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 January 2015, a prisoner 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, a prisoner at HMP Manchester, who died of blood in his lung cavity, pneumonia, drug abuse and hepatitis C on 20 January 2015. He was 36 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received at Manchester was undertaken. The prison cooperated fully with the investigation.

The man was remanded to HMP Manchester on 12 January 2015. His initial health screen indicated that he misused heroin, crack cocaine, prescription drugs and alcohol and he began a detoxification programme. He had low blood pressure and had a painful leg ulcer. Over the next week, he frequently said his ribs were painful but healthcare staff did not investigate further to determine what was causing the pain.

On 19 January, the man's blood pressure was extremely low and a prison GP sent him to hospital. He later died in hospital.

The man received good treatment for his alcohol and drug problems but the clinical reviewer found that the care for his physical condition was not equivalent to that he could expect to receive in the community and that healthcare staff missed opportunities to identify his declining condition. I am also concerned that when he went to hospital seriously ill, no one attempted to contact his family. There was no review of his risk assessment when his condition declined and it took too long to remove restraints when a doctor asked officers to remove them.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **August 2015**

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SUMMARY

1. On 12 January 2015, the man was remanded to HMP Manchester. A reception nurse noted that he had a history of alcohol and substance misuse and smoked cigarettes. He had a leg ulcer and hepatitis C. He said he had cracked his ribs in the past few days, but could not remember how.

2. The man tested positive for heroin, crack cocaine and tranquilisers. His leg ulcer was painful and nurses changed the dressing each day. He began a methadone maintenance programme.

3. On 14 January, the man told substance misuse staff his ribs were painful. A nurse noted his blood pressure and his withdrawal symptoms. The next day, he told a healthcare assistant that his ribs were still hurting. She checked his blood pressure and noted one reading was very low and another was very high. The nurse referred him to a doctor, who told him to increase his food and fluid intake and explained that low blood pressure could be caused by a mix of opiate and benzodiazepine medication. If the symptoms persisted, they might need to withdraw the methadone and a specialist substance misuse doctor would need to review him.

4. The man's blood pressure readings between 14 and 18 January were either low or in the normal range. On 16 January, he was not given methadone because his blood pressure was low. The next day, his blood pressure was within the normal range and he was able to take methadone again.

5. A few days later the man's blood pressure was very low. In the afternoon, he was coughing and looked unwell. A nurse spoke to a GP, who said he should go to hospital as an emergency. Three officers escorted him and used double handcuffs to restrain him.

6. The next afternoon, the man's condition deteriorated significantly. At 1.00pm, hospital staff asked officers to remove the handcuffs. He died about 40 minutes later.

7. The clinical reviewer considered that the man received good care for his substance misuse problems but the emphasis on this led to some of his other physical symptoms being overlooked. No one examined the cause of his chest pain and assumed this was the result of him breaking his ribs. The clinical reviewer considered that his symptoms such as pain, dizziness and coughing should have led a broader medical review at an earlier stage. He therefore concluded that the overall standard of healthcare was not equivalent to that he could have expected to receive in the community. We are not satisfied that the use of double handcuffs when he was taken to hospital was based on a fully considered risk assessment. We make three recommendations.

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

10. The investigator obtained copies of the man's relevant prison and medical records. The investigator and the clinical reviewer jointly interviewed seven staff at HMP Manchester on 10 March 2015, and the investigator interviewed a prison GP by telephone on 13 March.

11. We informed HM Coroner for the City of Manchester of the investigation, who provided the results of the post-mortem examination. We have given the coroner a copy of this report.

12. One of the Ombudsman's family liaison officers contacted the man's father to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He was unhappy with the healthcare his son has received and asked why he had not been admitted to the prison's healthcare unit when he first arrived. He asked why there was a four-hour interval between blood pressure checks when his blood pressure was low, and why he had not been taken to hospital sooner.

13. The man's family received a copy of the draft report and had no comments to make. The prison considered our draft report and recommendations, which they have accepted. The prison has also submitted an action plan detailing what they have done to address the issues we raised and this is included at the end of the 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. The prison healthcare centre includes an inpatient unit. There is a specialist wing (I Wing) for treating prisoners with substance misuse problems. At the time of the man's death, Manchester Mental Health and Social Care Trust provided general physical and mental health services and Greater Manchester West Mental Health Foundation Trust was responsible for clinical substance misuse services. Since 1 April 2015, Manchester Health has been the lead provider for health services and Lifeline Project provides substance misuse services.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Manchester was in November 2014. At the time of the inspection, substance misuse services were being recommissioned. Inspectors reported that existing substance abuse services were good, although alcohol services were limited. The standard of health services was found to be reasonably good and inspectors noted that staff in the inpatient unit provided compassionate care for men with complex health needs. Health promotion was excellent.

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. However, they were concerned about delays in appointing new healthcare staff.

Previous deaths at Manchester

17. The man's death was the fourth from natural causes at Manchester in the last year. We have previously raised the issue of a seriously ill prisoner being restrained without proper justification when going to hospital.

KEY EVENTS

18. On 12 January 2015, the man was remanded to HMP Manchester charged with theft. He had a long-standing history of heroin, crack cocaine, alcohol, and sedative drugs misuse. He also had hepatitis C.

19. At his initial health screen, the man saw two nurses and a prison GP for assessment. He told them he had a leg ulcer and nurses arranged to change the dressing on his ulcer each day. A nurse noted his blood pressure was slightly high (128/66) and his pulse rate was high (116bpm). He told her that he had cracked ribs, but he could not recall how this had happened. He tested positive for heroin, crack cocaine and tranquilisers. He began alcohol detoxification treatment and a methadone maintenance programme on the drug and alcohol treatment wing. He did not want help to give up smoking. He did not mention any chest pain to the GP.

20. On 13 January, the man told a substance misuse nurse he had a broken rib, which he found painful and made it difficult for him to move around. She noted in his medical record that he was alert and lucid but did not refer to any examination or treatment for his rib injury.

21. On 14 January, the man told a substance misuse healthcare support worker that he had painful broken ribs. She noted his blood pressure was very low (91/45), and then very high (the measurement was not recorded) and said she would recheck his blood pressure later. She referred him to a prison GP. The GP saw him later that day and considered that his low blood pressure was probably caused by the combination of medication he was taking and advised him to increase his food and fluid intake. The GP noted he had no cardiac history and no symptoms of chest pain or breathlessness, but that he had "dizziness due to pain". The GP did not indicate the source of the pain and did not examine him further, other than to check his pulse rate and blood pressure. He said that if his blood pressure dropped below 90mmHg after two readings in two hours, he should not take his methadone and a GP would need to review him. He suggested he might also need an ECG (an electrocardiogram test to record the rhythm and electrical activity of the heart).

22. Nurses checked the man's blood pressure at least twice daily. The next low readings were on 15 January. A substance misuse healthcare assistant took his readings at 8.55am and they were low (the best was 80/46). She checked again at 2.07pm and his blood pressure was 101/42 (still in the low range). She told him to increase his fluid and food intake and exercise to help increase his blood pressure. He told her he had a broken rib. At 7.42pm, a nurse checked his blood pressure and found it was low (82/47) and made a doctor's appointment for the next day.

23. At 9.23am on 16 January, the man said he felt dizzy. A nurse noted his blood pressure was low (93/48) and he was due to see the doctor later that day. (However, the doctor's clinic that day was subsequently cancelled.) At 11.33am, a nurse checked his blood pressure and noted it was still low (91/52), and his pulse was high (105bpm). Another nurse repeated the checks and got the same readings.

24. At 1.56pm, a nurse took the man's blood pressure. She noted it was low and his pulse high. Due to the low blood pressure reading, she said he could not take his methadone and referred him to the doctor. At 3.23pm, a nurse took his blood pressure again and it was within normal range (120/62), but his pulse was still high (128bpm).

25. On Saturday 17 January, a prison GP reviewed the man's medical notes but did not see him. He noted that nurses had recorded that his blood pressure was within normal range (101/61), and his pulse rate was high (120bpm). The GP said that he could receive his methadone and should be monitored. At 10.44am, a nurse noted his blood pressure was within normal range (101/61) and his pulse was still high (120bpm). At 4.10pm that afternoon, a nurse took his blood pressure which was low (88/54) and he had a high pulse rate (111bpm).

26. At 12.06pm on 18 January, a healthcare assistant recorded that the man's blood pressure was within normal range (108/64). She retook his blood pressure at 3.15pm, which was still low (93/56). At 4.11pm, a nurse took his blood pressure and it was higher (110/63).

27. First thing in the morning of 19 January, a nurse took the man's blood pressure and it was at the bottom of the normal range (96/43). Two hours later a healthcare assistant noted that his blood pressure was "alarmingly low" but did not note the reading. She consulted a nurse, who saw him and advised him to lie on his bed with his legs above his head to try to increase his blood pressure.

28. Just after 3.00pm, another prisoner asked the healthcare assistant to see the man, who had been shouting for help. She noted that he looked distressed, was coughing a lot and said his chest was tight. She asked him to lie on his side to help relieve the symptoms. His blood pressure had increased to 129/80 and his pulse rate was 100bpm. She noted that this was a huge improvement from the morning and that he could have his methadone. She had no further concerns and noted that his blood pressure would be checked later that day.

29. Wing staff became concerned about the man's health and asked a nurse to review him. She examined him in his cell at 7.39pm and noted he looked pale and said he had been coughing green sputum for the last three days. His blood pressure was 120/86, he had a rapid pulse at 122bpm and his oxygen saturation levels were 70%, which was very low. She contacted the out of hours prison GP, who advised that because of his oxygen levels and high pulse rate, he needed to go to hospital urgently. The ambulance was called at 8.01pm and paramedics arrived at 8.14pm.

30. Shortly after 9.20pm, the man was taken by ambulance to hospital. Three prison officers escorted him to hospital and restrained him using double handcuffs. (Double cuffing means the prisoner has his hands handcuffed together in front of him and has one wrist attached to a prison officer by an additional set of cuffs.) Once in hospital, he was restrained by an escort chain. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.)

31. In hospital, the man's condition deteriorated significantly. A hospital doctor asked the escort officers to remove the restraints. The officers first sought permission from a prison manager and removed the restraints at approximately 1.30pm. He stopped breathing, shortly afterwards. His heart stopped and attempts to resuscitate him were unsuccessful. At 2.00pm, a doctor confirmed that he had died.

Liaison with the man's family

32. No one had notified the man's family of his admission to hospital. After he died, the prison found they did not have any next of kin details for him. His offender supervisor had his grandmother's address and the prison's family liaison officer visited her the same day and informed her of his death. After enquiries with family members and the police, the family liaison officer was able to get in touch with his parents. The prison contributed towards the costs of the funeral in line with national guidance.

Support for prisoners and staff

33. The Governor issued a notice to prisoners and staff, informing them of the man's death and the support available. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures, in case they had been affected by the news of his death.

34. On 20 January, a prison manager debriefed the staff involved in the man's care to ensure they had the opportunity to discuss any issues arising, and to offer them support.

Post-mortem

35. A post-mortem examination concluded that the man died of a haemothorax (a collection of blood between the chest wall and lung), lobar pneumonia (pneumonia in the lung), chronic intravenous drug abuse and hepatitis C infection.

ISSUES

Clinical care

36. When the man arrived at Manchester, he was dependent on opiates and alcohol. He did not need admission to the inpatient unit and was located on the specialist wing for prisoners needing drug and alcohol treatment. The clinical reviewer considered it was appropriate that clinical staff trained in drug and alcohol misuse treatment took the lead in his clinical care and monitored him regularly. He was satisfied that the man received very good care for his substance misuse problems.

37. Although the clinical reviewer considered the man received good care and treatment for substance misuse, he was not satisfied that the care he received for his general physical health was equivalent to that he could have expected to receive in the community. He said nurses and healthcare support workers, based on the drug and alcohol treatment wing, noted his low blood pressure and high pulse rate, but there were too few reviews by GPs, which meant opportunities to diagnose pneumonia and its complications were missed.

38. The clinical reviewer noted that it was reasonable to monitor the man's blood pressure over five days, in case it was a result of his substance misuse treatment. However, he considered that other possible causes of his low blood pressure, especially when combined with an abnormally rapid pulse, should also have been investigated. There should have been more emphasis on physical examinations and tests such as a chest X-ray and blood tests to determine or exclude other causes of low blood pressure, such as infection, anaemia or electrolyte disturbance.

39. On 17 January, a prison GP did not see the man but noted his blood pressure and pulse rate and continued the plan to monitor him. The clinical reviewer believed that the GP should have made a more considered assessment to understand why a 37-year-old man on a stable dose of methadone, who had nearly completed an alcohol detoxification, had a continued low blood pressure and a raised pulse of 120bpm. He considered that his raised pulse rate was consistently ignored in assessments of his wellbeing, although by the morning of 19 January it had been well above 100bpm for four days in a row.

40. Although he noted that the man's condition noticeably deteriorated on 19 January, the clinical reviewer considered it was probable that the outcome would have been different if he had been admitted to hospital earlier than the evening of 19 January. On the morning of 19 January, his blood pressure was noted as 'alarmingly low'. Later that afternoon he had been coughing a lot and apparently distressed. The evening of 19 January was the first time he reported a history of coughing up sputum and he had not previously been noted to have been pale or sweaty. However, the clinical reviewer considered a doctor should have assessed him urgently earlier that day, in view of his symptoms.

41. The man had complained of chest discomfort when he arrived at the prison, just eight days before he died. Healthcare staff assumed this was the result of a rib injury, which he had reported. However, there was no record of this injury and no one ever physically examined his chest to determine the exact cause of the pain and to exclude other causes.

42. The clinical reviewer was concerned that there were missed opportunities to diagnose the man, partly because clinicians in the drug and alcohol service focused too much on issues around substance misuse, which meant that they did not consider alternative diagnoses. He considered that there was a need to review training and communication between the two clinical teams and had has made a number of recommendations in his review, which the Head of Healthcare will need to address to ensure that prisoners with complex and dual needs, such as the man, have their needs met. We make the following recommendation:

The Head of Healthcare should ensure that all healthcare staff fully investigate symptoms which might indicate an underlying serious disease and that prisoners who report pain are thoroughly examined to help determine the root cause.

Restraints and escorts

43. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between the prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that prison staff must take into account medical opinion about the prisoner's ability to escape and keep this under review as circumstances change.

44. A risk assessment was completed on 19 January when the man was taken to hospital, which required the use of "double cuffs" for the journey to hospital. Double handcuffs are usually required for moving category A or category B prisoners in good health. A nurse completed the medical section. She ticked boxes to indicate that his medical condition did not restrict his ability to escape unaided and restraints should not be removed for treatment, but did not make any written comments. There was no mention of his leg ulcer, which his prison record indicates caused his mobility to be poor.

45. The security assessment said he was a low risk of outside assistance, hostage taking and to hospital staff. He was assessed as a medium risk to the public due to the nature of his offence (he had been charged with theft but had not been convicted) and a medium risk of escape due to the insecure location. A prison manager, who authorised the use of restraints, said that as it was a medical emergency, he did not know where the man was going or the vulnerability of the site. He said that he had authorised three escort officers

to ensure there would be appropriate security if the handcuffs were removed for treatment.

46. We understand that the prison manager relied on the information available, but we are concerned that the healthcare assessment was merely a tick box exercise, with no meaningful assessment of the man's condition and how it affected his risk of escape. It is difficult to understand why the nurse ticked the box to say that restraints should not be removed for treatment, when he had agreed a three-person escort to allow for their removal if this was necessary. The security assessment indicated that the man was a risk of escape because of the insecure location, but this would always be the case for any prisoner going to hospital and was not based on his individual circumstances. We accept that in an emergency, it will not always be possible to have full information about a prisoner's risk. However, there was no review of the risk assessment the next day, after he had been admitted to hospital and his condition began to deteriorate.

47. We are also concerned that it took 30 minutes for officers to get permission to remove the escort chain after a hospital doctor requested this at around 1.00pm on 20 January, when the man's condition became critical. Officers eventually removed the restraints less than ten minutes before he stopped breathing. The prison manager had increased the standard escort from two officers to three to allow for this eventuality, so this was an unjustified length of time.

48. There is a need for all those involved in making decisions to ensure that they take a prisoner's health and mobility fully into account in risk assessments and that staff follow the guidance in the 2007 High Court judgment, including reviewing risk assessments as circumstances change. Ultimately, it is the Governor's responsibility to ensure that the process is managed properly, but the Head of Healthcare also needs to ensure that healthcare staff understand their responsibilities when assessing how health and mobility impacts on the risk of escape. We make the following recommendation:

The Governor and Head and Healthcare should ensure that risk assessments for prisoners attending hospital fully take into account individual circumstances, are based on the actual risk the prisoner presents at the time, and are reviewed as circumstances change. When hospital staff ask for restraints to be removed, decisions should be taken quickly.

Liaison with the man's family

49. Prison Rule 22 requires the governor to inform the prisoner's spouse or next of kin and any person who the prisoner may reasonably have asked should be informed when a prisoner is seriously ill. Prison Service Instruction 64/2011 also says that where prisoners have suffered sudden life-threatening harm, the prisoner's wishes on who they would like to be contacted must be obtained where possible.

50. There is no evidence that anyone considered contacting the man's family when he was taken to hospital seriously ill on 19 January and no evidence that anyone asked him whether he wanted anyone to be contacted. While the

prison had no next of kin details recorded, no one attempted to locate and contact his family until after his death. This meant that his family did not have the opportunity to spend any time with him before he died. We make the following recommendation:

The Governor should ensure that staff notify a prisoner's next of kin as soon as possible when a prisoner becomes seriously ill.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that all healthcare staff fully investigate symptoms, which might indicate an underlying serious disease and that prisoners who report pain are thoroughly examined to help determine the root cause.

2. The Governor and Head and Healthcare should ensure that risk assessments for prisoners attending hospital fully take into account individual circumstances, are based on the actual risk the prisoner presents at the time and are reviewed as circumstances change. When hospital staff ask for restraints to be removed, decisions should be taken quickly.

3. The Governor should ensure that staff notify a prisoner's next of kin as soon as possible when a prisoner becomes seriously ill.