PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent investigations

Investigation into the death of a man at North Manchester General Hospital while a prisoner at HMP Manchester in March 2012

Report by the Prisons and Probation Ombudsman for England and Wales

January 2013

This is the report of an investigation into the death of a man at HMP Manchester who died in March 2012, at Manchester General Hospital. I extend my condolences to his family and others affected by his death

The investigation was carried out by one of my investigators. A clinical reviewer was appointed to produce a review of the clinical care the man received in prison.

The man was sentenced to nine years imprisonment in May 2011. He had been diagnosed with COPD before he went to prison. While in prison his condition deteriorated and on 9 March, after suddenly getting worse, he was taken to Manchester General Hospital where he died.

Overall, the man received a good level of care at HMP Manchester. However, we have identified areas for improvement. These include the need to discuss end of life care fully with terminally ill prisoners. I am also concerned that a seriously ill prisoner, who was susceptible to infection, was sharing a cell with another prisoner who was unwell.

Although the man's family were able to be with him when he died, I believe the prison should have appointed a family liaison officer sooner and notified the family as soon as he was taken to hospital. Finally, I am concerned that the use of restraints applied to the man, when he went to hospital on 9 March, did not reflect the actual risk he presented. Delays in contacting families and inappropriate use of restraints are issues that have been raised in previous death in custody investigations at HMP Manchester.

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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **January 2013**

CONTENTS

SUMMARY

1. The man was convicted of serious offences and was sentenced to nine years imprisonment on 27 May. Following sentencing he was sent to HMP Manchester.

2. In 2006 before coming to prison the man was diagnosed with chronic obstructive pulmonary disease (COPD)[1]. He was already at the end stage of the disease and had a life expectancy of approximately three years, although it was noted that, should the man contract an infection, his health could rapidly decline.

3. At Manchester prison the man suffered several chest infections and exacerbations of his COPD which resulted in him spending time in hospital. His condition was managed by the prison healthcare department which included a multidisciplinary team (MDT) meeting. When his condition deteriorated rapidly, on 9 March 2012, he was admitted to North Manchester General Hospital where he died the next day.

4. Overall, the man's care was well managed by Manchester. We make five recommendations as a result of this report, about prisoners who are at a high risk of infection sharing a cell, risk assessments for the use of restraints and the need to discuss with terminally ill prisoners their wishes about resuscitation. We also recommend that a family liaison officer is appointed for terminally ill prisoners and that families are notified as soon as seriously ill prisoners are taken to hospital.

[1] COPD is also known as emphysema and is a progressive lung disease.

THE INVESTIGATION PROCESS

5. The investigation was opened by one of my investigators on 14 March 2012. He visited the healthcare unit and viewed the man's cell. The investigator met members of the prison management team, staff and prisoners involved in the man's care and a member of the Independent Monitoring Board. He also issued notices announcing the investigation to staff and prisoners asking them to contact another of my investigator with any relevant information. There was no response to the notices.

6. A review of the man's clinical care was carried out by a clinical reviewer, on behalf of Manchester Primary Care Trust (PCT). My investigator was given copies of the man's medical and prison record. The clinical review is annexed to this report.

7. HM Coroner for Manchester was informed of the investigation. The Coroner will be provided with a copy of this report to assist with his enquiries.

8. One of the Ombudsman's family liaison officers wrote to the man's family on 25 April 2012, outlining the purpose of the investigation and inviting them to raise any concerns. His family did not raise any concerns at this stage.

9. The investigation has assessed the main issues involved in the man's care including his diagnosis and treatment, liaison with his family, his location and security arrangements, whether compassionate release was considered and whether appropriate palliative care was provided.

10. As part of the consultation process, the man's family received the draft report. The man's family said they agreed with the recommendations made, chiefly those surrounding family liaison and the use of restraints. The man's family were particularly concerned that they were not told of his deterioration in health at an earlier stage.

11. The report was also sent in draft to the Prison Service. Their response to the recommendations is included on page 15.

HMP MANCHESTER

12. HMP Manchester is a high secure prison near the city centre. It 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.

13. Healthcare at HMP Manchester is provided by Manchester Mental Health and Social Care Trust (MMHSCT). 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. There is a full time doctor supported by a part time doctor and locums, plus qualified general and mental health nurses and healthcare assistants. Specialists in mental health, dental care, opticians and areas of secondary visit the prison regularly.

Her Majesty's Chief Inspectorate of Prisons

14. HM Chief Inspectorate of Prisons (HMCIP) last carried out an inspection of Manchester in September 2011. It reported that health care was generally good and had improved since the previous inspection in July 2009. Primary care services and provision for prisoners with life long conditions were judged to be good. They commented that prisoners had good access to a wide range of clinics run by visiting specialists and were able to have consultations with some external hospital specialists using tele-medicines (appointments by video link).

15. The inspectorate found that although GP appointments were allocated promptly, but there was a high rate of recorded non attendance at GP and other healthcare appointments which needed investigation. HMCIP found that external hospital appointments were not often cancelled and there were good palliative care arrangements.

Independent Monitoring Board

16. All prisons have an Independent Monitoring Board (IMB). Members of the Board are unpaid volunteers from the local community and have full access to the prison. They help to ensure that standards of care and decency are maintained. In their latest annual report covering 1 March 2011, to 12 February 2012, they commented that the palliative care cell which had now been in use for just over a year was "bright clean and very functional" and had "proved to be an asset".

Previous deaths at Manchester

17. The man's is the eighth natural cause death to have occurred at Manchester prison in the last twelve months, including one death that occurred after the man's. In previous deaths at Manchester we have been critical about the use of restraints and delays in contacting the families of seriously ill prisoners taken to hospital. It is disappointing to have to report similar concerns here.

ISSUES

The diagnosis of the man's terminal illness

18. The man was convicted of serious offences in April 2011. He was sentenced to nine years imprisonment and sent to HMP Manchester.

19. In 2006, while in the community, the man had been diagnosed with chronic obstructive pulmonary disease. He was seen as an outpatient at Borders General Hospital, Melrose, Scotland at their respiratory clinic. In June 2008, he underwent a CT scan of his thorax. A report written by a consultant physician in respiratory medicine, said that the CT scan "demonstrated widespread emphysema [COPD] particularly in the upper lobes". At this time he was described as extremely breathless on minimal exertion.

20. After the man's arrest (in June 2010) his solicitors asked the consultant physician to provide a report on his prognosis, the impact on any custodial sentence to his health and the medication/ treatment require. The consultant physician wrote;

> "…given that the man's FEV [the volume of air that can forcibly be blown out in one second, after full inspiration] is just 0.6 litres [low] and especially if he continues to smoke, I would say that his life expectancy is indeed in the order of three years. However, if complications were to arise his life expectancy could be shorter".

21. The clinical reviewer commented that when the man arrived at Manchester prison he was at the end stage of his disease and had a poor prognosis. She raised no concerns about the timeliness of the man's diagnosis.

Informing the man about his condition and treatment

22. The man was aware of his condition before he came into prison. In 2008, he was offered a course of pulmonary rehabilitation which included exercise training, structured education on his condition, advice on how to manage it and group support. A referral was made by a prison doctor at Manchester to Airedale hospital on 30 June 2011 when the man first went to prison on remand. Airedale can provide 'telemedicine' allowing for medical consultations to take place between patients in their home (or in this case prison) via a televised link direct with their consultant in the hospital. Airedale provided information and advice on his condition to the man and healthcare staff this way.

23. Prison Nurse A was responsible for managing prisoners with asthma and respiratory disease at the prison. At interview, she told the clinical reviewer that the man fully understood his diagnosis and prognosis.

24. The clinical reviewer commented that the prison health care team were fully aware of the man's condition and had obtained and recorded the respiratory consultant's report which was written before his imprisonment. They had also

obtained his GP records, which the clinical reviewer described as good practice. We have no concerns about how the man was informed about his condition and treatment.

The man's medical appointments and treatment

25. The man's condition was managed by the prison healthcare department. He was seen by a respiratory consultant at Airedale using the televised link and was referred to outside hospital when his COPD required more intensive medical intervention.

26. A community mental health nurse, A, saw the man on 26 September 2011, because he was having trouble coming to terms with his sentence and was concerned that he would die in prison. The man was seen again by the nurse four weeks later. She discharged him from her care because she considered that his mood was appropriate for his situation and his issues were more about prison and sentence management.

27. The man's condition deteriorated on 4 November 2011 and he was admitted to the prison's inpatient unit. Later that day, he was transferred to North Manchester General Hospital by emergency ambulance. He remained in hospital until 17 November. On 21 November, he was taken back to hospital after complaining of severe pain in his left leg. He was discharged the next day with a diagnosis of deep venous thrombosis (DVT)[2]. The clinical reviewer commented that, following his discharge from hospital, the man was prescribed appropriate medication to thin his blood to help prevent future clotting.

28. After his admission to hospital on 4 November, North Manchester General Hospital prescribed oxygen with a nasal catheter (a tube for the nose) to assist when his COPD got worse. Prison healthcare staff were able to provide the man with an oxygen concentrator for his room[3]. The man was moved to a larger cell to accommodate the extra equipment. The clinical reviewer commented that he was seen by medical staff in a timely manner when his COPD got worse. He was treated appropriately and was also seen by a respiratory consultant when required.

29. A referral was made by North Manchester General Hospital for the man to be assessed for long term oxygen therapy. However, when the cardio respiratory department later contacted the prison to arrange a suitable date for his appointment, healthcare informed the hospital that his oxygen saturation level had now stabilised (at 95% or above). The hospital advised that the referral for long term oxygen therapy was no longer required and he was discharged from their care.

30. The clinical reviewer commented that:

[2] DVT is a blood clot that forms in a vein deep inside a part of the body.

[3] An oxygen concentrator for his room is a safer alternative to oxygen cylinder and enables the patient to self administer oxygen when required.

> "The treatment he [the man] received was appropriate, current and followed NICE guidance for the treatment of COPD. The man was transferred in a timey manner to an outside acute general hospital when he required more intensive treatment for exacerbation of his respiratory disease. He was referred in a timely manner to appropriate medical personnel when he was suffering from acute medical episodes for assessment, diagnosis and treatment".

The man's pain relief and medication

31. When the man arrived at the prison he was already being prescribed phyllocontin, seretide, and salbutamol inhalers for the treatment of his COPD and asthma. Lorazepam was prescribed for depression. While in prison, he was authorised to keep his medication with him.

32. The clinical reviewer considers that the man was prescribed appropriate antibiotics, steroids and inhalers for the management of his COPD. We agree with her findings.

Liaison with the man's family

33. In the early hours on 10 March 2012, hospital staff requested that the man's next of kin should be contacted due to his rapid deterioration. Senior Officer (SO) A tried to contact the man's wife who lived in the Scottish borders by telephone, but without success. He therefore asked the Lothian and Borders Police to attend her address. The man's family were at his bed side when he died. Manchester prison confirmed that they paid for the man's funeral.

34. Good practice would be to appoint a family liaison officer at an early stage when a prisoner is diagnosed with a terminal condition. This provides the family with a single point of contact should they have any concerns about their relative. It would also benefit the prison to have already established a relationship should they need to contact the family in the event of a sudden deterioration and hospitalisation, as they are required to do under Prison Rule 22. This says:

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

35. In the man's case the prison did not begin to attempt to contact his family until alerted by the hospital, in the early hours of 10 March that his next of kin should be contacted. We consider that the man's family should have been contacted, in line with Prison Rule 22, when he was taken to hospital by emergency ambulance on 9 March.

The Governor should ensure the appointment of a family liaison officer when a prisoner is diagnosed with a terminal illness.

The Governor should ensure that the next of kin are immediately contacted when a seriously ill prisoner is admitted to hospital.

The man's location

36. Following an initial period of observation in the prison's in-patient unit the man was moved to a standard prison wing, which he requested. He was a smoker and the inpatient healthcare department was a smoke free environment which he found difficult. Health care staff saw and treated him on the wing and transferred him to inpatient healthcare or outside hospital only when his condition required it. He was allocated a larger cell in health care when he was unwell and needed equipment and more nurse intervention.

37. On 9 March 2012, the man was seen by healthcare following a request from wing staff. He was having difficulty breathing and a note in his medical records states, "pad mate has had a cold and [he] thinks this may have made him worse". The man was given oxygen and his salbutamol inhaler to help ease his breathing.

38. Healthcare staff tried to move him to in-patient healthcare that morning but the man was reluctant because he would not be able to smoke. After his condition deteriorated further he was taken by emergency ambulance to North Manchester General hospital. He remained in hospital until he died.

39. The man's cell mate had suffered with a cold in the days before the man was admitted to hospital on 9 March. Because of his COPD and asthma, the man was prone to catching chest infections. Consideration should have been given to whether it was appropriate for the man to share a cell when his cellmate became unwell.

The Governor and Head of Healthcare should ensure that, when there are significant risks of infection, seriously ill prisoners are allocated single cells.

Compassionate release

40. Early release on compassionate grounds is a means by which prisoners who are seriously ill can be permanently released from custody before their sentence has expired. The criteria for early release for indeterminate sentenced prisoners are set out in Prison Service Order (PSO) 4700. Among the criteria is an expectation that the prisoner is suffering from a terminal illness and death is likely to occur very shortly. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) within the National Offender Management Service (NOMS). Various reports are required to make up the application, including reports by the prison doctor (usually supported by further information from the

hospital consultant or equivalent expert), the prison's probation officer and the Governor.

41. The man was admitted to hospital on 4 November 2011 following a deterioration in his condition. On 15 November, healthcare were advised by the hospital that his condition was improving but he still required two litres of oxygen a day. Prison Nurse B contacted the man's offender supervisor the following day and informed him of the man's condition and poor prognosis. Nurse B explained that in the near future release on temporary license or on compassionate grounds might be required and she suggested that the required paperwork be started. The man's offender supervisor advised Nurse B that he would come and see the man when he was discharged from hospital, but felt that the compassionate release process should be instigated by the man's legal team.

42. On 6 December, Manchester prison held a multidisciplinary team meeting to discuss the man. It was considered at this time that his condition was stable.

43. The man committed his offences in England but at the time of his arrest was resident in Scotland. Because of this, he was under dual supervision by both the English and Scottish authorities. The man's offender supervisor sent an email to Nurse B which stated: "We discussed in November in relation to his 'potentially' being released at some future point on compassionate grounds". In this email the man's offender supervisor re-iterated that the man's legal team needed to start the process, and then be provided with regular reports on the man's worsening condition.

44. There is no further mention of the issue of compassionate release until 8 March 2012 when the man's offender supervisor made a note in the man's offender management file to say that he had received a report about release on compassionate grounds. When asked what this was, the man's offender supervisor said it was a blank application. The man died two days later in hospital before any compassionate release documentation had been completed.

45. Although COPD is a terminal condition, it is often very difficult to predict the length of time a sufferer has left to live. It is therefore unlikely that an application for compassionate release would have been successful for the man before 8 March. The man's deterioration after that time was very rapid and allowed little time for an application to be made and the appropriate assessments completed.

Palliative care plans

46. After the man was discharged from hospital on 17 November, a prison, made a note in the man's medical records stating that a more palliative approach was required. This needed to include a discussion with the man to determine his wishes if his condition further deteriorated.

47. Manchester prison employs a specialist palliative care nurse and uses the Liverpool Care Pathway[4] for the care of the dying. The clinical reviewer commented that, when the man was not experiencing an exacerbation of his COPD, he was reasonably well within the limits of his condition and lived on a residential wing for three months before his death. The man's illness was terminal, but he did not need a palliative care plan at that stage.

48. The nature of the man's medical condition was such that a respiratory infection could cause a rapid deterioration in his health. There is no evidence in his medical records to suggest that a discussion took place with the man to determine his wishes if his health deteriorated, in particular whether he wished to be resuscitated in the event of a cardiac or respiratory arrest.

The Head of Healthcare should ensure that prisoners who are suffering from terminal conditions are consulted about their views on resuscitation in the event of a cardiac or respiratory arrest.

Restraints, security and bed watch

49. The man was taken by emergency ambulance to North Manchester General Hospital on the evening of 9 March 2012. Before his transfer a risk assessment was conducted which showed that the man was regarded as a high risk to the public, low risk to hospital staff and a medium risk of escape. In the risk assessment SO B stated that the man should be double cuffed[5] and escorted by three officers. The restraints could be removed only if the man's condition was considered to be life threatening.

50. On arrival at hospital at 6.47pm, hospital doctors asked for restraints to be removed so that medication could be administered. Escort staff contacted an operational manager, A, to seek permission for the restraints to be removed. The bedwatch log shows that the level of restraints was reduced to an escort chain[6]. At 2.25am on 10 March, hospital staff asked for the man's family to be contacted because his condition had deteriorated further. Escort staff then sought permission to remove restraints because they were hindering the man's medical treatment. The man's restraints were removed but it is unclear from the records what time this happened.

51. The man's risk assessment indicated he was regarded as a high risk to the public. We do not believe this was properly considered. The risk assessment also showed that he had impaired mobility and used a wheelchair due to breathing difficulties on exertion. Due to the man's medical condition, it is difficult to understand how his risk of escape was assessed as medium. The use of double cuffs is equally hard to justify and the presence of three officers should have been more than adequate as a security precaution. The medical condition and mobility of a prisoner needs to be fully considered as part of the

[4] The Liverpool Care Pathway for the Dying Patient (LCP) is a care pathway covering palliative care options for patients in the final days or hours of life. It aims to help doctors and nurses provide quality end-of-life care.
[5] When double cuffs are used one set is applied to the prisoner's wrists and one cuff of the second set is attached to the prisoner and the other to one of the escorting officers.
[6] An escort chain is a long chain with a handcuff at both ends, one for the prisoner and the other attached to an officer.

decision making process and levels of restraints must be proportionate to actual security risk, balanced by considerations of care and decency.

The Governor should ensure that a prisoner's health and mobility and actual risk at the time are fully considered and taken into account in deciding the level of escorts and whether restraints are needed when a prisoner is taken to hospital.

CONCLUSION

52. The man was diagnosed with COPD before he came into prison in June 2010. He had a poor prognosis and was clearly a very unwell man. His condition was appropriately managed by the prison's healthcare department. Following a deterioration in his health he was moved to hospital where he died with his family at his bedside on 10 March 2012. We consider the prison should have appointed a family liaison officer at an earlier stage and contacted the man's family as soon as he was taken to hospital.

53. The man's condition was relatively stable in the months before his death. However, his condition meant that he was susceptible to infection as a respiratory infection could cause a rapid deterioration in his health. We do not believe he should have shared a cell. His deterioration was too rapid for an application for compassionate release to have been made.

54. There is no evidence that a discussion took place with the man to determine his wishes if his condition deteriorated, including whether he wished to be resuscitated.

55. We do not consider that the level of restraints used when the man was taken to hospital was appropriate or necessary for a seriously ill man.

RECOMMENDATIONS

1. The Governor should appoint a family liaison officer when a prisoner is diagnosed with a terminal illness.

   Accepted – Manchester will arrange for an appropriate member of staff to engage with the next of kin or nominated person when a prisoner has been diagnosed as being terminally or seriously ill.

2. The Governor should ensure that the next of kin are contacted immediately when a seriously ill prisoner is admitted to hospital.

   Accepted – When a prisoner is admitted to hospital with a serious illness then their next of kin will be contacted by staff. In cases where prisoners are able to give their consent, they will be consulted prior to their next of kin being contacted.

3. The Governor and Head of Healthcare should ensure that, when there are significant risks of infection, seriously ill prisoners should be allocated single cells.

   Accepted – All cells on the healthcare unit are single cells. If a patient is seriously ill then this is where they will be located. If ever this is not the case then a decision can be made by the GP for a 'medical single cell' on normal location, if clinically indicated.

   The only exception to this would be when staff give consideration to the wishes of the seriously ill prisoner and whether they would take comfort from being located in a cell with another prisoner. If they had been made aware of the risks and had expressed a wish to be allocated a shared cell, then a risk assessment would take place for an appropriate prisoner to be identified to cell share. The suitability for cell-sharing will depend both on the cause of the illness and on the health and well-being of potential cell sharers.

4. The Head of Healthcare should ensure that prisoners who are suffering from terminal conditions are consulted about their views in the event of a cardiac or respiratory arrest.

   Accepted – Staff will continue to monitor patients who have end stage chronic diseases and discuss DNR arrangements with them on an individual basis.

5. The Governor should ensure that a prisoner's health and mobility and actual risk at the time are fully considered and taken into account in deciding the level of escorts and whether restraints are needed when a prisoner is taken to hospital.

   Accepted – The individual risk assessment in relation to application of restraints is completed with consideration to protecting the public at all times and reducing the risk of escape. A risk assessment of the prisoner takes place prior to them leaving the establishment and a decision about the

appropriateness of restraints will be made at this point. A full risk assessment will then take place at the hospital which takes into account the prisoner's current mobility and level of risk. This is reviewed regularly and restraints are removed when considered appropriate.