

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr George Pringle a prisoner at HMP Manchester on 8 July 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 George Pringle died in hospital on 8 July 2016 of lower abdominal cancer while a prisoner at HMP Manchester. He was 77 years old. I offer my condolences to Mr Pringle's family and friends.

The investigation found there was a missed opportunity to send an urgent referral to a specialist, but the clinical reviewer noted that this would not have prevented Mr Pringle's death. Despite this omission, the clinical reviewer was still satisfied that Mr Pringle's standard of care at the prison was equivalent to that he could have expected to receive in the community.

I am concerned, however, that the use of restraints when Mr Pringle was admitted to hospital in June, was not justified by fully considered risk assessments, which took into account his health and mobility. This is an area of concern that I have raised previously, and expect the Governor to ensure staff are aware of the legal position.

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**

**February 2017**

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# Summary

## Events

1. On 11 December 2015, Mr George Pringle was remanded into custody for sexual offences and sent to HMP Manchester. On 15 April 2016, he was sentenced to 18 months imprisonment.
2. Mr Pringle suffered from type 2 diabetes, hypertension, high cholesterol and arthritis of the spine. During his first reception health screen, Mr Pringle told a prison nurse he had pain in his lower abdomen and rectum. On 15 December, a prison GP prescribed laxatives for constipation.
3. On 8 March 2016, Mr Pringle complained again of constipation and a locum prison GP prescribed a further course of laxatives. The GP noted that Mr Pringle's abdomen was soft and not bloated or tender.
4. Blood tests on 22 March indicated that Mr Pringle was anaemic and, on 5 April, a locum GP sent him to hospital – he had a raised breathing rate and dizziness. Hospital doctors confirmed Mr Pringle had anaemia, gave him a blood transfusion and prescribed iron tablets. A hospital consultant discussed Mr Pringle's abdominal pain and made a referral for an endoscopy (an examination of the oesophagus, stomach and small intestine) but did not indicate if the appointment was routine or urgent.
5. Mr Pringle continued to complain of constipation and lower abdominal pain. On 26 April, he went to hospital and hospital doctors diagnosed constipation. A prison GP noted that Mr Pringle had returned to Manchester without a discharge summary but did not ask the healthcare administration team to contact the hospital or to ask for the date of the endoscopy examination.
6. Mr Pringle complained of very loose faeces and weight loss on 24 May, and a prison GP made an urgent two week wait referral to a consultant gastroenterologist. (This is an urgent referral, for suspected cancer.) Mr Pringle had a gastroscopy (an examination of the oesophagus, stomach and small intestine) and a colonoscopy (an examination of the inner lining of the rectum and colon) on 9 June. A consultant gastroenterologist diagnosed severe oesophagitis (inflammation of the lining of the oesophagus).
7. On 17 June, prison officers found Mr Pringle collapsed on the floor of his cell. A locum prison GP arranged for an emergency ambulance to take Mr Pringle to hospital, where he remained until he died.
8. Mr Pringle had a CT scan on 22 June, which revealed that he had lower gastrointestinal cancer. His condition declined quickly and he died at 6.00am on 8 July.

## Findings

9. The clinical reviewer found that prison GPs missed the opportunity to refer Mr Pringle to a hospital specialist for suspected cancer when he returned to Manchester from hospital on 26 April 2016. A discharge summary and

endoscopy referral could have been sought. However, she considered that earlier investigations into his symptoms would not have prevented his death. Following his diagnosis, Mr Pringle quickly deteriorated and active treatment was not possible. Overall, we are satisfied that Mr Pringle received an appropriate standard of care at the prison, equivalent to that he could have expected to receive in the community.

10. We are concerned that prison managers decided to restrain Mr Pringle when he was admitted to hospital on 16 June, even when he received intravenous treatment and was in a poor state of health. While we recognise that restraints were removed shortly after his cancer diagnosis, we do not consider that the earlier decisions were based on carefully considered risk assessments which took full account of Mr Pringle's treatment and limited mobility and how they affected his risk of escape.

## **Recommendations**

- The Head of Healthcare should ensure that GPs follow the NHS cancer referral guidelines issued by the National Institute for Health and Clinical Excellence (NICE).
- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

## 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 her. No one responded.
12. The investigator obtained copies of relevant extracts from Mr Pringle's prison and medical records.
13. NHS England commissioned a clinical reviewer to review Mr Pringle's clinical care at the prison.
14. We informed HM Coroner for City of Manchester District of the investigation who gave us the cause of death. We have given the coroner a copy of this report.
15. The investigator wrote to Mr Pringle's stepson to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not respond to our letter.
16. The investigation has assessed the main issues involved in Mr Pringle's care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.
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 provide 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 Manchester

21. Mr Pringle was the fourth person to die of natural causes at Manchester since January 2015. There have been two other natural cause deaths since Mr Pringle died. We have previously commented on the use of restraints.

# Findings

## The diagnosis of Mr Pringle's terminal illness and informing him of his condition

22. On 11 December 2015, Mr George Pringle was remanded into custody for sexual offences and sent to HMP Manchester.
23. At a reception health screen Mr Pringle confirmed his medical conditions, which included type 2 diabetes, hypertension, high cholesterol and arthritis of the spine. A prison nurse created an older person's care plan and a diabetes care plan to manage Mr Pringle's physical and clinical needs. These included instructions to ensure he received his prescribed medication which a GP prescribed the same day. Mr Pringle told the nurse that he had pain in his lower abdomen and rectum. He declined to see a prison GP because he had not washed and preferred to wait for an appointment.
24. On 14 December, a prison nurse completed a routine second health screening. Mr Pringle said he had pain in the right side of his abdomen and constipation. The nurse made a GP appointment for the next day. A prison GP prescribed Mr Pringle laxatives for constipation on 15 December. There was nothing else of significance in the records between December and March 2016.
25. The next significant event was recorded on 8 March 2016, when Mr Pringle complained again of constipation. A locum prison GP prescribed a different laxative. The GP noted that Mr Pringle's abdomen was soft and not bloated or tender.
26. A prison nurse carried out a diabetic review on 22 March, and noted that Mr Pringle's blood sugars were high. A blood test indicated that Mr Pringle was anaemic and his diet was poor.
27. On 5 April, a locum prison GP examined Mr Pringle, who had a raised breathing rate and dizziness. The GP arranged for Mr Pringle to go to hospital. Hospital doctors gave Mr Pringle a blood transfusion and prescribed iron tablets to treat anaemia.
28. A hospital consultant discussed Mr Pringle's abdominal pain with him on 7 April, and made a referral for an endoscopy (a camera examination of the digestive tract) to rule out a gastro-intestinal bleed. The consultant did not indicate if a routine or urgent appointment was required. Mr Pringle returned to Manchester on 8 April. Later, on 15 April 2016, he was sentenced to 18 months imprisonment.
29. On 26 April, a prison GP examined Mr Pringle who complained of constipation and lower abdominal pain. A rectal examination did not reveal any masses or blood in his faeces. The GP arranged for an ambulance to take Mr Pringle to hospital. Hospital doctors diagnosed constipation and prescribed laxatives. Mr Pringle was returned to Manchester the same day.
30. A prison GP noted that Mr Pringle had returned to Manchester without a discharge summary and he was unclear of the plan for Mr Pringle's future care.

The GP did not ask the healthcare administration team to contact the hospital for the discharge summary or for the date of the endoscopy examination.

31. On 24 May, Mr Pringle told a prison GP his faeces were like liquid and he had lost weight. The GP arranged a full set of blood tests and made an urgent referral to a gastroenterologist under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks. The GP asked a healthcare administration assistant to contact the hospital for the endoscopy appointment date.
32. The next day, a locum prison GP assessed Mr Pringle, who complained of feeling weak and lethargic. Mr Pringle had a raised heart rate. The GP arranged for an ambulance to take Mr Pringle to hospital. In hospital, Mr Pringle had an electrocardiogram (ECG) with normal results. His abdomen was bloated but an x-ray did not reveal any blockages. Mr Pringle returned to Manchester the same day.
33. On 9 June, Mr Pringle was sent to hospital for a gastroscopy (an examination of the oesophagus, stomach and small intestine – also referred to as an upper gastrointestinal endoscopy), and colonoscopy (an examination of the inner lining of the rectum and colon). A consultant gastroenterologist diagnosed severe oesophagitis (inflammation of the lining of the oesophagus). They planned a repeat gastroscopy in two months time and a CT scan.
34. On 17 June, prison officers found Mr Pringle collapsed on the floor of his cell. A locum prison GP immediately attended to assess Mr Pringle. His blood sugars and blood pressure were low and his abdomen was bloated. The GP suspected that Mr Pringle had an accumulation of fluid in the abdominal cavity. He arranged for an emergency ambulance to take Mr Pringle to hospital.
35. Hospital doctors treated Mr Pringle with intravenous vitamins and inserted an ascetic tap to drain the fluid in his abdomen. Mr Pringle had a CT scan and, on 24 June, a consultant gastroenterologist told him that the results of the CT scan revealed he had lower gastrointestinal cancer.
36. The clinical reviewer commented that, when Mr Pringle returned to Manchester from hospital on 26 April, prison GPs missed the opportunity to contact the hospital for the discharge summary and the date of the endoscopy. Prison GPs did not make a referral under the 'two week rule' for suspected cancer until four weeks later. We consider that this should be standard practice as soon as GPs suspect that a prisoner has cancer but note that this would not have affected the treatment outcome for Mr Pringle as the cancer had spread to other parts of his abdomen and he deteriorated rapidly. However, it could make a difference in other circumstances. We make the following recommendation:

**The Head of Healthcare should ensure that GPs follow the NHS cancer referral guidelines issued by the National Institute for Health and Clinical Excellence (NICE).**

### Mr Pringle's clinical care

37. Hospital doctors concluded that Mr Pringle's condition was not suitable for active treatment and he would receive palliative care. On 26 June, Mr Pringle said he

did not want anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect. On 28 June, hospital doctors inserted a syringe driver, which gave Mr Pringle a regular dosage of morphine to manage his pain and keep him comfortable. Mr Pringle continued to deteriorate and he died at 6.00am on 8 July.

38. The post mortem report indicated that Mr Pringle had died from cancer in the lining of his lower abdomen, which had spread to other parts of his abdomen.

### **Mr Pringle's location**

39. Mr Pringle lived in a single cell on the vulnerable prisoners' unit until his admission to hospital on 17 June 2016. We are satisfied that Mr Pringle was appropriately located throughout his illness and was quickly taken to hospital when his condition deteriorated.

### **Restraints, security and escorts**

40. 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 a 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 medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change
41. The risk assessment completed before Mr Pringle went to hospital on 17 June indicated that he was a high risk to the public and a medium risk to hospital staff. Mr Pringle was a medium risk of escape. The medical section of the form stated there was no objection to the use of restraints and that Mr Pringle had impaired mobility. A prison manager decided that staff should use handcuffs during the journey to hospital and an escort chain if Mr Pringle needed treatment or admission to hospital. (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.)
42. When hospital doctors admitted Mr Pringle on 17 June, prison staff applied an escort chain. Hospital doctors treated Mr Pringle with intravenous vitamins and on 20 June, they inserted an ascetic tap to drain the fluid in his abdomen. At 11.00am on 24 June, the hospital told prison staff that Mr Pringle's condition was terminal. Shortly after a prison manager authorised the removal of restraints.
43. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances. Mr Pringle was receiving intravenous treatment and had an ascetic tap in his abdomen, which further restricted his mobility. While we recognise that restraints were removed when Mr Pringle's condition became terminal we do not consider that prison managers appropriately considered how his condition, mobility and treatment affected his

ability to escape, in line with the High Court judgment. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.**

#### **Liaison with Mr Pringle's family**

44. On 23 June 2016, the prison appointed a chaplain as a family liaison officer. He contacted Mr Pringle's stepson, his nominated next of kin, and arranged for him to visit Mr Pringle in hospital on 24 June. Mr Pringle's stepson asked the chaplain to telephone him when Mr Pringle died.
45. At 9.45am on 8 July, the chaplain telephoned Mr Pringle's stepson and informed him of his death. He kept in contact with Mr Pringle's stepson until his funeral on 27 July. The prison contributed towards the costs in line with national policy.

#### **Compassionate release**

46. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months.
47. On 26 June, a prison manager visited Mr Pringle in hospital to ask if he wanted to apply for early release on compassionate grounds. Mr Pringle said he did not want to be released on compassionate grounds and preferred to move to a hospice for end of life care. The same day, a hospital doctor referred Mr Pringle to a hospice, but a bed was not available. Mr Pringle's condition deteriorated quickly and hospital doctors decided he was too unwell to move if a hospice bed became available and he should remain in hospital.
48. We are satisfied that the prison appropriately discussed compassionate release with Mr Pringle soon after he was diagnosed with cancer and did not apply for it, in line with his wishes.

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