Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Knott a prisoner at HMP Manchester on 3 September 2018

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*

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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 John Knott died on 3 September 2018, of bronchopneumonia related to lung cancer while a prisoner at HMP Manchester. He was 75 years old. I offer my condolences to Mr Knott's friends.

The standard of care Mr Knott received at HMP Manchester was equivalent to that which he could have expected to receive in the community. Symptoms were appropriately investigated and referrals to specialists were made where necessary. Mr Knott's mental health requirements in relation to his dementia diagnosis were consistently considered and reviewed. Adjustments were made to his care regime as he deteriorated, and on occasions where his cognitive functioning improved, he was invited to contribute to treatment decisions.

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

Sue McAllister CB
Prisons and Probation Ombudsman **January 2019**

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Summary

Events

1. On 31 May 2016, Mr Knott was remanded to HMP Manchester for sexual offences. He was convicted of these offences on 23 May 2017.

2. In October 2016, abnormal blood test results prompted a prison GP to refer Mr Knott for a number of investigations including a chest X-ray. The X-ray identified a shadow on his lung. Mr Knott had a further scan and he was diagnosed with lung cancer.

3. Mr Knott had become increasingly confused and he was diagnosed with dementia. Healthcare staff appropriately considered what was in Mr Knott's best interests, in line with the Mental Capacity Act 2005, and he was assigned an Independent Mental Capacity Advocate. A Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order was put in place and appropriately revisited when his cognitive abilities improved.

4. Mr Knott initially refused treatment for his lung cancer but he eventually agreed to radiotherapy. Radiotherapy reduced the tumour to the extent that he was discharged from the hospital's oncology clinic in December 2017.

5. A deterioration in his general condition in May 2018, led to further investigations and a hospital admission in August. During that admission, Mr Knott was diagnosed with tumours in his lung and brain. Mr Knott died in hospital on 3 September 2018.

Findings

6. We are satisfied that the standard of care Mr Knott received at HMP Manchester was equivalent to that which he could have expected to receive in the community.

7. Staff appropriately monitored Mr Knott and made referrals for further investigations where necessary. His physical and mental health needs were thoroughly and compassionately addressed.

8. Alternative locations were also sought for Mr Knott in the light of his dementia diagnosis, but his increased nursing needs and the severity of the charges he was facing made placing him in an appropriate location difficult.

9. Although we are satisfied that Mr Knott was not restrained when he was escorted to hospital appointments, we are concerned that the risk assessments were not available for us to see.

Recommendations

- The Governor should ensure that escort risk assessments are retained.

The Investigation Process

10. 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.

11. The investigator obtained copies of relevant extracts from HMP Manchester's prison and medical records.

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

13. We informed HM Coroner for City of Manchester District of the investigation. The coroner informed us of the cause of death. We have sent the coroner a copy of this report.

14. The investigator wrote to Mr Knott's named next of kin 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.

15. The investigation has assessed the main issues involved in Mr Knott'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.

16. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HM Prison Manchester

17. 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

18. The most recent inspection of HMP Manchester was published in November 2018. Inspectors reported that compared to their last inspection in 2014, where the prison achieved reasonably good outcomes against their healthy prison tests, at this inspection there had been a deterioration on most outcomes. They observed, however, professional interactions between healthcare staff and prisoners and clinical records and care plans were very good. Continuity of care was also good with most locum GPs and agency nurses working at the prison regularly. A dedicated nurse provided annual health checks and age-related screening.

Independent Monitoring Board

19. 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 2018, the IMB noted that 50% of residential wings did not have the desired levels of staff on duty and the fabric of the building was generally in poor condition. They commended plans to improve cells so that they would be fit for wheelchair users and described the healthcare provision as excellent.

Previous deaths at HMP Manchester

20. Mr Knott's was the tenth death from natural causes at HMP Manchester in the preceding three years. There are no similarities with those cases.

Findings

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

21. On 31 May 2016, Mr Knott was remanded to HMP Manchester for sexual offences. He was convicted of these offences on 23 May 2017.

22. A nurse conducted Mr Knott's first night reception screen at the prison. He noted that Mr Knott was a smoker and had minor health concerns including tinnitus and a poor short-term memory. The nurse decided that Mr Knott could be appropriately located on a normal residential wing.

23. Mr Knott had many blood tests either because of suspected infections (in July 2016 he was diagnosed with cellulitis) or as part of other age-related reviews.

24. On 6 October 2016, a prison GP reviewed Mr Knott's blood test results and identified raised levels of 'Brain Type Natriuretic Peptides' (hormones secreted by the heart), indicating heart failure. A prison GP arranged for Mr Knott to have further investigations including an ECG (electrocardiogram), a chest X-ray and blood tests for a certain protein (troponin).

25. The X-ray and the blood tests were completed and reviewed by a prison GP on the same day. The X-ray identified a shadow on Mr Knott's lung and the prison GP made an urgent referral to specialists under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks.

26. An appointment for a further lung scan was arranged for 18 October, but Mr Knott was so agitated and aggressive in the prison's reception area that the appointment was cancelled. It was rescheduled for 24 October, and went ahead as planned.

27. On 26 October, Mr Knott was due to discuss the results of his lung scan with a respiratory specialist at the hospital but he refused to attend. A prison GP asked hospital staff to send him the scan results so that he could discuss the results with Mr Knott. The results strongly indicated lung cancer. The prison GP discussed the scan results with Mr Knott but Mr Knott could not remember the X-ray, the scan or his refusal to attend the appointment. The prison GP recorded that he explained the results to Mr Knott and that not having any treatment would kill him. Mr Knott instantly forgot the conversation he had had with the prison GP.

28. A prison GP arranged an assessment of Mr Knott's cognitive abilities for 27 October, and a 'Best Interests' meeting for 28 October. There had been on-going concern about Mr Knott's ability to process and retain information and his self-care had declined to the extent that he was moved to the prison's healthcare unit that same day.

29. We agree with the clinical reviewer that the care Mr Knott received in terms of his diagnosis was equivalent to that which he could have expected to receive in the community. We are satisfied that healthcare staff appropriately investigated Mr Knott's symptoms, made timely referrals to secondary care providers and discussed his diagnosis with him.

Mr Knott's clinical care

30. On 27 October 2016, a consultant psychiatrist assessed Mr Knott and diagnosed him with dementia.

31. On 28 October, the 'Best Interests' meeting was held. The Mental Capacity Act (2005) requires that any decision made on behalf of an adult lacking capacity, must be done in their best interests and covers financial, health and social care decisions. A prison GP chaired the meeting, attended by nurses and a psychiatrist. The meeting concluded that Mr Knott should be discussed further with a locum psychiatrist and legal advice should be sought from the Manchester Mental Health and Social Care Trust.

32. On 31 October, a nurse updated Mr Knott's care plan to advise healthcare staff to take all opportunities to discuss Mr Knott's diagnosis and treatment options with him. There were regular notes throughout the record confirming that this had happened. Mr Knott's capacity to understand what was happening to him fluctuated. He had developed a swelling in his hand (first noted on 20 November 2016) which was thought to be an indirect result of the tumour, and staff reported different responses from him about his understanding of this. At times, Mr Knott denied that he had cancer and on other occasions he refused any radical forms of cancer treatment.

33. Discussions between healthcare professionals about Mr Knott's capacity to understand and his decision to decline treatment continued. On 16 December, a respiratory specialist wrote a letter to the healthcare team at the prison and said that she did not feel it was in Mr Knott's best interests to go ahead with radical treatment given the risks and benefits, and she recommended palliative care. The letter was reviewed by a prison GP on 5 January 2017.

34. On 6 January, a prison GP signed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order (which means that in the event of cardiac or respiratory arrest no attempt at resuscitation will be made) on Mr Knott's behalf. The prison GP also arranged for Mr Knott to be assigned an Independent Mental Capacity Advocate (IMCA) to act as a safeguard and to help Mr Knott make important decisions.

35. Further discussions with Mr Knott, the IMCA and healthcare staff resulted in agreement that Mr Knott did agree to 'consider' treatment options such as radiotherapy. Treatment took place between April and May. As Mr Knott had accepted treatment, a prison GP revisited the DNACPR order with him on 25 April, and Mr Knott said that he did not want to be resuscitated.

36. On 23 November, a review of the radiotherapy treatment was sent to a prison GP. A scan in October had identified that the tumour had reduced and, on 21 December, Mr Knott was discharged from the hospital's oncology clinic.

37. Mr Knott remained in the prison's healthcare unit and, on 23 May 2018, he was moved to the enhanced care suite because he had had a number of falls and, overall, his condition was declining. Arrangements were made for him to be nursed on an 'open door policy' (which means his cell door was not locked to enable healthcare staff to provide him with care when he needed it).

38. On 24 May, a prison GP referred Mr Knott to see a specialist after he reported visual and auditory hallucinations. The prison GP was concerned that the cancer might have returned and spread, but an MRI scan (Magnetic Resonance Imaging) was clear. A brain scan was planned for 21 June.

39. Although Mr Knott was closely monitored by nursing staff, his general condition continued to decline. Care plans were updated, checks increased, pressure sores managed and a pressure relieving mattress was provided.

40. The brain scan appointment for 21 June was cancelled because of emergencies at the hospital and it was rearranged for 2 July. The results of the scan were sent to a prison GP on 19 July, and showed a mass on the right side of Mr Knott's brain. Steroids were prescribed to reduce the swelling. A referral was in place to check if the cancer had spread to his thorax, abdomen or pelvis and a plan to scan his entire body was put in place.

41. On 28 August, Mr Knott was admitted to hospital when he failed to respond to antibiotic treatment for what was thought to be a lung infection. Hospital staff diagnosed pneumonia. An entire body scan took place on 31 August, and the results identified an extensive tumour in Mr Knott's right lung and his brain, and it was suspected that the cancer had also spread to his liver. Mr Knott remained in hospital.

42. At 10.53am on 3 September 2018, it was confirmed that Mr Knott had died.

43. The clinical reviewer concluded that the clinical care Mr Knott received was equivalent to that which he could have expected to receive in the community. Staff appropriately monitored Mr Knott and responded to any deterioration in his condition or new symptoms. Clinical notes were of a good standard.

Mr Knott's location

44. Mr Knott was located in the prison's healthcare unit from 28 October 2016, and he was moved to the enhanced care suite on 23 May 2018. We are satisfied that this was appropriate.

45. Because of Mr Knott's mental health issues, the healthcare team explored the possibility of alternative placements for him. On 28 October 2016, Mr Knott was considered for placement at a Psychiatric Intensive Care Unit or an Older People's Services location. However, the severity of the charges against him led to these options being rejected.

46. A referral to a medium secure psychiatric unit, was also considered but this was put on hold because of Mr Knott's lung cancer diagnosis. The idea was revisited on 21 May 2018, when a doctor from the secure psychiatric unit assessed Mr Knott. He concluded that Mr Knott's nursing care needs were beyond the secure psychiatric unit capabilities.

47. We are satisfied that alternative locations were explored for Mr Knott.

Restraints, security and escorts

48. 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.

49. For his last admission to hospital on 28 August 2018, Mr Knott was not restrained. Paperwork relating to all other escorting arrangements was incomplete, with most risk assessments missing. However, the evidence dating back to April 2017, when Mr Knott received radiotherapy treatment following his first cancer diagnosis, indicated that he was not restrained on these previous hospital visits. We make the following recommendation:

    The Governor should ensure that risk assessments are retained.

Liaison with Mr Knott's family

50. Some weeks before Mr Knott's death, a chaplain was assigned as the prison's family liaison officer (FLO). Mr Knott was not in contact with his family but had named a friend as his next of kin. The FLO contacted the next of kin on 28 August, and he visited him to inform him of Mr Knott's declining health the same day. The next of kin felt unable to visit Mr Knott because of his own health issues. When Mr Knott died on 3 September, the FLO visited the next of kin to inform him of Mr Knott's death.

51. Mr Knott's funeral was held on 11 October 2018, and the FLO attended. The prison contributed to the costs of the funeral in line with national policy.

Compassionate release

52. 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.

53. Mr Knott had been convicted of sexual offences but he had not been sentenced so he was still a remand prisoner and, as such, he was not eligible to be considered for early release.

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