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 a man in June 2014 at HMP Manchester

Our Vision

To be a leading, independent investigatory body,
a model to others, that makes a significant contribution
to safer, fairer custody and offender supervision.

This is the investigation report into the death of a man, who died of heart disease in June 2014, at HMP Manchester. He was 52 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received at HMP Manchester was undertaken. The prison cooperated fully with the investigation. I regret the delay in issuing this report, caused by the need to wait for post-mortem and toxicology reports.

The man was remanded to prison in December 2011. He went to HMP Manchester later that month and remained there after he was sentenced to life imprisonment in November 2012. He had epilepsy, for which he received appropriate care at the prison. There was no indication that he suffered from heart disease, although an over 50s health assessment in January 2013, did not explore this possibility. In February 2013, he began to have seizures and healthcare staff monitored him and managed his medication more closely. In May, a prison GP noted that he had not had a seizure for a month.

In June, an officer found the man unresponsive in his cell. It was apparent that he had been dead for some time. Two other officers had seen him in his cell earlier that day, but neither had spoken to him and both thought he had been asleep when they saw him.

While there was no reason for healthcare staff to suspect that the man had a heart problem, I agree with the clinical reviewer that his risk factors for heart disease should have been explored at his health assessment in January 2013, in line with equivalent NHS checks. Apart from this, the care he received at Manchester was very good and equivalent to that he could have expected to receive in the community. While it does not appear that this would have helped him, I am concerned that the officer who unlocked his cell on the day he was found dead, did not check his welfare at the time, as officers should do.

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 **June 2015**

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SUMMARY

1. In December 2011, the man was remanded to HMP Liverpool and moved to HMP Manchester later that month. In November 2012, he was sentenced to life imprisonment and remained at HMP Manchester. He had epilepsy, and doctors prescribed appropriate medication and implemented an epilepsy care plan. There was nothing to suggest that he had heart problems. From January 2012, he kept his epilepsy medication in his cell to administer at suitable times. Nurses sometimes had to remind him to collect further stocks.

2. In January 2013, the man had an over 50s health assessment. A nurse reviewed his epilepsy management, mobility, appetite and other minor matters but the assessment did not screen for kidney, stroke or risk of heart disease, as national guidelines recommend.

3. From February 2013, the man had a number of seizures, and staff administered medication under supervision. In May 2014, after he had not had a seizure for some weeks, his GP allowed him to keep a month's supply of medication in his cell.

4. One morning in June, an officer unlocked the man but did not try to get a response from him. Later that morning an officer saw him in his cell but thought he was asleep and did not disturb him. At lunchtime, another officer went to his cell several times and at first, like the other officers, thought he was asleep. When he tried to wake him, he did not respond. The officer then realised that he had died and it was apparent that he had been dead for some time.

5. The officer radioed an emergency medical code and control room staff called an ambulance. A doctor and a nurse attended and the doctor pronounced the man dead at 12.12pm.

6. The clinical reviewer concluded that the standard of healthcare the man received at HMP Manchester was equivalent to that he could have expected to receive in the community. We make two recommendations - about screening for risk of heart disease and unlock procedures.

THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners at HMP Manchester informing them of the investigation and inviting anyone with relevant information to contact her. No one responded.

8. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison records. She interviewed four members of staff in March 2015.

9. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.

10. At first, there was some uncertainty about the cause of the man's death and we were unable to proceed with our investigation until we received the post-mortem and toxicology results. These were not available until 23 December 2014, six months after he died. We are sorry for the consequent delay in issuing this report.

11. We informed HM Coroner for City of Manchester District of the investigation, who provided the post-mortem report. An inquest was held on 24 February 2015 and found that the man died from natural causes, as a result of heart disease.

12. One of the Ombudsman's family liaison officers contacted the man's family, who did not have any specific issues for the investigation to consider. The family were informed the draft was available, but did not wish to receive a copy or make any comment.

13. The prison also considered our draft report and raised a factual inaccuracy which has been amended. They submitted an action plan addressing our recommendations which is at the end of this report.

HMP MANCHESTER

14. 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 men. Manchester Mental Health and Social Care Trust provide 24 hour nursing care. The prison's healthcare centre includes an inpatient unit.

HM Inspectorate of Prisons

15. The report of the most recent inspection of HMP Manchester in November 2014 has yet to be published. At the previous inspection in September 2011, inspectors reported that the quality of healthcare was generally very good and there were a number of points of good practice. There was a designated senior nurse to lead the care of older prisoners over 50. Patients with life-long conditions and inpatients had good care plans.

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to February 2014, the IMB noted that the health and welfare of prisoners was given high priority.

Previous deaths at HMP Manchester

17. There has been only one other death from natural causes, at Manchester in the past two years. There were no similarities with the man's case.

KEY EVENTS

18. On 12 December 2011, the man was remanded to HMP Liverpool, and on 16 December moved to HMP Manchester. He had epilepsy and a prison GP prescribed phenytoin and carbamazepine. A nurse created an epilepsy care plan. A month later, records show that staff were concerned that he was not complying with his medication regime. On 3 February 2012, he told a prison GP that taking his medication in the morning made him feel strange. The GP arranged for him to keep stocks of his medication in his cell so that he could take it a time that suited him better.

19. On 15 November 2012, the man was sentenced to life imprisonment for murder and attempted murder and remained at HMP Manchester.

20. The man sometimes forgot to request his repeat prescriptions and his epilepsy nurse had to remind him to do this. He did not always attend appointments with the nurse.

21. On 24 January 2013, a nurse carried out an over 50s assessment with the man. She reviewed his mobility, appetite, epilepsy management, bowel habits and hearing and created a generic 'older person's care plan', to be reviewed a year later. The assessment did not include kidney, stroke or cardiac risk factors.

22. Between February 2013 and April 2014, the man had a number of seizures and did not always take his medication as prescribed. For a while, healthcare staff stopped allowing him to keep his medication in his possession and administered his medication under supervision. Gradually they allowed him to keep more medication in his possession. On 27 May 2014, a prison GP agreed that he could keep four weeks' supply in his cell. The doctor noted that he had not had any very recent seizures. He had no other significant health issues during his time at Manchester.

23. One morning in June an officer unlocked the man's cell. He thought the man was asleep and did not try to get a response from him. He did not note whether he was breathing.

24. Between 9.00am and 10.00am, two officers were checking cells. An officer went to the man's cell. He said that the man was lying in his bed, on his right hand side, facing the wall. He thought he was asleep and did not have any reason to disturb him so he left the cell when he finished the checks. He did not notice anything remarkable about his appearance.

25. Later that morning, shortly before midday, an officer went into the man's cell and saw he was in bed lying on his stomach. He told him to go and get his lunch. When he got no response, he thought he was asleep. He knew that the man had complained before about staff not waking him for lunch, so he went back two or three times to try and rouse him by calling him. Eventually, he looked more closely and saw that his arm, which was not covered by the sheet, was discoloured. He put his hand on his shoulder to turn him over and

noted that he was cold. When he turned him towards him, he saw that his expression was fixed.

26. The officer was certain that the man was dead. He called for help and radioed an emergency medical code. The time was approximately 12.02pm. A Senior Officer and other staff attended. Control staff called an ambulance at 12.03pm. An officer brought a defibrillator but all present agreed that the man had died, rigor mortis was present and resuscitation would not be possible.

27. At approximately 12.10pm, a prison GP and a nurse arrived, bringing emergency equipment. The nurse noted that the man had 'pooling' on one side of his body. (When the heart stops pumping blood, it settles in certain areas and is a sign of death.) The GP could find no signs of life and, at 12.12pm, declared him dead.

Contact with the man's family

28. The prison's family liaison officer established that the man had not given any next of kin details. She discovered that his family had been victims of his offence. She liaised with the police and found details of his sister, who had not been a direct victim. She and a senior manager visited her at approximately 5.00pm that evening and informed her that her brother had died. They offered their condolences and support. The prison arranged and paid for the funeral in line with national guidance.

Support for staff and prisoners

29. At 2.00pm on 21 June, the Governor debriefed the staff involved in the emergency response and informed them of available support if they needed it. A notice informed other staff that the man had died.

30. A notice informed prisoners of the man's death and support available from Samaritans and wing staff if they needed support. Staff checked prisoners considered at risk of suicide or self-harm, in case they had been adversely affected by the news of his death.

Post-mortem

31. A post-mortem examination found that the man had died from ischaemic heart disease (a reduced supply of blood to the heart) but could not rule out that his epilepsy might have contributed to his death. Phenytoin was present in his system but the doctor could not confirm if the concentrations detected were sufficient to have controlled his epilepsy. The inquest concluded that he had died of heart disease.

ISSUES

Clinical care

32. The clinical reviewer concluded that the man's care in prison was equivalent to that he could have expected to receive in the community. She said that his care at Manchester was largely excellent and the healthcare team took a multidisciplinary approach towards managing his periods of non-compliance with epilepsy medication.

33. The clinical reviewer noted that when the man had an over 50s health assessment, this concentrated on his mobility and epilepsy and did not screen for potential heart disease, stroke or kidney disease. The NHS Healthcheck which was rolled out in April 2012 recommends that all patients between 40 and 74 are screened for these conditions. While there was little to indicate that he was high risk for cardiac disease, the health assessment would have been an opportunity to discuss and screen for other issues including cardiac risk factors, in line with the NHS check. We make the following recommendation:

    The Head of Healthcare should ensure that all eligible prisoners are offered health assessments in line with the NHS Healthcheck, which includes screening for heart and kidney disease and stroke.

Emergency response

34. We do not know what time the man died, but it is evident that he had been dead some time when he was found at midday. When the officer unlocked his cell in the morning, he did not speak to him or try to get any response. The officer said that he would not normally do this when unlocking prisoners, unless they were already obviously awake. He said he generally just did a 'headcount'. Another officer saw but did not get a response from him later that morning.

35. We appreciate the difficulties, especially on a Sunday morning when prisoners are not expected to work. However, at unlock, officers should take active steps to check on a prisoner's wellbeing. The Prison Officer Entry Level Training (POELT) manual states that "Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead".

36. Prison Service Instruction 10/2011 states that:

    "Reports from the Prisons and Probation Ombudsman on deaths in custody have identified cases in which a prisoner has died overnight … but staff

unlocking them have not noticed that the prisoner had died. This is not acceptable...

“[Differing] arrangements will depend on the local regime, but there need to be clearly understood systems in place for staff to assure themselves of the well being of prisoners during or shortly after unlock ... Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process.” We make the following recommendation:

The Governor should ensure that, when a cell door is unlocked, officers take active steps to satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that all eligible prisoners are offered health assessments in line with the NHS Healthcheck, which includes screening for heart and kidney disease and stroke.

2. The Governor should ensure that, when a cell door is unlocked, officers take active steps to satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and Function Responsible
1	The Head of Healthcare should ensure that all eligible prisoners are offered health assessments in line with the NHS Healthcheck, which includes screening for heart and kidney disease and stroke.	Accepted	As part of the reception screening process all prisoners who meet the eligibility criteria for a NHS health check will be identified. Those prisoners who will be staying at HMP Manchester will be invited for a NHS health check.	30 September 2015 Head of Healthcare
2	The Governor should ensure that, when a cell door is unlocked, officers take active steps to satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.	Accepted	A notice to staff will be issued with regard to staff satisfying themselves of the wellbeing of prisoners. The Heads of Residence will also brief custodial wing managers of the need to be aware and satisfied of an individuals' wellbeing and include this in staff performance development records.	30 September 2015 Heads of Residence