

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Frank Baldwick a prisoner at HMP Manchester on 30 October 2016

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

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*



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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.

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

Mr Baldwick died on 30 October 2016 of bronchopneumonia, at HMP Manchester. Mr Baldwick was 92 years old. I offer my condolences to Mr Baldwick's family and friends.

Mr Baldwick was frail and had a number of health problems. As his health deteriorated, the prison cared for him well and appropriately addressed most of his health issues. However, this deterioration was in part due to the effects of leukaemia, and it is of concern that he was not being treated for this despite an apparent diagnosis almost a year earlier. As a result, I cannot consider the clinical care Mr Baldwick received for leukaemia to be equivalent to that he could have expected in the community.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

May 2017

Contents

- Summary 1
- The Investigation Process 3
- Background Information 4
- Key Events 5
- Findings..... 9

Summary

Events

1. On 20 October 2015, Mr Frank Baldwick was sentenced to three years' imprisonment for sex offences, and was sent directly to HMP Manchester. Mr Baldwick's initial health screening revealed a history of stroke and angina, but no outstanding medical appointments. He was also noted to be growing frail due to old age.
2. On 8 November, Mr Baldwick fell in his cell and was moved to the healthcare unit for observations and tests. On 12 November, he was diagnosed with AF (Atrial Fibrillation - a heart condition which causes an irregular and often an abnormally fast heart rate). A prison GP referred Mr Baldwick to the hospital to be assessed for deep vein thrombosis (DVT) on 17 November.
3. The same day, blood test results showed signs of a lymphoproliferative disorder (a range of conditions where the white blood cells are produced in excess – this can include leukaemia). The following day, a prison GP referred Mr Baldwick for an urgent haematology assessment to check for possible cancer.
4. On 23 November, Mr Baldwick went to hospital to be assessed for deep vein thrombosis (DVT) after a haematoma (a swelling of blood) in his leg grew rapidly. Mr Baldwick's haematology appointment was scheduled for the same afternoon, so the prison GP informed the hospital about this. On 26 November, a different prison GP chased the hospital about this appointment, which appears not to have happened. There is no record of Mr Baldwick attending this appointment.
5. The hospital diagnosed Mr Baldwick with a leg ulcer, rather than DVT, and treated him. He returned to prison on 6 January 2016.
6. Over the next few months, healthcare staff at the prison managed Mr Baldwick's leg ulcer according to a care plan. In April, Mr Baldwick spent two weeks in hospital with breathing difficulties, but otherwise he had no relevant health concerns until October.
7. On 10 October, a prison GP diagnosed Mr Baldwick with an infected ulcer in his foot and referred him to hospital. The ambulance did not arrive until late in the evening and after consulting a GP, officers cancelled it. Mr Baldwick went to the hospital the next morning, and remained there until he died at 1.20pm on 30 October

Findings

8. As Mr Baldwick's condition deteriorated, the prison cared for him well. Prison doctors made timely referrals to specialists, and supported him to attend hospital appointments.
9. We are concerned that the prison failed to manage Mr Baldwick's leukaemia satisfactorily. The prison GPs correctly and promptly referred Mr Baldwick to the hospital for suspected cancer, and initially chased this up. However, there is no record of Mr Baldwick attending the haematology appointment, or of when he

was diagnosed with leukaemia. Given that Mr Baldwick's medical records mention it, we would have expected there to have been a treatment plan. We agree with the clinical reviewer, that in the absence of an accurate record, healthcare staff could not effectively treat Mr Baldwick for his range of symptoms.

10. The prison also failed to put up any notices informing staff and prisoners of Mr Baldwick's death. While the prison did debrief the bed watch staff on duty at the time, we are concerned that they did not do enough to ensure all staff were supported effectively following his death.

Recommendations

- The Governor and the Head of Healthcare should ensure that prison and healthcare staff communicate effectively with each other and outside agencies to ensure that prisoners' appointments are not missed, and diagnoses are properly recorded and acted upon.
- The Head of Healthcare should ensure that healthcare staff properly record all important information about prisoners' care and appointments in line with Nursing and Midwifery Guidelines.
- The Governor should ensure that notices are posted to inform staff and prisoners about the death of a prisoner, and that all staff involved are offered effective support.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Manchester informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
12. The investigator obtained copies of relevant extracts from Mr Baldwick's prison and medical records.
13. NHS England commissioned a clinical reviewer to review Mr Baldwick's clinical care at the prison.
14. We informed HM Coroner for Manchester of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
15. One of the Ombudsman's family liaison officers contacted Mr Baldwick's daughter to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Baldwick's daughter said she knew Mr Baldwick had some problems with his blood cell count, but did not know about the leukaemia. Mr Baldwick's daughter spoke highly about the way the prison kept her informed and particularly the support offered to her by the prison family liaison officer.
16. Mr Baldwick's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.
17. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Background Information

HMP Manchester

18. 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 provides 24 hour nursing care and the healthcare centre includes an inpatient unit

HM Inspectorate of Prisons

19. The most recent inspection of HMP Manchester was in May 2015. Inspectors reported that health services were reasonably good, and most prisoners were satisfied with the quality of healthcare. They further commented that staff on the inpatients' unit provided compassionate care for patients with complex needs.

Independent Monitoring Board

20. 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.

Previous deaths at HMP

21. Mr Baldwick was the fourth prisoner to die of natural causes at Manchester since January 2016. There were no significant similarities between the circumstances of Mr Baldwick's death and the previous deaths at the prison.

Key Events

22. On 20 October 2015, Mr Frank Baldwick was sentenced to three years' imprisonment for sex offences, and was sent directly to HMP Manchester.
23. When he arrived at Manchester, a nurse reviewed Mr Baldwick at an initial health screen. Mr Baldwick had no outstanding medical appointments, but had medication for angina. He said he had chosen not to take this medication for the four months before his admission. Later that day, Mr Baldwick saw a prison GP, who noted that he had had a stroke four to five years previously. The GP advised Mr Baldwick to take statins (a medication to lower cholesterol) and aspirin for this, but Mr Baldwick opted only to take the aspirin.
24. A nurse conducted a second health screen with Mr Baldwick on 21 October. The nurse noted that Mr Baldwick was progressively growing frail due to his age, and had problems with his hearing and sight. The nurse noted Mr Baldwick had generally stable blood pressure and planned for this to be frequently monitored.
25. On 8 November, healthcare staff saw Mr Baldwick after he had fallen in his cell. Mr Baldwick said that he had pain from his bad back, which also caused him difficulties getting in and out of bed or chairs. Mr Baldwick was prescribed paracetamol for the pain and transferred to the healthcare unit for observation. He remained there for the next few weeks.
26. On 12 November, Mr Baldwick had an electrocardiogram (ECG – which measures the electrical rhythm of the heart) and was diagnosed with atrial fibrillation (AF – a heart condition which causes an irregular and often an abnormally fast heart rate). A prison GP discussed treatment options with Mr Baldwick, who said he did not want to take anticoagulation medication (drugs that work to prevent blood clotting), but agreed to take beta-blockers to treat his abnormal heart rhythm.
27. On 17 November, a prison GP examined Mr Baldwick and observed swelling in his left leg. He referred Mr Baldwick to the hospital to be assessed for DVT (Deep Vein Thrombosis). The same day, the prison received blood test results which showed signs of a lymphoproliferative disorder (which covers a range of conditions where the white blood cells are produced in excess and can include leukaemia). The next day, a GP referred Mr Baldwick to the haematology department at the hospital for an urgent assessment and advice. He was placed on a two week waiting period for this review.
28. A prison GP reviewed Mr Baldwick on 19 November, when it was agreed he would start the beta-blockers that day. The GP also explained about the referral to the hospital for a scan on his leg to rule out DVT. The GP noted that Mr Baldwick was not aware of the haematology referral and explained to him about the risk of cancer and that this referral was necessary to rule it out.
29. At 5.30am on 21 November, Mr Baldwick rang his cell bell requesting pain relief for his leg. A nurse attended and gave him paracetamol through his cell hatch, and booked him in for a GP review. Later that morning, a prison GP examined Mr Baldwick and diagnosed a large haematoma (a solid swelling of clotted blood

within the tissues), but noted this was not infected. He advised that this be kept under observation.

30. At 4.00am the next morning, a nurse examined Mr Baldwick in his cell after he rang his cell bell. The nurse observed a tiny tear near Mr Baldwick's haematoma, with a watery blood like substance seeping out. A prison GP examined Mr Baldwick later that morning and noted the break of skin above the haematoma. He noted the plan set in place by two previous GPs, along with the hospital referrals, and advised that this plan should continue.
31. On 23 November, a prison GP examined Mr Baldwick after fresh reports of problems with his leg. He observed that Mr Baldwick's haematoma had rapidly increased in size, was weeping blood and was giving Mr Baldwick pain up to his left thigh. He sent Mr Baldwick to hospital, and informed the hospital that Mr Baldwick had a haematology appointment there that afternoon. There is a reference to an appointment in Mr Baldwick's prison medical records, but no detail as to when this haematology appointment was, or of him attending an appointment during his time in hospital. He was admitted as an inpatient.
32. On 26 November, a prison GP reviewed Mr Baldwick's medical notes after a conversation with Mr Baldwick's daughter, and realised that his haematology appointment was due. He then spoke to one of the hospital doctors about this, and requested an inpatient referral instead. He also sent a fax to the hospital, which included Mr Baldwick's abnormal blood test results.
33. Healthcare staff from the prison phoned the hospital regularly for updates on Mr Baldwick. On 11 December, a nurse spoke with the Sister on Mr Baldwick's ward, and noted being told that Mr Baldwick had leukaemia which was not currently being treated.
34. Mr Baldwick was discharged back to the prison from the hospital on 6 January 2016. Mr Baldwick did not have DVT but a chronic leg ulcer. A care plan was drawn up to manage his condition. Mr Baldwick was located in the healthcare unit at the prison to enable healthcare staff to care for him properly.
35. On 8 January, a prison GP saw Mr Baldwick in surgery, where they discussed Mr Baldwick's intention not to be resuscitated in the event of a cardiac arrest. He completed the paperwork for this, and shared this information with the nursing staff. He also recorded that Mr Baldwick had been diagnosed with leukaemia, AF and hypertension, but there is no record whether this was discussed at the consultation.
36. The healthcare staff at HMP Manchester treated Mr Baldwick for his leg ulcer and a number of infections over the next few months in line with all clinical standards. Further ulcers were also dealt with appropriately at the prison.
37. On 30 April, Mr Baldwick was sent to hospital with breathing difficulties, where he remained until 13 May. In the discharge letter, a hospital doctor requested a haematology outpatient appointment to be made for Mr Baldwick, regarding a long term follow up for chronic lymphocytic leukaemia (CLL).
38. Over the next few months, Mr Baldwick's leg ulcer was treated according to a care plan. There were no other relevant events relating to Mr Baldwick over the

next few months, and no record of Mr Baldwick attending any appointments at the hospital.

Mr Baldwick's admission to hospital

39. On the afternoon of 10 October, a prison GP saw Mr Baldwick after a request to review his foot wound. He observed that the bone appeared visible, there was an offensive smell and the area around the fifth toe appeared hollow. He diagnosed an infected ulcer and referred Mr Baldwick to hospital. It was recorded at 2.39pm that an ambulance had been arranged by the control room to transfer him to hospital.
40. An ambulance arrived at 9.17pm, and the duty governor queried whether it was essential given the late hour. A nurse contacted a GP at home, who agreed that if Mr Baldwick's observations were stable he could be taken to hospital in the morning. Mr Baldwick was observed as stable and the ambulance was cancelled. Mr Baldwick was transferred to hospital on the morning of 11 October.
41. Mr Baldwick remained in hospital until he died at 1.20pm on 30 October.

Contact with Mr Baldwick's family

42. Mr Baldwick's next of kin was his daughter. She had taken power of attorney from October 2015 and healthcare staff regularly consulted her about his medical issues.
43. The prison appointed an officer as the family liaison officer on 29 October 2016, as she had had a lot of contact with Mr Baldwick's daughter throughout Mr Baldwick's time in hospital. She called Mr Baldwick's daughter at 0.45am on 30 October, and explained that Mr Baldwick only had hours to live. Mr Baldwick's daughter said she would speak directly to the hospital, as she lived too far away to arrive before he died.
44. On afternoon of 30 October, the officer called Mr Baldwick's daughter to inform her that Mr Baldwick had died. Mr Baldwick's daughter said she already knew, having spoken directly to the hospital. The officer and a chaplain continued to offer support to Mr Baldwick's daughter.
45. Mr Baldwick was cremated on 12 December. The prison contributed towards the cost of the funeral in line with national policy.

Support for prisoners and staff

46. The prison did not post any notices to inform other prisoners or staff of Mr Baldwick's death.
47. The duty governor held a telephone debrief with the bed watch staff on duty. He asked two officers whether they needed anything, and explained that the staff care team were available if needed.

Post-mortem report

48. The post-mortem report concluded that the immediate cause of death was bronchopneumonia (inflammation in the lungs). The report also noted that old

age and chronic lymphocytic leukaemia (a type of cancer that affects the white blood cells and tends to progress slowly over many years) contributed to his death.

Findings

Clinical care

49. The clinical reviewer concluded that Mr Baldwick received an equivalent level of care at HMP Manchester to that he would have expected to receive in the community for most of his conditions. However, the care Mr Baldwick received for his leukaemia could not be regarded as equivalent due to the lack of documented treatment.
50. Mr Baldwick received a thorough health screen on reception at Manchester, and had follow up health screens and GP reviews in his first few days there. The health concerns Mr Baldwick had from his time in the community were managed effectively. Mr Baldwick was diagnosed with atrial fibrillation and a leg ulcer during his time at Manchester, and the clinical reviewer found the management of these conditions to have been in line with the recommended guidance. He was referred promptly for assessments and to hospital when needed.
51. There was a delay taking Mr Baldwick to hospital in October 2016. A prison GP had referred Mr Baldwick to accident and emergency with a suspected infected ulcer during the afternoon of 10 October. Records show that at 2.39pm the control room had arranged an ambulance, but it did not arrive until 9.17pm. The prison could not clarify when the ambulance was called, or why it took so long to arrive. When the ambulance did arrive, the duty governor queried whether it was essential given the time of day, and it was cancelled following a discussion with a GP at home. On his advice, Mr Baldwick was kept under observations overnight and sent to hospital the next morning. The clinical reviewer observed that any delay posed a high risk of sepsis for Mr Baldwick due to his infection, but was satisfied that healthcare staff appropriately managed this risk by monitoring him. In these circumstances, we make no recommendation about this.
52. We are concerned however, about the management of Mr Baldwick's leukaemia. Abnormal blood results showing signs of a lymphoproliferative disorder arrived at the prison on 17 November 2015. A prison GP correctly referred Mr Baldwick to the haematology department the next day to check for a suspected cancer. Mr Baldwick was given a two week outpatient referral window, and an appointment was scheduled for the afternoon of 23 November. When Mr Baldwick was referred to the hospital that morning by the GP for a DVT assessment, the GP informed the hospital about Mr Baldwick's haematology appointment. On 26 November, another GP contacted the hospital to inform them that Mr Baldwick was on a two week haematology referral, and that he was concerned he might miss it. He followed this up with a fax to the hospital which also contained Mr Baldwick's blood test results.
53. Mr Baldwick's prison medical records contain no reference to him attending this haematology appointment, but there are references to him being diagnosed with leukaemia. On 11 December 2015, a nurse records speaking to the Sister on Mr Baldwick's ward, who said he had leukaemia which was not currently being treated. On 8 January 2016, a prison GP recorded that Mr Baldwick was currently diagnosed with leukaemia. And, on 13 May, Mr Baldwick's discharge letter from the hospital to the prison, after an unrelated stay, requested a

haematology appointment in regards to a long term follow up for chronic lymphocytic leukaemia. These are the only references we can find in the documents relating to Mr Baldwick's leukaemia management, and there is no evidence of Mr Baldwick receiving any treatment for leukaemia.

54. We agree with the clinical reviewer that the care Mr Baldwick received for his leukaemia was not equivalent to that he could have expected in the community. The clinical reviewer observes that the lack of information in Mr Baldwick's medical records means healthcare professionals could not effectively provide continuity of care for Mr Baldwick, or treat all his symptoms holistically. Even Mr Baldwick's daughter was not aware of this diagnosis, despite have a lasting power of attorney and being regularly consulted over her father's care.

The Governor and the Head of Healthcare should ensure that prison and healthcare staff communicate effectively with each other and outside agencies to ensure prisoners' appointments are not missed, and diagnoses are properly recorded and acted upon.

The Head of Healthcare should ensure that healthcare staff properly record all important information about a prisoners' care and appointments in line with Nursing and Midwifery Guidelines.

The use of restraints

55. When prisoners have to travel outside of the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk taking into account factors such as the prisoner's health and mobility.
56. A risk assessment was completed for Mr Baldwick prior to his escort to hospital on 11 October 2016. He was deemed to be low risk and no restraints were necessary.
57. We consider that the prison acted appropriately in deciding not to restrain Mr Baldwick.

Support for prisoners and staff

58. The prison did not display any notices informing staff or prisoners of Mr Baldwick's death, and they have confirmed this was an oversight on their part.
59. Mr Baldwick was only on a regular wing at the prison for less than a month before being cared for either in the hospital wing, or at external hospital. A telephone debrief was held with the two prison officers on bed watch duty when Mr Baldwick died, in which they were offered support and informed about the staff care team. But, the prison did not debrief the healthcare staff, and did not take adequate steps to ensure they were supported following Mr Baldwick's death.

The Governor should ensure that notices are posted to inform staff and prisoners about the death of a prisoner, and that all staff involved are offered effective support.

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