Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Albert Starkie a prisoner at HMP Manchester on 18 October 2016

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Albert Starkie died on 18 October 2016 of a heart attack at HMP Manchester. Mr Starkie was 80 years old. I offer my condolences to Mr Starkie's family and friends.

Mr Starkie suffered from several long term medical conditions when he arrived at Manchester. The clinical reviewer concluded that his care was well managed and of the standard that he could have expected to receive in the community.

We are satisfied that when Mr Starkie collapsed the emergency response and the decision not to attempt resuscitation were appropriate.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Richard Pickering
Deputy Prisons and Probation Ombudsman **April 2017**

Contents

Summary

Events

1. On 26 September 2016, Mr Albert Starkie was remanded into custody for sexual offences. Four days later, he was sentenced to 16 years in prison.

2. Mr Starkie had a history of chronic obstructive pulmonary disease (COPD – lung disease), angina, chronic kidney disease, ischaemic heart disease and an irregular heartbeat. A prison GP admitted him to the prison's inpatient unit for further assessment of his physical and healthcare needs. Healthcare staff prescribed Mr Starkie various medications to treat his conditions.

3. On 17 October, Mr Starkie complained of increased episodes of severe angina and underwent an electrocardiogram (ECG – a test to measure the electrical activity of the heart) and urgent blood tests. The tests showed abnormal results caused by his irregular heartbeat. A prison GP discussed his care with a hospital heart failure nurse and arranged an appointment for a heart failure review. Mr Starkie died before the appointment could take place.

4. At 4.30pm on 18 October, a prison nurse gave Mr Starkie his prescribed medication. Mr Starkie did not complain of feeling unwell and the nurse did not note any concerns. At 5.30pm, a prison officer gave Mr Starkie his evening meal and locked his cell.

5. At 7.30pm on 18 October, a prison officer found Mr Starkie collapsed in his cell and called an emergency code blue (which indicates a prisoner has symptoms including chest pain and difficulty in breathing). Nurses attended and decided not to start CPR because clear signs of death were present. A prison doctor attended at 9.00pm and confirmed that Mr Starkie had died.

Findings

6. When Mr Starkie arrived at Manchester, he was suffering from several long term medical conditions, which were well managed by appropriate care plans. The clinical reviewer considered that healthcare staff continuously assessed his complex needs and GPs sought advice from hospital specialists.

7. We are satisfied that the emergency response and the decision not to attempt CPR were appropriate. We agree with the clinical reviewer that the standard of care Mr Starkie received at Manchester was equivalent to that he could have expected in the community.

The Investigation Process

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

9. The investigator obtained copies of relevant extracts from Mr Starkie's prison and medical records.

10. NHS England commissioned a clinical reviewer to review Mr Starkie's clinical care at the prison.

11. We informed HM Coroner for City of Manchester District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

12. One of the Ombudsman's family liaison officers contacted Mr Starkie's mother and daughter, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They had no specific matters for the investigation to consider.

13. Mr Starkie's family received a copy of the initial report. They pointed out a factual inaccuracy and this report has been amended accordingly.

14. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Background Information

HMP Manchester

15. 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 and the healthcare centre includes an inpatient unit.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Manchester was in October and November 2014. Inspectors reported that health services were reasonably good, and most prisoners were satisfied with the quality of healthcare. Despite some caring staff, support and personal provision for many prisoners with disabilities was poor. Inspectors found that staff did not adequately manage the acute social care needs of some prisoners.

Independent Monitoring Board

17. 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 2016, the IMB reported that inpatient care was often hampered by lack of available staff but, that given the financial restraints, they believed that healthcare staff offered the best possible level of care to their patients. Social workers attended the prison at regular intervals to complete Social Care Assessments in accordance with the Social Care Act 2015.

Previous deaths at HMP Manchester

18. Mr Starkie was the fifth person to die of natural causes at Manchester since January 2015. There has been one other natural cause death since Mr Starkie died. There were no similarities with previous deaths.

Key Events

19. On 26 September 2016, Mr Albert Starkie was remanded in custody for sexual offences and sent to HMP Manchester. Four days later, Mr Starkie was sentenced to 16 years in prison and returned to Manchester.

20. At an initial health screen, a nurse noted that Mr Starkie had a history of chronic obstructive pulmonary disease (COPD – the name for a collection of lung diseases such as chronic bronchitis and emphysema), angina, chronic kidney disease, ischaemic heart disease and an irregular heartbeat. He used a glyceryl trinitrate (GTN) spray to relieve his chest pain from angina, an inhaler to relieve his COPD symptoms and took medication to regulate his heart rate.

21. The same day, a prison GP saw Mr Starkie and decided he should be located in the inpatient unit to allow healthcare staff to assess his physical needs. Mr Starkie was a frail, elderly man who used a walking stick and was dependent on a wheelchair when he moved around the prison. Nurses created an older person's care plan to manage Mr Starkie's medical conditions and an inpatient care plan to manage his daily living needs. Mr Starkie had a catheter and nurses created a care plan to reduce his risk of infection.

22. On 10 October, a prison GP prescribed Mr Starkie antibiotics to treat a urine infection. On 11 October, another prison GP assessed Mr Starkie and noted no new issues of concern.

23. On 17 October, Mr Starkie told a prison GP that his episodes of angina attacks had increased and his GTN spray did not always help. The GP arranged a full set of blood tests and Mr Starkie had an electrocardiogram (ECG – a test to measure the electrical activity of the heart). The results were abnormal due to Mr Starkie's irregular heartbeat. Mr Starkie's serum troponin 1 level (proteins which are released when the heart muscle is damaged) were mildly elevated. The GP noted that kidney disease could also cause a raised protein level in the blood.

24. The same day, the GP discussed Mr Starkie with a heart failure nurse at the hospital. The nurse said Mr Starkie was no longer under their care but due to his symptoms, she arranged an appointment on 25 October for a heart failure review. The GP prescribed isosorbide mononitrate to improve Mr Starkie's circulation and reduce his angina pain.

18 October 2016

25. At 11.35am on 18 October, the GP assessed Mr Starkie, who said he had not experienced any new angina pain. The GP discussed Mr Starkie's raised protein level with a medical registrar at the hospital. The registrar agreed that Mr Starkie's kidney disease likely caused the raised protein level and did not recommend any further investigation.

26. At 4.30pm, a nurse gave Mr Starkie his prescribed medication. Mr Starkie did not complain of feeling unwell and she did not note any concerns. At 5.30pm, an officer gave Mr Starkie his evening meal and locked his cell.

27. At approximately 7.30pm, the officer completed a routine check on Mr Starkie and saw him lying on the floor on his left side. He entered Mr Starkie's cell and radioed an emergency code blue (which indicates a prisoner has symptoms including chest pain and difficulty in breathing). The control room immediately called an emergency ambulance.

28. A healthcare assistant arrived at 7.32pm and a nurse arrived immediately after with the emergency bag. At approximately 7.34pm, three nurses arrived at Mr Starkie's cell. The nurses moved Mr Starkie onto his back so they could examine him further. The nurses agreed that it was not appropriate to start cardio pulmonary resuscitation (CPR) because Mr Starkie did not have a pulse, he had fixed pupils, his neck was rigid and they saw a pool of blood to his left side.

29. At 7.46pm, an ambulance arrived and the ambulance crew agreed that CPR was not appropriate. A prison GP confirmed at 9.00pm that Mr Starkie had died.

Contact with Mr Starkie's family

30. On 18 October 2016, the prison appointed a prison chaplain as family liaison officer. At 11.30pm, the chaplain and a prison manager visited Mr Starkie's wife at home. Mr Starkie's wife was not in and they were unable to reach her by telephone.

31. At 8.30am on 19 October, the chaplain and a prison manager visited Mr Starkie's wife at home again and told her that Mr Starkie had died. They offered her and Mr Starkie's daughter condolences and support.

32. The chaplain remained in contact with Mr Starkie's wife and daughter until his funeral on 10 November. The prison contributed to the costs in line with national instructions.

Support for prisoners and staff

33. After Mr Starkie's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

34. The prison posted notices informing other prisoners of Mr Starkie's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Starkie's death.

Post-mortem report

35. The coroner concluded that the cause of death was acute myocardial infarction. Mr Starkie also suffered from ischaemic heart disease.

Findings

Clinical care

36. Mr Starkie was an elderly and frail man, who suffered from several chronic medical conditions. When he arrived at Manchester, a prison GP decided he should be located in the inpatients unit and nurses created appropriate care plans to manage his care. Healthcare staff also continually assessed Mr Starkie's complex needs and discussed his care with specialists when required.

37. We agree with the clinical reviewer's conclusion that the standard of care Mr Starkie received was equivalent to that he could have expected in the community.

Emergency response

38. When Mr Starkie was found collapsed in his cell on 18 October, an officer appropriately called an emergency code blue, which resulted in the immediate attendance of healthcare staff and the calling of an ambulance.

39. After arriving at Mr Stakie's cell, the nurses decided not to start CPR because clear signs of death were present. The clinical reviewer noted that the nurses who examined Mr Starkie were up to date with their CPR training. She was satisfied that the decision not to commence CPR was appropriate to maintain Mr Starkie's dignity.

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