PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of the man in June 2012 at HMP Manchester

This is a report of an investigation into the death of a man who died in June 2012 at Manchester prison. He was 72 years old. He died from pneumonia and heart disease. I offer my condolences to his family and friends.

A review of the man's clinical care was carried out by a clinical reviewer on behalf of the local Primary Care Trust. Manchester prison cooperated fully with the investigation.

The man was already unwell when he arrived at Manchester prison in February. Shortly after his arrival, he was moved to the prison's healthcare unit where he was well looked after. He was diagnosed with possible lung cancer but was too unwell to have this confirmed. A preliminary post-mortem report confirmed lung cancer. A toxicologist subsequently considered that he might have died from toxic levels of drugs. However, a final post-mortem found that in fact he had not had lung cancer but had died from pneumonia and heart disease. The pathologist considered that the high levels of drugs found in his body at the end of his life were most likely the result of his inability to metabolise them because of multiple organ failure.

The man appears to have had an appropriate standard of healthcare at Manchester. Although diagnosed with suspected lung cancer, which turned out not to be the case, He never received any treatment for cancer. His pain relief was for his vascular problems. The post-mortem concluded that the diagnosis was not surprising and that he was too weak to undergo further exploratory investigations. The clinical reviewer is, therefore, satisfied that it was not inappropriate for the prison to follow the advice of the hospital consultant and not seek further diagnostic tests. However, there was a delay in one earlier referral to hospital and a lack of information from the hospital about his treatment while he was there.

The man made it clear that he preferred to spend the last days of his life in prison rather than hospital. I commend the prison for the sympathetic arrangements they made to support him. Healthcare staff also made good efforts to ensure his family, with whom he had not been in contact for some time, were informed of his illness. In contrast, I am concerned that, on some occasions when he was taken to hospital, restraints were used without a balanced risk assessment to justify their use. This is a matter that I have previously raised at Manchester. However, overall, I am satisfied that he received appropriate care and support at the prison.

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 **August 2013**

CONTENTS

SUMMARY

1. The man was remanded to Manchester prison on 3 February 2012, following allegations of serious offences. His health was assessed during the reception process. It was noted he was elderly and tired, and used a zimmer frame. A doctor established that he had a history of vascular problems and other illnesses for which he was receiving medication.

2. The man did not manage well on the standard prison wing where he was first allocated. He spent much of the day in bed and did not eat or drink much. He was moved to the prison's healthcare inpatient unit for ongoing assessment and treatment. He frequently complained of pains in his legs and suffered with ulcerated feet. On 1 March, a doctor examined him. Blood tests and an X-ray were ordered, and he was referred to see a hospital consultant.

3. On 21 March, a consultant diagnosed the man with suspected lung cancer as well as other vascular problems. Because of his poor health no further tests or investigations were carried out to confirm this.

4. On 19 April, the man collapsed and was admitted to hospital. He remained there until 11 June and, during that time, staff at the prison were told that he was expected to die. However, he seemed to improve and was well enough to undergo a leg graft while in hospital.

5. When the man returned to the prison he initially seemed much better, but his health deteriorated quickly. A Macmillan cancer support team was contacted for advice about his care and he received intensive nursing in the inpatient unit. An end of life pathway was put in place on 21 June before he died. Initially lung cancer was regarded as the cause of death but it was later established that he died from pneumonia and heart disease.

6. The man appears to have received an appropriate standard of care at Manchester. The clinical reviewer is satisfied that it was not inappropriate for the prison to accept the hospital consultant's diagnosis of possible cancer. Indeed, the post-mortem found the diagnosis not to be surprising and that he was too weak to undergo further exploratory tests. However, there was a delay in one earlier referral to hospital and a lack of information from the hospital about his treatment while he was there. We are also concerned that the use of restraints when he went to hospital was not fully justified by a risk assessment. Recommendations are made about these matters.

THE INVESTIGATION PROCESS

7. A Prisons and Probation Ombudsman investigator visited Manchester prison on 28 June. He met members of the prison's management team, members of the Independent Monitoring Board (IMB) and the Head of Healthcare and visited the inpatient unit where the man lived for much of his time at the prison. The lead investigator issued notices to staff and prisoners about the investigation.

8. The local PCT appointed a clinical reviewer to review the clinical care the man received at the prison. The clinical reviewer and investigator visited Manchester on 24 July and interviewed staff. The investigator wrote to the Governor with initial feedback on 31 July.

9. A preliminary post-mortem report was provided by HM Coroner for the City of Manchester. The preliminary post-mortem report indicated that the man died from pneumonia, carcinoma of the lung, ischaemic and valvular heart disease and pseudomembranous colitis. We received the final post–mortem report on 13 February 2013 which concluded that he died from pneumonia and valvular heart disease, and did not have lung cancer. High levels of morphine, codeine, paracetamol and mirtazipine were found in his blood. The toxicologist reported that his death could have been caused by the toxic levels of drugs in his system, but the pathologist thought it was more likely that he died of pneumonia due to heart disease.

10. A copy of our report has been sent to the Coroner.

11. One of the Ombudsman's family liaison officers contacted the man's son to inform him of the purpose of the investigation. He did not identify any specific matters he wished the investigation to address.

12. 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.

HMP MANCHESTER

13. HMP Manchester operates as both a high security prison and as a local prison serving the courts of the Greater Manchester area. It can hold more than 1,200 male remand, convicted and sentenced prisoners.

14. Healthcare at the prison is commissioned by the NHS. There is 24 hour nursing care and the healthcare centre includes an inpatient unit. A range of in-house and visiting specialist clinics are provided. The healthcare team is led by a full time doctor, supported by a part time doctor and locums. Qualified general and mental health nurses and healthcare assistants make up the permanent healthcare team.

Her Majesty's Inspectorate of Prisons (HMIP)

15. HMIP last carried out an inspection of Manchester in September 2011.

16. With regard to healthcare, the report said:

> "Health services had improved. Transition to a new provider was being managed well. Partnership working was very good, with effective clinical governance systems. An up-to-date health needs assessment was being prepared. Improvements had been made to the health care environment and more were under way but a treatment room on E wing was not fit for purpose. Infection control was very effectively managed. Primary care and life-long condition provision was good and there was efficient use of tele medicine and new X-ray facilities. Pharmacy and dental services were good.
>
> Although some prisoners complained about waits to see GPs, the doctor could usually be seen within two days but high rates of non-attendance at health care appointments needed investigation. Prisoners waited too long in health care before and after being seen. Inpatient care had improved. Good palliative care was provided."

17. HMIP also commented on the "constant throughput" of prisoners at Manchester requiring palliative care. They judged that the prison's palliative care and end of life care policy were "compassionate" and there was good partnership working with local hospice services.

Independent Monitoring Board (IMB)

18. Independent Monitoring Boards consist of unpaid volunteers from the local community who monitor day to day life in the prison to help ensure proper standards of care and decency. Manchester IMB published its most recent annual report in May 2012. It covers the period from March 2011 to February 2012.

19. The IMB reported the following on healthcare:

"Healthcare is now provided by Manchester Mental Health and Social Care Trust (MMHSCT). The transition of provision from Manchester Primary Care Trust to MMHSCT went smoothly.

The palliative care cell which has now been in use for just over a year has proved to be an asset. It is a much larger cell than a normal cell. Nurses have more space to give extra care to those prisoners whose needs demand it. There is better facility to hoist patients in and out of bed and/or the shower. It is a bright, clean and very functional room which recently had a new floor installed. Board members on rota duty have spoken to prisoners located there who have made very positive comments about their accommodation."

Previous deaths at Manchester

20. There have been nine deaths from natural causes of Manchester prisoners since the beginning of 2011. The appropriateness of the use of restraints has been raised in previous investigations into deaths from natural causes at Manchester. Similar recommendations are repeated in this investigation.

ISSUES

The diagnosis of the man's terminal illness

21. The man's medical history included a heart murmur (when the heart contracts), left ventricular heart failure (when the heart has lost the ability to pump blood around body tissues) and aortic valve disease (a valve in the heart). His mobility was poor and he used a zimmer frame.

22. On 3 February 2012, the man was remanded to HMP Manchester. In his first two weeks at the prison, wing staff were concerned that he was not eating or drinking much and spent most of his time in his cell. On 16 February, he was admitted to the prison's healthcare inpatient unit for monitoring and assessment.

23. The man was assessed by prison doctors on three occasions in February. He had problems with his feet, which were described as purple and cold to the touch. On 23 February 2012, a doctor noted that he needed a cardiology and vascular referral, but that he was on remand and possibly only at the prison for a short time. The doctor wrote that once he found out how long he would be at Manchester, he would make a decision or notify his GP. There is no record that these referrals were made.

24. On 1 March, another doctor examined the man. He noted that he appeared very lethargic and had no appetite. The doctor recorded that he had a history of cardiac problems. He found that he had low air entry on his right lung and his liver appeared slightly enlarged. He referred him for an appointment with a hospital consultant, asked that he be seen as a priority and that he have an X-ray.

25. A chest X-ray was carried out a week later and the hospital report recorded that the man had a "two and a half centimetre round apparent focal mass projected at the periphery of the left upper lobe. This was associated with a moderate sized right pleural effusion (a build up of fluid between layers of tissue lining the lungs and the chest cavity). The heart appears enlarged". This needed further evaluation by a chest physician and a Computerised Tomography scan (CT scan, a scan that provides detailed images of the body). On 8 March, a doctor made an urgent referral because of suspected lung cancer.

26. On 21 March, a consultant respiratory/palliative physician saw the man at hospital. He noted that he had increased breathlessness, decreased energy and appetite and weight loss over a number of months. He had an abnormal X-ray, and his blood tests showed some anaemia and abnormal liver function. The consultant reviewed the results of a CT scan he had had on 15 March, which showed bilateral effusions (fluid between the lining of the lungs) an enlarged heart and a more focal lesion in the left lung which could be a tumour. The consultant noted that he had peripheral vascular disease (heart disease) and a lung malignancy (lung cancer) was suspected but he was not well enough to undergo any further investigations. He wrote to the man's

solicitor on 5 April to say that it was likely that he had lung cancer as well as vascular disease. He said that the tumour appeared small and was not showing any symptoms, but that the life expectancy for a person with such a tumour was around a year.

27. The final post-mortem report concluded that the man did not have lung cancer and the mark on his lung was attributed to a previous episode of tuberculosis. The post-mortem report indicated that it was not surprising that the lesion was thought to be lung cancer, and he was too weak and frail to undergo exploratory tests to confirm the diagnosis.

28. The toxicologist was concerned that the man had possibly toxic levels of drugs in his blood. The pathologist considered the toxicologist's findings, but concluded that he was probably unable to metabolise the drugs because of his terminal multi-organ failure. The pathologist concluded that it was more likely that he died of pneumonia caused by heart disease, than a medication overdose.

29. Although the man's diagnosis of lung disease was unconfirmed, the hospital consultant decided that he was not well enough to undergo further diagnostic tests. In her revised clinical review, the clinical reviewer concludes that it was appropriate for the prison to follow the advice of a consultant and not request further diagnostic tests, but manage his care as if his diagnosis had been confirmed. The clinical reviewer concludes that community health providers would have followed the advice of hospital consultants as the prison did, so the outcome for him would have been the same if he was in the community.

30. We are satisfied that once the chest X-ray identified that the man had a mass on his lung he was referred to a consultant for further investigation promptly. However, a referral to the cardiology and vascular teams, the need for which was identified by a doctor on 23 February, appears not to have been actioned until he was admitted to hospital on 19 April. It is not clear why the doctor did not make the referral himself and it is of particular importance given his revised cause of death.

The Head of Healthcare should ensure that prisoners are referred for hospital appointments whenever a need is identified by prison doctors.

Informing the man about his condition and treatment

31. The consultant explained to the man at the 21 March appointment that he appeared to have lung cancer which, due to his other health problems, could only be treated palliatively. He asked whether the cancer could have been a result of working in coal mines when he was younger, but the consultant said smoking was the more likely cause.

32. The prison nurse who accompanied the man to the appointment, recorded that she discussed his diagnosis of suspected cancer with him. He said he was feeling okay but wished he had not asked the consultant to explain his condition which had come as a shock. She explained that staff were there to

help him if he wished to discuss anything. A doctor also offered to answer any questions.

33. The consultant saw the man again on 4 April, where it was explained that, although it appeared he had lung cancer, he was not strong enough for an investigative operation. Although the suspicion of cancer was well founded, it was discovered after his death that he did not have cancer. He received no active treatment for lung cancer. The consultant told him that, taking into account his health problems, he probably did not have long to live. A prison nurse spent some time talking to him about his illness. She and other members of staff spent time supporting him and discussed his end of life care plan. The prison doctors spent some time with him explaining his options for resuscitation in the event of a cardiopulmonary arrest. He decided that he would not want to be resuscitated and this was recorded in his medical record.

34. On 13 April, a psychiatrist assessed the man to check how he had been affected by his possible diagnosis. He reported poor sleep and appetite, which the psychiatrist considered understandable in the circumstances. He said his mood had been normal but he felt he was "in a tunnel with a solid wall in front of him". He said he believed that staff were caring for him appropriately. The psychiatrist found no signs of any major mental illness.

35. On 16 April, a doctor spoke to the man about his illness, mood, pain and resuscitation issues. The medical record notes that he had had a change of his mind, was apparently in denial about the seriousness of his condition and asked that resuscitation should be attempted if it became necessary.

36. We are satisfied that the man was given full information about his condition in line with the consultant's diagnosis. Both the medical and nursing staff discussed his diagnosis with him and the care that he would receive. He was supported physically and emotionally. The clinical reviewer finds that he was given timely and appropriate information and that communication with his healthcare staff was at least equal, if not better, than he could have expected in a community setting.

The man's medical appointments and treatment

37. The man had no ongoing hospital appointments for cancer treatment. However, at 12.12 am on 20 April, he was taken to hospital by ambulance after appearing unresponsive and having oxygen administered. He stayed in hospital until he was discharged on 11 June. Healthcare staff at the prison were not given any information about the treatment he had received in hospital or advice about any continuing treatment needs. He said that he had a vascular graft to his legs but there was no further information about this and no evidence of surgery. A prison nurse had to contact the hospital to obtain information about his treatment and needs.

38. The clinical reviewer concludes that the man was seen by medical staff within acceptable timescales and that when he collapsed he was transferred to

outside hospital in a timely manner. However, it is a concern that discharge information was not provided as a matter of course when he left hospital to allow appropriate continuity of care. There is no indication that this affected his care as prison healthcare staff contacted the hospital.

The Head of Healthcare should agree a protocol with local hospitals to ensure that patient information is shared with prison healthcare staff when a prisoner is discharged.

The man's pain relief and medication

39. The man experienced pain from the vascular problems in his lower legs for which he was prescribed oramorph and co-codamol. At the end stage of his illness, the oramorph was changed to diamorphine (an opiod painkiller used for severe pain control). Although the toxicology report indicated some concern about the level in his body when he died, the pathologist was satisfied that this was most likely because he was unable to metabolise them at the end of his life.

40. The man appeared to suffer from difficulties relating to his chest problems three months before he died. He was prescribed diuretics (for water retention) because of the breathlessness at the end stages of his life.

41. On 19 June, the man was referred to community Macmillan nurses for assessment and advice. They visited him on 21 June, and gave advice and equipment to aid his care. They discussed providing a syringe driver to administer pain relief gradually, but meanwhile healthcare inserted Venflon (a drip) to administer morphine. He died before a syringe driver was obtained.

42. The clinical reviewer notes that the man was treated for pain due to his vascular problems rather than possible cancer. Despite the medication he was prescribed, he sometimes complained that he was in pain. The clinical reviewer notes that vascular pain can be very difficult to control and concludes that he received appropriate medication and pain relief which was altered when necessary.

Liaison with the man's family

43. A nurse discovered that the man had four sons and a daughter, but he had had no recent contact with them. Social Services acted as his Appointee (a person given the legal right to act on behalf of an individual when they are unable to act for themselves on account of age, illness or disability). On 10 April, a nurse telephoned his Appointee, who agreed to let his social worker know that he wanted to inform his children about his state of health. The nurse was given telephone numbers for his sister and one of his sons, with whom he had had no contact since 2005. He said he did not want his sister to be informed.

44. The man's Appointee telephoned the nurse the next day and said that this family appreciated that he wanted them to be told about his illness, although

they were no longer in contact. A member of staff at the hospital gave a nurse details of his uncle, with whom he still had contact.

45. After the man's admission to hospital on 20 April, a nurse telephoned the Appointee to update her. A member of the prison's chaplaincy team contacted one of his sons and told him about his father's condition. His son visited him in hospital on 22 April.

46. On 22 June, the prison chaplain and a nurse visited the man's son, who was his nominated next of kin, to break the news of his father's death, but there was no answer at his home. They spoke by telephone later that afternoon. The next day the chaplain spoke to him again. He explained that the prison would contribute towards funeral expenses and that Social Services (as Appointee) and the prison would help to arrange the funeral. Representatives from the prison attended the funeral, which was held on 11 July.

47. We are satisfied that the prison made reasonable efforts to locate, inform and notify members of the man's family about his condition and involve them in his care. They also had regular contact with his appointee.

The man's location

48. For almost all of his time at Manchester, the man lived in the healthcare inpatients unit where his needs were appropriately assessed and met.

49. On 11 April, the man moved to the enhanced care suite in healthcare where his cell door was left open at all times. An officer stayed with him, either just outside the door or in the cell and alerted nurses when he needed help. When he came back from his hospital stay on 11 June he returned to the same arrangements.

50. As the man's condition deteriorated further, he was moved to an adapted cell which had an electric bed with a pressure relieving mattress to alleviate possible bed sores. He had said he did not want to be moved from the prison to hospital. On the night he died, the officer watching over him sat in his cell with him as he knew that death was imminent and he wanted to keep him company and be able to alert healthcare staff quickly if necessary.

51. We consider that the man's location in the inpatient unit was suitable to meet his needs and wishes and allowed a high level of nursing intervention and interaction with other staff.

Compassionate release

52. The man was remanded into custody on 3 February 2012. A notice that bail had been refused on 8 February was noted in his prison file. The reasons for refusal were that the court felt he was likely to re-offend and unlikely to attend court if given bail.

53. Sentenced prisoners who are diagnosed with a terminal illness can apply to be released from prison on compassionate grounds, either temporarily or permanently, subject to strict criteria. Prisoners on remand, such as the man, are not eligible but can apply to the court for release on bail. His solicitor applied for bail before he died but this was turned down because of the seriousness of the charges he was facing. We consider that staff at Manchester did what they could to inform and support his solicitor in applying for bail.

Palliative care plans and end of life pathway

54. The palliative care lead at the prison was notified of the man's diagnosis of suspected cancer on 21 March. A palliative care plan was started which included daily monitoring and assessment.

55. On 11 April, a nurse referred the man to the community Macmillan nurses. Following his hospital admission on 20 April, she telephoned the Macmillan nurses to update them, although they had not visited him at this point.

56. After his discharge from hospital, the man was referred to the Macmillan team again on 19 June. On 21 June, a doctor noted that "he should enter the Liverpool Pathway". (The Liverpool Care Pathway, LCP, is recommended by the Department of Health as a best practice model for care of the dying. It covers palliative care options in the final few days or hours of life.)

57. The clinical reviewer is satisfied, and we agree, that the man had comprehensive assessments and care plans, and received a good standard of care in line with current guidance. Even though it was confirmed after he died that he did not have cancer, the clinical reviewer concludes that the prison delivered suitable palliative care.

58. The nurse in charge had a full understanding of the use of the LCP but the clinical reviewer notes that not all the healthcare staff fully understood the use of the LCP. This did not affect the man's care but the Head of Healthcare will wish to note the clinical reviewer's comments about this.

Restraints, security and bedwatch

59. On 21 March, when the man attended hospital for tests, it was noted in the PER (Person Escort Form) that restraints were used, but there is no risk assessment to explain the decision. When he attended an appointment on 4 April, it was noted in the PER that he was a risk to children but restraints were not used. Again there is no evidence of a risk assessment.

60. When the man was escorted to hospital in the early hours of 20 April, the PER again noted that he was a risk to children. A risk assessment indicated that there were medical reasons why restraints should not be used, and that his medical condition meant that his ability to escape would be restricted. It was noted that, although he was charged with sexual offences, he was a standard prisoner with no adjudication history. He was described as a confused man

whose health was deteriorating. The risk assessment appears incomplete and it is not clear what decision was taken and by whom. A subsequent restraint log shows that restraints were used until 8.00am on 20 April when a governor instructed staff to remove restraints for decency reasons.

61. For the remainder of the man's hospital stay it was agreed that restraints would not be used, but that two prison officers should be present. However, on 29 May at 2.40pm when he attended an ultrasound scan to assess the condition of the arteries in his legs an escort chain was used. (This is a six foot long chain with a handcuff at each end attached to the prisoner and an officer.) The escort chain remained on until he returned to the ward at 3.40pm. There is no explanation or justification for this in the record, other than the officers on duty had spoken to the prison.

62. On 4 June, the man was transferred to another hospital for a scan. An escort chain was used during the transfer, which was removed once he reached the ward. A review of his security arrangements was carried out on 9 June by a senior manager at the prison. Due to his age and medical condition it was concluded that restraints were not necessary. Restraints were not used again after that date.

63. An agreement between the National Offender Management Service (NOMs) and the National Health Service in 2008, covers the use of restraints. It said:

> "Using handcuffs or other restraints on terminally ill or seriously ill prisoners is considered inhumane by the courts, unless justified by security considerations".

64. There were no properly completed risk assessments which took account of the man's health and mobility and how this impacted on his risk to support the use of restraints. Given his poor health and lack of mobility, it is difficult to see how the use of restraints was justified at any time during this period of hospitalisation.

The Governor should ensure that risk assessments for hospital escorts reflect the prisoner's actual risk at the time taking into account his health and mobility and that all risk assessments are fully documented.

RECOMMENDATIONS

To the Governor

1. The Governor should ensure that risk assessments for hospital escorts reflect the prisoner's actual risk at the time taking into account his health and mobility and that all risk assessments are fully documented.

   The prison accepted this recommendation. They said:

   "The individual risk assessment in relation to application of restraints is completed with consideration to the prison service's primary objective of protecting the public at all times and reducing the risk of escape. A risk assessment of the prisoner takes place prior to him leaving the establishment. Unless there is a medical requirement the assessment remains in place until such times that they are located in the hospital whereupon a full assessment will take place which takes into account the prisoner's mobility and level of risk. An escorting chain will be applied at the earliest opportunity and restraints are removed completely if medical intervention necessitates it."

To the Head of Healthcare:

2. The Head of Healthcare should ensure that prisoners are referred for hospital appointments whenever a need is identified by prison doctors.

   The prison did not accept this recommendation. They said:

   "The doctor's System One entry is as follows – I saw the man today in Inpatients. His memory is clearly poor. Needs cardiology referral and vascular from here. On remand at the moment – when I find out how long here I will make a decision, If only here for a short time I will notify his GP.

   HMP Manchester state that this demonstrates on 23 February 2012, a full decision had not yet been made as to whether these referrals were appropriate."

   The PPO has reflected this in the chronology, but as no subsequent referral appears to have been made at any stage, the recommendation still stands.

3. The Head of Healthcare should agree a protocol with local hospitals to ensure that patient information is shared with prison healthcare staff when a patient is discharged.

   The prison accepted this recommendation. They said:

“We have been working closely with the discharge project team at the hospital to ensure communication around discharge is optimal. All hospitals should furnish the patient with interim discharge information.”