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

Report by the Prisons and Probation Ombudsman for England and Wales

July 2012

This is the report of an investigation into the circumstances surrounding the death of a man, a prisoner at HMP Manchester. He died of a rare heart condition (pericarditis) in August 2011. I offer my condolences to his family and others affected by his death.

The investigation was carried out by an investigator. The local Primary Care Trust (PCT) appointed a clinical reviewer to conduct a clinical review into the standard of healthcare the man received while in custody at HMP Manchester. Manchester prison cooperated fully with the investigation. I apologise for the delay in issuing this report.

During the short time the man spent at Manchester, he had little contact with the healthcare services. He was found collapsed in his cell in August, and he was taken to hospital later that day. His condition continued to deteriorate and he was moved to the intensive care unit. The hospital staff informed the escorting prison officers that his condition was critical, and his family needed to be informed. Unfortunately, his condition declined rapidly and he was pronounced dead before his family could see him.

According to the clinical review, the level of care the man received while at HMP Manchester was equal to that which he could have expected to receive in the community. He had a history of substance misuse and lost weight while in prison. However, his death was sudden and the result of a rare condition which is difficult to diagnose and about which he displayed few symptoms. Accordingly, the clinical review concludes that this could not reasonably have been foreseen or prevented by staff at HMP Manchester. However, the investigation does draw attention to the serious delays in letting his family know that he was very ill in hospital. While there were problems with the contact number which he provided, this should not have prevented the prison informing them at an earlier stage. I also consider the level of restraints used was not always justified by level of evident risk posed by him.

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 **July 2012**

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SUMMARY

1. The man was serving an eight month sentence at HMP Manchester. He was a long term heroin user and an alcoholic. When he first arrived at Manchester on 24 May 2011, he started a methadone maintenance programme and completed a ten day alcohol detoxification programme.

2. During the short time he spent at Manchester, he had little contact with healthcare services. He took his methadone as prescribed and occasionally requested paracetamol for headaches related to a head injury he had sustained some years previously.

3. On 10 August, the man was examined by a doctor. His blood pressure was checked, which was in the lower end of the “ideal” range, and he had lost almost 6 kilograms (kg) since May. The doctor was concerned about a possible underlying illness and referred him for a blood test and an urgent chest X-ray. He did not attend for the blood test and the chest X-ray was due two weeks later, on 25 August.

4. The man attended education at approximately 9.30am on the morning of 25 August. He said he felt unwell and asked to return to his cell, where he was found collapsed at about 11.20am. Two officers and two nurses assisted him to the healthcare centre so he could be examined by a doctor. The doctor examined him and due to his condition, advised that he should be taken to hospital, which he reluctantly agreed to.

5. All prisoners who leave hospital for external healthcare services are subject to a risk assessment. Despite being assessed as medium to low risk, in line with a risk assessment completed on 18 August, but signed off on 25 August, the man was taken to hospital escorted by two officers using double cuffs.

6. Hospital doctors were unsure of his diagnosis but his condition was assessed as serious and he was admitted to hospital. The following day he was moved to the intensive care unit (ICU), as his condition continued to decline. His restraints were removed and the officers who were with him were advised that his family should be told that his condition was critical. Unfortunately, his condition deteriorated rapidly and he was pronounced dead before his family could see him.

7. The clinical review shows that the level of care the man received while at HMP Manchester was equal to that which he could have expected to receive in the community. Pericarditis[1] is an uncommon condition and he did not have any of the symptoms associated with it.

8. As the man was presenting with non-specific symptoms, it was appropriate for him to have been referred for investigative tests. Pericarditis is a condition that can be hard to diagnose and he did not have the symptoms usually associated with it, so we agree with the clinical reviewer’s assessment that

[1] Inflammation of the fluid filled sac that surrounds the heart.

medical professionals at Manchester would not have been able to foresee or prevent his death.

9. The man's family should have been informed of his admission to hospital when his condition declined. Although efforts were made to contact his next of kin shortly before his death, the appropriate Prison Rule and protocols were not followed. Had they been, he might have seen his family before he died.

THE INVESTIGATION PROCESS

10. The Ombudsman's office was formally notified of the man's death on 27 August 2011. Notices were subsequently issued to staff and prisoners at HMP Manchester to inform them of the investigation process and asking anyone who had information relevant to the investigation to contact the investigator. No one responded to these notices.

11. HM Coroner for City of Manchester District was informed of the investigation. The investigator also requested a copy of the post-mortem report. A copy of the investigation report will be sent to the Coroner to assist his enquiries.

12. A clinical reviewer was appointed by the local Primary Care Trust (PCT) to conduct a clinical review of the care the man received in custody. She received copies of all relevant medical and prison documentation relating to him. HMP Manchester was tardy in organising interviews. This delayed the investigation, and affected the timeliness of the clinical review which we received on 30 March 2012.

13. Manchester police conducted an investigation following the death of the man. Their investigation concluded that there was no third party involvement in his death.

14. The investigator received all documentation relating to the man's time in custody. She reviewed prison and health records and liaised with the Governor throughout the course of the investigation. She informed him of her preliminary findings. On 15 and 16 November 2011 and 24 and 25 January 2012, both she and the clinical reviewer interviewed four officers, five healthcare staff and a member of the chaplaincy who had been involved in the man's care.

15. One of the Ombudsman's family liaison officers (FLO) contacted the man's family shortly after his death. She explained the investigation process and invited them to ask any questions about his care. His family's concerns are listed as follows:

    - During visits, his partner noticed that he had lost weight, and his complexion had become yellow. His family would like to know if he was having the correct treatment and if anyone in the prison had noticed the deterioration of his health. This issue is addressed in paragraph 90**.**

    - The police told the family that he was in hospital and that he was dying. His family were concerned that they were not told about his condition or contacted when he was admitted to hospital. This issue is covered in paragraphs 91 to 103**.**

    - His partner was concerned that she had to wait for his property to be returned. We understand that his property was returned to his family on 4 November 2011, which we agree was an unreasonable delay.

- The family asked if an alleged assault just before he died contributed to his death. The findings of the associated police investigation are explained at the end of the key events section.

16. The man's family received a copy of the draft report as part of the consultation period. They highlighted their disappointment that the suspended nurse was not interviewed, given that she provided treatment to his prior to his death, this is referred to in paragraph 43 of the report. They would like to comment that he would never say one of his daughters had died as he loved them both dearly. They also commented about him being allowed to wear his coat in prison, particularly as this was against prison policy. This has been clarified in paragraph 52.

17. The report was also issued for consultation with the Prison Service. The responses have been reflected in the final report.

HMP MANCHESTER

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

19. Healthcare at HMP Manchester is commissioned by the local PCT. 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.

Integrated drug treatment system (IDTS)

20. The integrated drug treatment system (IDTS) aims to increase the volume and quality of substance misuse treatment available to prisoners, with particular emphasis on: early custody; improving the integration between clinical and Counselling, Assessment, Referral, Advice and Throughcare services (CARATs); and reinforcing continuity of care from the community into prison, between prisons, and on release into the community.

21. The man was on methadone maintenance, a heroin substitute, while at Manchester. According to the IDTS policy, prisoners requiring a methadone prescription need to provide evidence of opiate use, either a urine sample or evidence of withdrawal or both. If it is unclear what amount they were prescribed in the community, the methadone dose would initially be very low and then gradually increased until it reached a level at which the prisoner can be safely maintained. However, the prison can continue a confirmed prescription from the community. This would be reviewed at five to seven days, at six weeks and at twelve weeks. There will then be a review every thirteen weeks for those remaining on treatment and, unless there are specific reasons such as being on remand, on a short sentence or health reasons, they would gradually be detoxified.

Counselling, Assessment, Referral, Advice and Throughcare services (CARATs)

22. CARATs workers run programmes and offer counselling and support for those addressing substance misuse in prison. They can also make referrals to rehabilitation centres for prisoners on release.

Assessment, Care in Custody and Teamwork (ACCT)

23. The ACCT system is a Prison Service-wide process for supporting and monitoring those prisoners thought to be at risk of harming themselves. An ACCT plan can be opened by anyone working in the prison if they have any concerns that a prisoner might have tried, or, in the future, might try to harm himself.

Her Majesty's Chief Inspector of Prisons

24. HM Chief Inspector of Prisons (HMCIP) last carried out an unannounced full follow-up inspection of Manchester in September 2011. In the report, the inspectorate reported that:

> "Health care was generally very good and we identified a number of points of good practice. In particular, the emphasis on improvement and good staff-prisoner relationships created the conditions for good quality care."

25. The inspectorate reported that more prisoners than in 2009 were satisfied with the overall quality of health care. NHS re-organisation had meant that services were in transition but this was being managed well to ensure continuity. Despite doctor appointments being allocated quickly following applications from prisoners, there was a high record of non-attendance and there were many complaints from prisoners that they were not being taken to their appointments.

Previous deaths at Manchester

26. In the last two years, there have been five deaths through natural causes at Manchester, before the man's. A recommendation has also been made in a previous investigation report regarding the removal of restraints. An investigation into a death shortly after his also highlighted a delay telling a prisoner's next of kin that he had been admitted to hospital with a serious illness.

KEY EVENTS

27. The man was sentenced to eight months imprisonment on 24 May 2011 and was sent to HMP Manchester. It was not his first time in prison.

28. He underwent a first reception health screen with a nurse. She noted in his medical record that he appeared settled and did not raise any concerns. He said that he was addicted to heroin and an alcoholic. He was also a smoker. The nurse referred him to the doctor for further assessment of his substance misuse and recorded his weight, which was 63kg.

29. The man saw another nurse once he had finished his health screen. He told her that he felt ill when he did not drink alcohol and he felt ill at the time of the screen. She noted in his medical record that he appeared slightly agitated and had told her that he had last used drugs before going to court that morning. She recorded that he was not presenting with any withdrawal symptoms and was unable to give a urine sample. He was booked to see the detoxification doctor the following morning and moved to the detoxification wing.

30. A doctor assessed him the next morning. It was noted in his medical record that he had provided a urine sample that had tested positive for morphine[2] . The doctor started him on a methadone[3] stabilisation programme over the next five days, increasing his dose gradually from 10 millilitres (ml) to 40ml. He also started on a ten day alcohol detoxification programme and was prescribed chlordiazepoxide[4], ascorbic acid[5] and thiamine[6]. The doctor advised that he was to have a blood test to monitor his liver function due to the amount of alcohol that he had been consuming.

31. On 31 May, the man had a five day review with a CARATs worker. According to his medical record, he had said he was "very depressed and emotional". He was advised to apply for a doctor's appointment and to speak with a member of chaplaincy, which he agreed to do. No further concerns were noted and he completed his alcohol detoxification programme the following day.

32. On 3 June, a doctor reviewed his blood test results. His renal profile and liver function test were said to be "abnormal, but expected" and no further action was to be taken. During interview with the investigator, the doctor explained:

    > "This is a man who drank alcohol very heavily; it was shortly after his admission and he has slight abnormalities in his liver function test, in his liver profile … So on 3 June, so he's only been in a few days, he's still

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[2] Morphine is a strong opiate pain relief.
[3] Methadone is used as a substitute to heroin.
[4] Used for short term relief of anxiety symptoms associated with alcohol withdrawal.
[5] A vitamin C supplement, which helps the body repair itself and boosts the immune system.
[6] A vitamin B supplement that helps maintain proper functioning of the heart, and the nervous and digestive systems.

doing his detox, it's not something I get particularly worried or concerned about."

33. Later that day, an officer spoke to the man, who told him that he was nine days into his methadone maintenance programme and was missing his children. The officer subsequently opened an ACCT monitoring document out of concern that he might harm himself. He was offered support, for example from a Listener[7], and was reviewed weekly. A couple of weeks later he said he felt more settled and "was OK". The ACCT document was then closed and the avenues of support that were available to him were reiterated.

34. On 7 June, the man moved to a wing that provided group work for prisoners who have completed their detoxification programmes. A doctor made an entry in his medical record that day regarding a methadone review. He did not examine or assess him, however it was recorded that he was to continue on the 30ml dose that he was currently taking.

35. The man had a 28 day substance misuse review with a CARATs worker and an IDTS nurse on 22 June. According to his medical record, he felt his current dose of methadone was therapeutic and he did not want any further intervention from the CARATs team, as he was due to be released in September. The nurse explained to the investigator that working with CARATs was voluntary, and they would then only see patients during reviews and at medication times. She described him as a quiet person who did not seek active care or intervention. She said like most drug users he was not in the best of health but, other than a grey complexion, he did not look unwell.

36. During the evening of 28 June, the man pressed his cell bell. An officer responded and he told him that he was feeling "low in mood" and had been experiencing thoughts of suicide. The officer subsequently opened another ACCT document. He was again offered additional support and he applied for full time education to help minimise the amount of time he was alone in his cell. He was referred back to the CARATs team to appoint a community drug worker for when he was to be released.

37. According to the man's medical record, he complained of a headache on 2 July. He said that he did not have any neck pain and was not drowsy. He was given two paracetamol tablets and was advised to see a doctor if his symptoms persisted.

38. Following a threat to self harm on 6 July, his ACCT observations were increased. He was seen by a mental health nurse the following morning and he agreed to speak to staff if he felt like self harming again.

39. The ACCT document remained open for a further three weeks. It was closed as a result of "an upturn in his outlook and mood". He was again advised of the support mechanisms that were available to him. During an ACCT post

[7] A Samaritans supported Listener scheme in place for prisoners who are in distress or crisis and need to talk in confidence. Listeners are prisoners who have volunteered for the role and have been trained by the Samaritans.

closure review, he said that his sleep pattern was much better and he was seeing the Mental Health In-Reach Team[8]. It was recorded that he had reached all his care goals and he said that he felt he could talk to staff on the wing about how he was feeling.

40. During the morning of 8 July, the man became unsettled and wanted to be moved to the vulnerable prisoner (VP) unit[9]. He was under the impression that his safety was under threat, due to a letter he had received from another prisoner.

41. An officer went to his cell to inform him that he would be moving to another wing. Another officer told the investigator that at this point, the man was demanding to be let out of his cell. He then tried to push past the first officer. The officer and a Principal Officer (PO) made their way to his cell to assist the first officer in restraining him and moving him to the segregation unit[10].

42. The PO was responsible for observing the control and restraint to check the correct procedures and control techniques were being used. During the move, he became concerned about the man's breathing. He was in a bent over position, which is often used during control and restraint procedures, but his breathing was laboured. The PO, aware of the possible dangers, ordered the restraint to be stopped, and he was put into the recovery position. Staff were told to remain vigilant, in case he needed to be put back under restraint.

43. The PO requested medical assistance and the on-call emergency nurse arrived a few minutes later. They asked the man how he was feeling, checked his breathing and took his blood pressure. There is no entry in his medical record about the interactions the nurse had with him. The investigator was told that the nurse has been suspended from duty, for reasons unrelated to this investigation, so she was not interviewed. After the restraints had been removed and he had been examined by the nurse, he appeared to relax and his breathing seemed to settle. He walked, unrestrained, to the segregation unit. He was examined by staff and then moved straight to the VP unit.

44. On 11 July, the man was moved to another VP unit and continued to be maintained on a 30ml dose of methadone daily. The following day, he complained of a headache. He was not suffering from any neck pain or drowsiness and was issued paracetamol. He was again advised that, if his symptoms persisted, he should see the doctor.

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[8] The Mental Health Team look after prisoners who have been identified as having mental health problems. All prisoners who have been identified are seen and assessed by the Primary Mental Health Team. The Secondary Team deal with prisoners who are identified as having severe and enduring mental illness. (Amended following the NOMS feedback)

[9] A prisoner can be separated from the main prison population at their own request. This can be for reasons relating to their offence or any feelings of vulnerability.

[10] Prisoners are moved to the segregation unit following a control and restraint. This is to help de-escalate the situation before moving them to more appropriate accommodation.

45. On 15 July, the man told an officer that he needed to speak to a member of the chaplaincy team. He said that a few days previously he had found out from his solicitor that his daughter had died. A further entry later that day by another officer said that he seemed "bizarre". His solicitor told the investigator that he had spoken to him via video link on 12 July. During this meeting, he told him that he did not have any grounds to appeal his sentence. The solicitor said he was then contacted by a member of the chaplaincy team on 15 July. He was in the office with the member of chaplaincy during their telephone conversation. He confirmed that he had seen him via video link a few days previously and told him that he was not able to appeal his sentence. He explained that he had definitely not said his daughter had died.

46. The man was assessed by a doctor on 20 July in relation to the headaches that he had been experiencing. He told the doctor that he often suffered with headaches as a result of a head injury some years previously. He requested paracetamol, which the doctor issued. He also said that he was having trouble sleeping. He was waking during the night and would end up reading or watching television. The doctor gave him advice regarding his sleeping pattern, which he agreed to try, before being reviewed in a few weeks time. The doctor told the investigator during interview that:

> "I've not written down an examination, but generally I would, if it was an acute head or an acute headache or whatever, I would normally go through all the cranial nerves and blood pressure and things like that."

He went on to say that he thought paracetamol would treat the man's headaches and they discussed his sleep pattern.

47. The man was scheduled to attend a follow up appointment with a doctor on 26 July. His medical record shows that he did not attend this appointment, but no reason was recorded.

48. All prisoners' telephone calls are recorded and stored for 90 days, although not all calls are transcribed. His telephone calls were transcribed following his death, which is usual following a death in custody. On 3 August, he told his partner that he had been having to force food down. The investigator asked staff about his weight and his appearance. A nurse explained:

> "He was a very slim built man but most people who take opiates are because they don't tend to eat very well.
>
> "It's difficult to monitor weight because they do come in painfully thin so you know you do tend to see weight gain but usually after the first month and by that point their metabolism have sorted themselves out and that's when we usually tend to see any gain in weight. By that point [the man] was on A wing anyway with very little contact from the IDTS team, morning medication administration and such. But he didn't appear to be losing weight he just seemed to stay stable but he didn't look as under-weight as some that came in."

49. The man attended an appointment with a doctor on 10 August. He again requested paracetamol for intermittent headaches. His blood pressure was checked, which was in the lower end of the "ideal" range, and his weight was recorded as 56.7kg, a loss of nearly 6kg since May. He said that he was not experiencing any diarrhoea or vomiting and that he did not like the food served at Manchester.

50. The doctor examined him and found that his chest was clear and his abdomen was soft. He was to have a routine blood test and was issued paracetamol. The doctor referred him for an urgent chest X-ray and planned a review two weeks later with the test results. His medical record shows that he did not attend for the blood test. The doctor said that although he was quite well he examined him, his blood pressure was slightly low and he had been concerned about how thin he was. He decided blood tests and an X-ray were necessary to see if there was any underlying cause.

51. The man missed his methadone dose on 11 August. He had been on the wing, but had walked straight past the treatment hatch[11]. The entry in his medical record said that he had been told before about missing his treatment before going to work as it was then classed as refusal. A nurse explained to the investigator that the nurses follow up prisoners who miss their dose to find out why. If they miss two consecutive doses, then the prisoner is referred to the doctor to discuss their prescription. According to his records, he did not miss two consecutive doses of methadone. She said that methadone stays in a person's system for 36 hours; therefore it is not likely that he would have felt any ill effect from missing a dose.

52. During a telephone call with his daughter on 20 August, the man said that he had "gone like a skeleton" and was not happy about it. (As the telephone calls between him and his family were transcribed after he had died, staff would not have heard him talking about how much weight he had lost.) The investigator asked officers and nurses about his appearance. No-one, apart from a doctor, had raised any concerns and explained that he wore a big coat when he was walking around, which hid his frame. We are surprised that he was allowed to wear a coat in the prison. Subsequent to issuing the draft report, we received Manchester's facilities list which shows what prisoners are allowed in prison. The list shows that "hooded jackets" are not allowed and it is believed he had a coat without a hood. Staff also said he did not look jaundiced[12], but described him as pale and looked like he needed a rest. There are no entries in his medical record to suggest that any medical professionals thought he appeared jaundiced.

53. On 24 August, the man spoke to his partner and daughter on the telephone. He said that he was not getting any "trouble", staff had sorted things out for him and he was happy. He said that he had a new cell mate, but was feeling a bit drained.

[11] Where prisoners go to collect their medications at specific times during the day. It is on the wing and is staffed by nurses who dispense the medications.
[12] Yellow colour of the skin or eyes. It can be a symptom of health problems.

54. Also on 24 August, a doctor prescribed the man Gaviscon[13]. There is no indication in his medical record to explain why he needed Gaviscon. The doctor told the investigating police officers following his death that he did not see or examine him and he prescribed the Gaviscon in response to a medication request. There is no information in his medical record to say who had made the request.

Events of August 2011

55. The man attended morning education on 25 August at about 9.30am. During education he complained that he was not feeling well and returned to his cell. A Senior Officer (SO), who works on his wing, told the investigator that another prisoner told her that he had gone back to his cell. She said that this was very unlike him, as he hated being in his cell. About half an hour later, a prisoner informed her that he had collapsed in his cell.

56. The SO and an officer went to his cell and found him sitting on the cell floor, against the pipes. The SO told the investigator that he said he went a bit dizzy but he appeared to be struggling to breathe. The officer, who had a medical background, tried to take his pulse but could not get a reading as his pulse was racing. The officer radioed for a nurse to attend urgently.

57. The SO said the man did not have his big coat on and it was apparent how much weight he had lost. He was a slim man anyway and struggled to find trousers to fit him at the waist, but when she saw him in his cell she could see the outline of his ribs. She said that he was still able to talk.

58. A nurse responded as the emergency response nurse, along with another nurse to support her because she was new to the role. She explained to the investigator that the man looked unwell and very thin and fatigued. After taking his observations, she and the SO took him to healthcare. He was able to get himself up off the floor and walk over to the healthcare centre unaided, but very slowly. He got there at about 11.20am. The nurse did not make an entry in his medical record about her interactions with him as the emergency nurse. She said that she had made a joint entry with the doctor and had been told she did not need to make a separate entry.

59. A doctor examined him and noted that he was feeling weak and tired. His weight was 57kg, his chest was clear, and urgent blood tests were requested.

60. The man was reluctant to go to hospital and had to be persuaded by the doctor. During the consultation, escort services arrived to take him for the chest X-ray for which he had been referred two weeks previously. The doctor assured him that he would have further tests at hospital and they needed to establish what was causing his symptoms. He reluctantly agreed and was taken to hospital. The doctor told the investigator that he appeared quite unwell compared to when he saw him on 10 August. He took a detailed

[13] Used to relieve indigestion and heartburn.

history from him and was so concerned about his weight loss that he decided he needed to go to hospital.

61. An escort risk assessment had been completed on 18 August, in preparation for the hospital escort for his chest X-ray. The medical assessment on the form was not completed or signed. No other section was updated, and he was recorded as a medium to low risk. A senior manager signed the form which required the use of double cuffs and two officers to escort him to hospital.

62. The man was taken to hospital at 1.00pm and arrived ten minutes later. He was admitted as an inpatient. Later that evening, the officers accompanying him were asked to put masks on covering their mouths and sit outside his room, as it was suspected that he might have been suffering from tuberculosis[14]. There is no record that the escort risk assessment was revisited and he remained in double cuffs. Extra escort chains[15] were requested from Manchester to enable staff to sit outside the room.

63. During the early hours the man was moved to the infectious diseases ward. It was noted that his condition was deteriorating. There is no information to suggest that the prison's security department were informed of his deterioration or that consideration was given to informing his family, or reviewing his escort risk assessment.

64. The man asked to return to the prison. He was assured by the bedwatch officers that once he was well enough to do so, he would be discharged and would be able to return to his wing. He was assessed by a doctor at 8.00am. The doctor thought that he had pneumonia and said that he would have to stay in hospital for a few days.

65. A nurse from Manchester prison made an entry in his prison medical record at 8.45am. She wrote that she had telephoned his ward and spoken to hospital staff about his well being. She was told that they did not have a diagnosis and did not think his restraints needed to be removed, but suggested his family should be told about his condition. The hospital told the nurse that he could be moved to the ICU soon.

66. The nurse explained that she gave this information to the security staff, but did not contact his family. She explained that healthcare staff do not normally speak to families. She could not remember the name of the person she gave the information to and this was her only involvement. There is no record of her contact with the security department.

67. At 9.00am, the man was taken to the High Dependency Unit (HDU) and a catheter was fitted. It had been established that he did not have tuberculosis. The restraints risk assessment was reviewed and in light of the deterioration in his condition, double cuffs were removed and a single escort chain was

[14] A serious bacterial infection of the lungs
[15] A long chain with a handcuff at both ends. An officer is handcuffed to the prisoner via a chain long enough for the prisoner to be able to use the toilet without being removed from a mechanical restraint.

applied. Staff were now able to sit in the room with him as he was no longer thought to be infectious.

68. The man's family attempted to visit him at Manchester prison that day. When they arrived at the prison, they were told that they had the wrong day for the visit and that he was in his cell and would not be attending the visits area. They then left. They were not told that he was in fact in hospital and there was no attempt to try and rearrange the visit for them to go to the hospital.

69. The man was moved to ICU later that afternoon. Medical staff asked the bedwatch officers to remove the escort chain, due to his condition. The duty governor was contacted and authorised the chain to be removed. Later that evening, his condition deteriorated further and he was started on dialysis[16].

70. There is no evidence that he was considered for release on temporary licence (ROTL). In certain circumstances a prisoner will be allowed to leave prison on a temporary licence, for precisely defined and specific activities that cannot be provided in prison, including urgent medical treatment.

71. According to the man's bedwatch log, during the morning he was incoherent and thought that he was in prison rather than in hospital. At 11.50am, the consultant in charge of his care said that he had a chest infection and his liver and kidneys were not working properly. It was noted that he might have been able to move back to a ward later that afternoon, however he would remain in hospital for the next few days.

72. An officer made an entry in the bedwatch log at 1.30pm that the doctor had said the man had a blood clot in his liver. When he was told, he pulled the catheter out while it was still inflated, which caused a bleed. Nurses attempted to stop the bleed, which proved difficult due to the blood thinning medication he was taking for the blood clot. The officer said during interview that at that stage the doctor said they needed to contact his next of kin as he was very seriously ill and might die.

73. The man was delirious and the nurse in ICU told the bedwatch officers that he was very unwell. At 3.20pm a member of the prison chaplaincy was asked to contact the next of kin and inform them that he was very ill in hospital. The chaplain found a telephone number for his daughter and attempted to contact her a number of times, however the number did not work, because the telephone was broken.

74. At 4.00pm, the man said that he needed to use the toilet. As he had pulled his catheter out, he was given an urination bottle. When he stood up to use the bottle, he collapsed and his lips went blue and hospital staff attended to him.

75. Bedwatch officers were again told that it was imperative that his family were contacted and informed of his condition. As his daughter could not be

[16] A form of treatment that replicates many of the kidney's functions.

contacted, a member of the chaplaincy team asked the security department to check his records to see if there was an alternative telephone number. A member of staff in the security department said that there were no staff available at that time to do so. There is no record of the member of staff who was spoken to in security.

76. At 4.50pm, the police were asked to help locate the man's partner and inform her of his condition. By 5.15pm, the police had visited his partner's house and informed her that he was very unwell in hospital.

77. His condition did not improve and hospital staff continued to provide medical assistance. He was pronounced dead at 5.35pm. Regrettably his family arrived at the hospital shortly before he died and they were informed of his death by a hospital doctor, before they had a chance to see him.

Post-mortem Examination

78. A post-mortem examination was carried out on 28 August. The post-mortem found that there were no illicit drugs or alcohol present in the man's blood or urine samples. The cause of his death was recorded as pericarditis. There was evidence of liver failure due to blood poisoning caused by the pericarditis.

Police Investigation

79. Manchester Police Service conducted an investigation after the man's death. During consultation with a hospital doctor, he said that he had been assaulted by another prisoner following a disagreement. He did not speak to prison staff about this and there is no evidence of an altercation in his prison records. Another prisoner was arrested following this allegation, although no charges were brought against him. The post-mortem report does not show any injuries consistent with being assaulted.

80. Following his death, there were rumours among prisoners that his drink had been spiked by another prisoner the morning that he collapsed. The toxicology reports showed no un-prescribed drugs or medications were present in his blood or urine at the time of his death.

Support for prisoners

81. Prisoners were informed of the man's death through a notice from the Governor which highlighted the support available. Listeners were made available to all prisoners who needed additional support. Prisoners who were subject to ACCT monitoring procedures were reviewed.

Staff Debrief

82. It is usual following the death of a prisoner to hold a debriefing session with staff involved in their care. These ensure that staff have an opportunity to discuss any issues arising, and for support to be made available. A "hot debrief" was held later that evening, chaired by the Duty Governor. Only the

bedwatch officers were present at the debrief meeting and it does not appear that other staff involved in the man's care, such as wing and healthcare staff were invited to the meeting.

83. Following a death in custody, staff should be offered ongoing support by the care team. When staff were asked by the investigator during interview if they felt they had been offered appropriate support, there was a varied response. An officer who was part of the care team said they had been asked if they were okay, but did not think that they were offered support. She thought that as she was part of the care team "it was just accepted that we were dealing with it fine". A wing officer who had been involved in the events of 25 August, but did not attend the hot debrief, said that she had found out that the man had died by word of mouth and was not told personally by a senior member of staff. She said that her colleagues were very supportive.

Support for family

84. Two members of the prison chaplaincy visited the man's family on 28 August. Various members of his family were present including his parents. His family raised concerns about not being told sooner that he was in hospital and were very upset. The role of the family liaison officer (FLO) was explained to his family and contact details were exchanged. A FLO was appointed. The family were helped through the funeral arrangements and a financial contribution was made in line with Prison Service Guidance. A funeral service was held in Manchester on 14 September 2011. The chaplain helped to arrange the funeral and attended on behalf of HMP Manchester.

ISSUES

Medical care

85. When the man arrived at HMP Manchester in May 2011, he told a nurse during his first reception health screen that he was a long term heroin user and an alcoholic. There were no other significant health concerns and he was referred to the doctor and the integrated drug treatment system (IDTS).

86. He completed a ten day alcohol detoxification and was on a methadone maintenance programme. He was observed only once during the five day period when his methadone dose was gradually increased to a therapeutic level. It is protocol for patients in that five day period to be observed daily. Prisoners going through alcohol detoxification are also at risk and require close monitoring. Although the clinical reviewer does not comment on the lack of monitoring of his alcohol detoxification, we are surprised that there was no evidence of routine monitoring throughout this ten day period.

87. The clinical reviewer says in her review:

> "The IDTS service did not follow the service's protocols. On this occasion it did not have an adverse effect on his wellbeing."

Although it did not affect his wellbeing, we make the following recommendation:

The Head of Healthcare and the IDTS manager should ensure that the required observations are completed for all prisoners beginning a methadone maintenance or alcohol detoxification programme.

88. During his brief time at HMP Manchester, the man had little contact with healthcare staff. He would occasionally ask for paracetamol for intermittent headaches that were associated with a historic head injury.

89. He saw a doctor on 10 August and he requested paracetamol for intermittent headaches, which the doctor issued. His blood pressure was checked, which was in the lower end of the "ideal" range. He was also weighed and had lost nearly 6kg since May. Due to the weight loss, the doctor was concerned that he might have had an underlying illness and referred him for blood tests and an urgent chest X-ray. He did not attend for the blood test on 12 August and the chest X-ray was arranged to take place two weeks later, on 25 August.

90. Following a request, a doctor prescribed Gaviscon for indigestion to the man on 24 August. He did not examine or see him in person. It is usual for "over the counter" medications, such as Gaviscon and paracetamol to be issued to prisoners without a consultation or examination. Although the symptoms of indigestion can be similar to those indicating a heart condition, there was no reason to suggest he was suffering from heart problems, so the clinical reviewer concludes it was not unreasonable for Gaviscon to be supplied.

91. On 25 August, the man was found collapsed in his cell. He was taken to the healthcare centre where he was examined again by a doctor, who found him to be weak and dehydrated. After looking back at his medical history, the doctor thought it would be appropriate for him to go to hospital for further tests to establish the cause of his symptoms. He was already due to have a chest X-ray that day. When he was admitted to hospital he underwent various tests. An initial diagnosis was made of tuberculosis, which then changed to a chest infection. His condition steadily deteriorated and his organs began to fail. He died a few days after being admitted.

92. The doctor said during interview that he had been shocked when he found out the man had died of pericarditis. He said that it was a very uncommon condition, which is not easy to diagnose. There is no evidence of him complaining of any symptoms associated with pericarditis (chest pain, fatigue, swelling of the legs or abdomen) during his time at Manchester. The clinical reviewer concludes in her review that:

> "The man's transfer to hospital was appropriate and carried out in a timely manner.
>
> The prison health care staff provided appropriate care and could not have prevented his death.
>
> The care was equal to that he would have received in the community."

93. Despite the man's history of substance misuse, he did not have very regular contact with healthcare services. Staff told the investigator that they did not have any concerns for his appearance or complexion given this history. There are no entries in his medical record that he was jaundiced or that his skin appeared yellow. He saw the doctor with non-specific symptoms on 10 August. The doctor noted he had lost nearly 6kg since May which had apparently gone unnoticed till then and appropriately referred him for further investigative tests. No other health concerns were recorded between then and 25 August. After his collapse, the response and medical decisions were timely and appropriate. Taking this information and the clinical review into consideration, and given the lack of relevant symptoms for the rare condition to which he succumbed, it does not appear that staff could reasonably have foreseen or prevented his death.

Informing the man's family of his admission to hospital

94. The man was taken to hospital on 25 August. The cause of his symptoms was unknown and he was admitted as an inpatient for investigative tests. HMP Manchester does not have a local policy for contacting the next of kin when prisoners are admitted to hospital. They follow a bedwatch protocol, which indicates that visits would not be allowed for the first week of an admission to hospital and thereafter visits would be booked through the standard booking procedure. This is, however, dependent on the patient's condition and the seriousness of his illness.

95. Although the policy sets out visiting guidelines, it does not stipulate that the next of kin cannot be contacted during their first week in hospital. When the man was first admitted, his condition was stable, but then began to deteriorate quite quickly. We consider his family should have been notified of his admission on 25 August.

96. His condition continued to deteriorate and the following day at 8.45am an entry was made in his medical record that hospital staff had indicated that his family should be made aware of his condition. A nurse in the prison contacted the security department to pass this on. She did not record who she spoke to or what was said between her and the security staff. No attempt was made to contact his next of kin at that stage.

97. Prison Rule 22 says that:

> "If a prisoner dies, becomes seriously ill, sustains any severe injury or is removed to hospital on account of a 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."

98. The man's condition deteriorated further and he was moved to the HDU later that morning. By the afternoon, he had been moved to ICU. His condition was very serious and if the bedwatch protocol and Prison Rule 22 had been followed appropriately, his family should certainly have been made aware by this point. A family liaison officer should also have been appointed to take charge of obtaining the contact details of his next of kin.

99. His family tried to visit him on 26 August. When they arrived at the visits centre, at approximately 2.00pm, they were told that they had the wrong day and he was in his cell. There is no record that the officer on reception in the visits centre tried to contact his wing for information or checked the computerised record system which would have shown he was in hospital.

100. It is apparent from the family liaison log that this issue was looked into by prison staff, after his death. His partner was told that the member of staff she had seen in the visits centre would have had no idea that he was critically ill in hospital. Although the staff member might not have known of his condition, more should have been done to establish where he was. Instead they were given the wrong information which had not been checked. It is unacceptable that the family were not provided with correct information, particularly as at the time he was in a serious condition.

101. At 1.30pm on 27 August, a hospital doctor told bedwatch staff that the man's condition was serious and he had a blood clot in the vein to his liver. One of the bedwatch officers said that security were contacted and told that his next of kin needed to know he was very unwell. They said they would do what they could, but he had given very limited information during his reception screening. She said that she contacted them again approximately half an

hour later, to see if they had been able to contact his next of kin, but they were still looking for a telephone number.

102. The security department asked a member of the chaplaincy team to contact the man's next of kin at 3.20pm. They asked them to access P-Nomis for contact details. His daughter was listed as his next of kin and her mobile telephone number was recorded. Despite several attempts, the chaplain was unable to get through to the number. (She has since explained that her mobile telephone was broken.) There is no record of why there was nearly a two hour delay in finding the contact number.

103. We note that the prison reception process requires only that prisoners should be asked for next of kin details; it is the prisoner's decision whether to provide them. The man listed his next of kin as his sixteen year old daughter and gave her mobile telephone number. We believe that prisons need to take into consideration who the contact details belong to when trying to contact families and the nature of the information to be given. It might not have been appropriate for a sixteen year old girl to be told over the telephone that her father was seriously ill in hospital.

104. At 4.00pm the hospital doctor repeated that it was imperative that his family were contacted. The chaplaincy had still not contacted the man's daughter, and asked the security department to look in his file to find an alternative telephone number to contact. The security department would have had access to records such as his PIN-phone records, which would have had details of the numbers he had called during his time at Manchester. They were told that there was no-one in security at that time to obtain his file. Given the seriousness of his condition, and the previous delay, it is concerning that this task was not given the priority it merited.

105. The chaplaincy continued to try the telephone number they had, but were still unsuccessful. At 4.50pm, the police were asked to help locate and inform his family that he was unwell in hospital. Within twenty minutes, the family had been told by the police and were on their way to the hospital. Unfortunately, it was too late. They arrived when medical staff were unsuccessfully trying to resuscitate him.

106. It is unacceptable that Prison Rule 22 was not followed. Prison Rules are a Statutory Instrument and have statutory force which should not be ignored. The protocols for informing a prisoner's next of kin of their admission to hospital were not followed either. PSO 2710 says that the prison must provide families with timely information and practical support. A family liaison officer should have been appointed at an earlier stage so they could have co-ordinated obtaining the next of kin details. No-one was appointed until a day after the initial request was made to contact the man's family. It is the responsibility of the prison to contact the family, not the police, unless there are exceptional circumstances. Although PSO 2710 sets out these guidelines in relation to a death in custody, the same principles should apply when a prisoner is seriously ill. This would have provided his family with the

opportunity to see him before he died. We repeat the recommendation made in another investigation report for Manchester:

The Governor should ensure that, unless there are properly documented serious and over-riding security implications, and subject to the prisoner's consent, families should be informed when a prisoner is in hospital with a suspected serious medical condition.

The Governor should ensure that reception staff ask prisoners for the telephone number of an appropriate adult to be contacted in the event of an emergency.

Record keeping

107. On two occasions, the emergency nurses did not record their interactions with the man in his medical record. This meant that the investigator and clinical reviewer did not know what examinations had taken place and how he was presenting. After his control and restraint, the emergency medical officer should have made an entry in his medical record. The extent of the examinations and his condition is still unclear as the staff member was unable for interview.

108. A nurse explained that she had made a joint entry with the doctor after assessing him prior to his admission to hospital on 25 August. She had been told that she did not need to make a separate entry. Although she was following the advice given to her and was relatively new to the role, it is advisable for all staff to make their own entries showing their examinations and findings.

109. The Nursing and Midwifery Council (NMC) is a regulatory body for England, Wales, Scotland and Northern Ireland. The NMC has clear guidelines relating to record keeping. Good record keeping is an integral part of nursing, and is essential to the provision of safe and effective care. A principle of good record keeping outlined by the NMC:

> "You should record details of any assessments and reviews undertaken, and provide clear evidence of the arrangements you have made for future and ongoing care. This should also include details of information given about care and treatment."

110. We endorse the recommendation made by the clinical reviewer in her clinical review:

The Head of Healthcare should ensure that all nursing staff fully adhere to the requirements for accurate and contemporaneous record keeping in accordance with the required standards of the Nursing and Midwifery Council.

Escort Arrangements

111. A risk assessment was carried out for the man's hospital appointment for his planned chest X-ray. Risk assessments should take into consideration factors such as the prisoner's behaviour in prison, the security of the hospital or ward they are in and the risk they present to the public, staff and themselves and their medical condition. Risk assessment should be reviewed regularly and amended if appropriate, for example if the prisoner's condition or their behaviour while in hospital changes.

112. When the man was taken to hospital on 25 August, he was escorted by two bedwatch officers and was restrained using double cuffs and an escort chain. The risk assessment used was originally intended for a planned escort and was completed a week before on 18 August. The medical section was not completed. The risk assessment was not updated on 25 August, in the light of his medical condition.

113. He was a category C prisoner. According to the risk assessment, there were no negative behaviour entries in his prison record, there were no issues that would have indicated a risk of him trying to escape. He was recorded as a medium risk to the public and of escape, and a low risk to staff. Despite being assessed as a low to medium risk, the decision was made to use double cuffs and two officers to escort him. There is no explanation why double cuffs were regarded as necessary. We regard this as inappropriate in the circumstances for a relatively low risk prisoner serving a short sentence.

114. His risk assessment was revisited and restraints were reduced when he was moved to the HDU. His condition had continued to deteriorate and he needed closer observation. A catheter was fitted. The restraints were reduced to an escort chain; however it is hard to see at that stage that he posed a real threat of escape or risk to the public such as to require the use of any restraints.

115. A hospital doctor asked for the restraints to be removed once the man had been moved to the ICU. This was authorised by the duty governor and allowed medical staff to provide medical interventions without any restrictions.

116. A recommendation has been made in a previous investigation report for Manchester that staff should not wait for hospital staff to ask for the restraints to be removed. Escort staff should use their initiative to contact the duty manager and advise that the escort risk assessment should be reviewed in light of a change in a prisoner's condition. As the man was weak on arrival at hospital and he continued to steadily to deteriorate, his risk assessment should have been reviewed. His condition had changed significantly since it had been done seven days before. His restraints should also have been removed at the earliest opportunity and bedwatch officers should not have waited for hospital staff to initiate the request.

The Governor should ensure that escort arrangements are proportionate to risk, that all relevant sections of the risk assessment are completed

and that full account is taken of a prisoner's health and physical condition and the impact this has on his actual risk.

Support for staff

117. Staff support following the man's death was not consistent. Those who had been involved in his bedwatch attended the "hot debrief" when his death was discussed but other staff involved in his care were not included. All staff, including wing officers and doctors, will be affected in different ways following a death in custody and should be offered adequate support. It is not clear that staff who did not attend were followed up after the debrief as Prison Service Guidance requires.

The Governor should ensure that all staff are offered appropriate support following a death in custody.

CONCLUSION

118. The man did not present with symptoms specific to pericarditis, which is an uncommon condition. Hospital staff thought he had a chest infection, so it is very unlikely that healthcare staff at HMP Manchester would have been able to diagnose it. Referrals for investigative tests were the appropriate course of action and the clinical review concludes that the referrals were timely and appropriate. When his condition deteriorated two weeks later, he was appropriately taken to hospital. The care he received in prison was equivalent to that he would have received in the community. However, we have concerns that the level of restraints used in hospital was not justified.

119. The prison did not inform the man's family of his admission to hospital when they should have done. This was a serious omission compounded by the fact that they were not told he was in hospital when they tried to visit him at the prison the day before he died. This meant that they did not have the opportunity to see him at the hospital before his death.

RECOMMENDATIONS

1. The Governor should ensure that unless there are properly documented serious and over-riding security implications, and subject to the prisoner's consent, families should be informed when a prisoner is in hospital with a suspected serious medical condition.

   Accepted – NOK details are routinely recorded and unless there are security concerns then arrangements should be put in place to ensure family are contacted. Security action plans will address the need to contact family members if a prisoner is admitted to hospital with a suspected serious medical condition. Security staff will also be briefed that it is not acceptable to delay or refuse assistance with NOK details if a prisoner is at hospital. It is accepted that it is the prison's responsibility to contact the NOK but in an emergency other agencies should be asked for assistance i.e. police.

2. The Governor should ensure that reception staff obtain the telephone number of an appropriate adult to be contacted in the event of an emergency.

   Accepted – The security action plan will address this to ensure that Reception staff ask and record the details of an appropriate adult to be contacted in the event of an emergency or document if the prisoner refuses to provide those details.

3. The Governor should ensure that escort arrangements are proportionate to risk, that all relevant sections of the risk assessment are completed and that full account is taken of a prisoner's health and physical condition and the impact this has on his actual risk.

   Accepted – This routinely happens via a collaborative risk assessment process which involves consideration of both health needs and potential security risks. Once a prisoner is discharged to hospital these arrangements are regularly reviewed. NSF guidelines on the use of restraints will be issued to all managers who sign off risk assessments.

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4. The Governor should ensure that all staff are offered appropriate support following a death in custody.

   Accepted – Staff are supported through the care team and via management support. This support is also extended through to the inquest stage of a death in custody. The establishment also has access to counselling services that should be published and made widely available to staff.

5. The Head of Healthcare and the IDTS manager should ensure that the required observations are completed for all prisoners beginning a methadone maintenance programme or going through alcohol detoxification.

Accepted – Regular monthly audits are now undertaken by the IDTS manager to ensure compliance and results shared with the head of healthcare. Random audits are also undertaken by prison management.

6. The Head of Healthcare should ensure that all nursing staff fully adhere with the requirements for accurate and contemporaneous record keeping in accordance with the required standards of the Nursing and Midwifery Council.

   Accepted – The NMC code for record keeping is available to all clinical staff either electronically or in hard copy. Reminders are sent regularly to staff regarding compliance. A record keeping audit is incorporated into the audit calendar, but the prison will also look to implement the tool used by MMHSCT for managers to routinely check on standards of record keeping.