monitoring of his condition would have been appropriate. The following recommendation is made to collate the suggestions made in the clinical review on this issue:

The Head of Healthcare should ensure that sufficient monitoring is put in place for prisoners on methadone prescriptions suffering from serious illnesses.

Was the man taking too much methadone prior to his death?

106. The post-mortem report confirms that the man's death was most likely caused by methadone toxicity. This could have been caused by ingestion of methadone above his prescribed level, or could have been as a result of his liver failing to effectively absorb the methadone. Two doctors said that they would have expected staff to notice the effects of high toxicity in his behaviour, if he had not absorbed methadone properly. For example, they would have expected his speech to be slurred and for him to be over-sedated. However, one doctor told the investigator "None of the nurses or prison officers reported any such signs of toxicity". His personal officer said that she did not see any difference in him in the days before his death.

107. A drug treatment nurse explained the supervised methadone dispensing procedure designed to ensure that prisoners take methadone to try to prevent them secreting it and passing it to other prisoners. (Certain medications are illicitly secreted and traded in prisons.) Prisoners come to the treatment hatch one at a time and are required to have a glass of water before and after taking methadone. This is to minimise the chance of the prisoner secreting the methadone for passing on at a later date. She said that they have approximately a minute with the prisoners and so are able to have a brief talk with them and assess their presentation. She explained that they would watch for signs of over-sedation in a prisoner which would include sleepiness, unsteadiness, blurred eyes and slurred speech. She explained that she had never seen him appear over-sedated and there is no evidence to suggest that he took more than his prescribed dose of methadone.

108. A Senior Officer (SO) worked on A wing at the time of the man's death. She told the investigator that she had never heard anything regarding him illicitly using drugs. There are security information reports regarding him and possible illicit drug use in January and February 2008, but the investigator has not found evidence of this in the months before his death.

109. The SO said that in the last six months, there had been some allegations of prisoners giving their methadone to others. However, she noted that staff were unaware of how this may have happened. She said that there was no evidence beyond the allegations. The investigator was told that, during March, April and May 2011, one security information report had been completed regarding the secretion of methadone for the purpose of selling. (This may be the allegation that the SO referred to.) The investigator was

told that the evidence was uncorroborated and from an untested source and did not identify any specific prisoners.

110. Although illicit drug usage continues to be a challenge for staff across the prison estate, there is no evidence that the man was actively engaged in such behaviour at the time of his death. The investigator asked a number of staff whether he was over-sedated in the days leading up to his death. Each person asked denied ever seeing him in such a state. The nurse who saw him on the morning of 24 May, said that he seemed upbeat and showed no signs of over-sedation. The specialist writes regarding this matter:

> "The view I would have taken in these circumstances then is that with regard to his severe liver disease the man was at risk of accumulation of his methadone. Ideally therefore one would therefore have wanted him to detoxify from methadone but even so forced detoxification would have been non-therapeutic and would, by virtue of increasing the risk of illicit drug or alcohol use, have been worse for his health. If the patient did not feel able to detoxify, one would need therefore to monitor for signs of drug accumulation. This would be done by observing for signs of drowsiness or confusion. All methadone in prison is supervised so that prisoners receiving methadone are seen by nursing staff every day. No concerns appear to have been raised as regards drowsiness or confusion prior to his sudden death."

The man's location

111. The man's family were concerned about his location in the prison and asked why he was not in hospital or in the healthcare unit. One of the prison doctors explained:

> "He was able to walk around, he was able to look after himself, he was able to work. There's absolutely no reason that he should have been on healthcare that I can see."

112. A nurse agreed that he was able to care for himself on the wing and his personal officer explained this: "He was fine; he would get this own meals, get water, go to work, get his treatments. He dealt with his illness his own way." A doctor explained that, had he been in the community, "he would have been in his own home rather than an inpatient in the hospital".

113. The clinical reviewer writes of this matter:

> "The man stayed on the wing as he wished during his illness to have the support of staff and fellow prisoners. If he was in the wider community it is unlikely that he would have been admitted to hospital and he would have been looked after at home."

114. The man wanted to be located on the wing and his wishes were appropriately taken into consideration. He was able to look after himself and encouraged

to be independent. Therefore, he was appropriately located at the time of his death.

115. The man's family, in their response to the draft report, expressed concern that he was not checked at any point prior to 5.30am, when he was found. The investigator put this question to the clinical reviewer who responded:

> "He had a serious medical condition but did not require him to be in hospital care. He was mobile and self caring and did not require any interventions with activities of daily living or any daily health interventions. There had not been any concerns raised by either discipline staff, medical staff or himself for any extra monitoring to be instigated. If he had been in the community he would not have been in hospital and it is very unlikely that any health or social care agency would have checked on him morning and evening. "

The man's diet

116. The man's family asked if he was on a special diet. An officer explained to the investigator: "He was just on a normal diet. Some days he could eat and other days he didn't, it was just each mealtime as it came really". Staff at Manchester confirmed to the investigator that a special diet could have been provided to him had it been considered appropriate.

CONCLUSION

117. The man had been prescribed methadone for many years, and was not prepared to contemplate ending this treatment. He was initially a remand prisoner which meant his methadone prescription was maintained at a high dose. Once he had been sentenced, his health had declined to the extent that the detoxification doctors did not consider it appropriate to mandate his detoxification. It was only at the end of his life, when he was assessed for a liver transplant, that he started a detoxification course.

118. Despite this small reduction in his methadone, he died due to chronic liver failure from advanced cirrhosis precipitating methadone toxicity. The clinical review finds that the substance misuse treatment provided to him was appropriate, although routine checks should have been recorded in accordance with good practice. The investigation found no evidence to suggest that he showed any signs of over-sedation. The care provided was, overall, appropriate and equivalent to what he would have received in the community.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that sufficient monitoring is put in place for prisoners on methadone prescriptions suffering from serious illnesses.

   This recommendation was accepted and the following commentary was provided:

   > "The Head of Healthcare has discussed this with the providers, Manchester Drug Services (MDS), and other stakeholders. An action plan has been implemented to ensure this recommendation is met."