Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Thomas King a prisoner at HMP Manchester on 30 May 2017

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.

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 Thomas King died on 30 May 2017 while a prisoner at HMP Manchester. His death was caused by sepsis, Guillain-Barré syndrome and Bickerstaff's brainstem encephalitis. Mr King was 62 years old. I offer my condolences to Mr King's family and friends.

While the clinical care Mr King received at Manchester was largely equivalent to that which he could have expected in the community, there were areas where it could have been better. I am concerned that staff did not adequately monitor his medication compliance and failed to process medical appointments promptly. I am also concerned that his risk of falling was never assessed, and that despite his mobility issues, he was not prioritised for ground floor accommodation.

I find it troubling that although Mr King clearly had mobility issues, he was restrained for nearly a week after being taken to hospital.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman **June 2018**

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Summary

Events

1. On 21 August 2014, Mr Thomas King was remanded to HMP Manchester. He was subsequently convicted of sexual offences and, on 22 December, sentenced to 10 years imprisonment and returned to Manchester.

2. A health screen completed on his initial reception revealed that Mr King had depression and was prescribed anti-depressants. He had asthma and a hernia, but otherwise had no physical health concerns. At the end of 2015, Mr King fell down some stairs and developed problems with his hip. He was diagnosed with osteoarthritis. He had limited mobility and pain which got progressively worse. In August 2016, officers moved him from the third floor to a cell on the second floor due to his mobility problems.

3. In December 2016, Mr King began exhibiting unusual behaviour, and complained of hearing voices. A visiting psychiatrist noted that he had suffered a relapse of his depressive disorder due to not taking his medication, and instructed staff to monitor this. Mr King continued not to take his medication and at a multidisciplinary meeting it was decided that he should be admitted to the healthcare unit if he did not improve. In January 2017, the psychiatrist reviewed Mr King, and was concerned by the voices he was hearing. He prescribed him anti-psychotic medication.

4. Mr King's condition deteriorated and, on 24 January, he was admitted to the healthcare unit. On 30 January, a different psychiatrist saw Mr King and noted that his mood was very flat, and he was hearing voices. He increased Mr King's anti-psychotic medication. On 13 February, the same psychiatrist reviewed Mr King and observed that he was much better, and that the increased medication appeared to have worked.

5. On 27 February, a prison GP saw Mr King following complaints of dizziness and falling. Three days later, he reviewed Mr King and noted that he had abnormal blood results. The result of an electrocardiogram (ECG) scan was also unusual. He consulted a hospital specialist, and decided that Mr King should remain under observation at the prison. The next day, Mr King was admitted to hospital after another abnormal ECG but was discharged later the same day.

6. On 4 March, a senior nurse reviewed Mr King after he appeared confused. She noted that his observations and an ECG scan were abnormal, and requested an ambulance. A prison GP monitored Mr King until the ambulance arrived. The senior paramedic initially refused to take Mr King to the hospital but agreed after a discussion with the prison GP, and Mr King was taken to hospital.

7. Mr King's condition steadily deteriorated while he was in hospital. Specialists suspected that he had Guillain-Barré syndrome and, on 15 March, he was transferred to hospital for further tests. On 25 April, doctors made a working diagnosis of Bickerstaff's brain stem encephalitis and, on 30 May, Mr King died at hospital.

Findings

Clinical care

8. The clinical reviewer concluded that, overall, the care Mr King received at Manchester was equivalent to that which he could have expected in the community. For the most part, healthcare staff provided excellent care for Mr King, and kept his complex medical conditions under close review.

9. However, healthcare staff failed to ensure that Mr King took his prescribed medication, despite being instructed to monitor this. A GP review was not scheduled when requested, and a risk assessment was never completed, despite Mr King being at risk of falling.

Location and carer support

10. Despite Mr King struggling with mobility issues from the end of 2015, he remained on the third floor of his wing for a further eight months, and was then only moved to the second floor rather than a more appropriate location.

Family contact

11. When Mr King's condition deteriorated in March 2017, prison staff made active efforts to locate his family. Having established contact with his wife, they kept her informed about his condition, and facilitated a visit so she could see Mr King before he died. We are satisfied that the prison acted appropriately in their contact with Mr King's wife.

Escorts, restraints and security

12. Mr King was restrained when he first went to hospital, and the restraints were not removed for nearly a week. Given that Mr King had serious mobility issues, we consider that the prison acted inappropriately by deciding not to remove his restraints until that point.

Recommendations

- The Head of Healthcare at Manchester should ensure that there are effective processes to ensure that prisoners take their medication, and that staff monitor this, as instructed by clinical professionals.
- The Head of Healthcare at Manchester should ensure that there are effective systems in place to ensure that medical appointments are processed when requested by clinical professionals.
- The Governor and Head of Healthcare at Manchester should ensure that staff complete risk assessments for prisoners who are at risk of falls.
- The Governor of Manchester should ensure that prisoners with mobility issues are considered for ground floor cells as a matter of priority.
- The Governor 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

13. 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.

14. He visited Manchester on 10 July 2017. He obtained copies of relevant extracts from Mr King's prison and medical records.

15. The investigator interviewed four members of staff at Manchester on 10 July 2017.

16. NHS England commissioned a clinical reviewer to review Mr King's clinical care at the prison. She, along with another clinical reviewer, conducted joint interviews with four members of staff at Manchester on 10 July.

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

18. One of the Ombudsman's family liaison officers contacted Mr King's wife to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She asked us to consider why she was unable to visit her husband until the day before his death. She also asked about whether the prison will contribute to funeral costs.

19. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

20. Mr King's family received a copy of the initial report. They pointed out some factual inaccuracies. This report has been amended accordingly.

Background Information

HMP Manchester

21. 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

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

Independent Monitoring Board

23. 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 2017, the IMB noted that a lack of prison officers on the healthcare wing sometimes hampered access to prisoners in need of medical assistance. However, the Board commended the "continued dedication of individual prison service and NHS staff in providing excellent medical services to prisoners in difficult circumstances."

Previous deaths at HMP Manchester

24. Mr King was the fifth prisoner to die of natural causes at Manchester since January 2016. There are no similarities between his death and the previous ones.

Assessment, Care in Custody and Teamwork

25. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service care-planning system to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce risk and how best to monitor and supervise the prisoner. Levels of observations and interactions are set according to the perceived risk of harm. Part of the ACCT process involves drawing up a caremap to identify the prisoner's most urgent and pressing issues, set goals to help resolve the issues and identify who is responsible. The ACCT plan should not be closed until all of the actions on the caremap have been completed.

Guillain-Barré syndrome and Bickerstaff's brainstem encephalitis

26. Guillain-Barré syndrome is a rare but serious autoimmune disorder in which the immune system attacks healthy nerve cells in the peripheral nervous system. This leads to weakness, numbness, and tingling, and problems with balance and coordination. It can eventually cause paralysis.

27. Bickerstaff's brainstem encephalitis (BBE) is a rare inflammatory disorder of the central nervous system, characterised by ophthalmoplegia (weakness or paralysis of the eye muscles), ataxia (lack of voluntary coordination of the muscles) and disturbance of consciousness (drowsiness, stupor or coma). It is often associated with Guillain-Barré syndrome and may be a clinical variant.

Key Events

28. On 21 August 2014, Mr Thomas King was remanded to HMP Manchester. A nurse reviewed Mr King at a health screen on reception. She noted that three weeks earlier he had taken a drug overdose but he told her that this had been "on impulse" and he had no thoughts of self-harm. Later that day, a prison GP saw Mr King and noted that he had been diagnosed with depression before entering prison, and was prescribed citalopram. He observed that Mr King engaged in coherent conversation, and had no suicidal thoughts, or psychotic features. Mr King also had asthma and ongoing hernia problems, but no other physical health concerns.

29. The following day, mental health nurse performed a mental health assessment for Mr King. He confirmed Mr King's diagnosis of depression and previous suicide attempt, and opened an ACCT document for him.

30. On 18 September, the prison GP diagnosed Mr King with anxiety and a depressive disorder, and referred him to the prison's mental health in-reach team (MHIT). Mr King was reviewed regularly as part of the ACCT process but this was closed on 17 October. On 19 December, Mr King was again made subject to ACCT procedures due to concerns about his upcoming sentence hearing.

31. On 22 December, Mr King was sentenced to ten years imprisonment.

32. On 16 January 2015, Mr King's ACCT document was closed, but the MHIT kept him under review. On 19 February, a psychiatrist, reviewed Mr King, and prescribed him mirtazapine (an anti-depressant) alongside his citalopram.

33. On 13 June, Mr King experienced acute confusion, and was admitted to the healthcare unit as an inpatient. On 19 June, a psychiatrist, reviewed Mr King and diagnosed him with severe depressive disorder with psychotic features. He prescribed aripiprazole (to treat psychosis) and zopiclone (to improve sleep quality). Further investigations revealed that Mr King had a urinary tract infection which was treated with antibiotics. On 29 June, another psychiatrist, reviewed Mr King but found no evidence of mental illness. He suggested that his confusion was caused by the urinary infection. He removed aripiprazole from Mr King's prescription, but increased his dose of mirtazapine. On 13 July, Mr King was discharged from the healthcare unit to normal prison accommodation.

34. On 14 December, an occupational therapy assistant saw Mr King in his cell after he was observed limping and wincing in pain as he walked. Mr King told him that he had fallen down the stairs two days earlier. He said he had been given paracetamol for the pain and told to see a GP if it got any worse. On 22 December, a prison GP reviewed Mr King and diagnosed a lower back strain. He prescribed stronger pain killers, and advised Mr King to remain active.

35. On 9 February 2016, a prison GP reviewed Mr King after he complained of hip pain. She increased his pain relief prescription and sent him for an x-ray. On 5 April, she noted that Mr King was diagnosed with osteoarthritis in his hip and referred him to a physiotherapist. She also prescribed him tramadol (a strong opioid pain killer) to be administered once daily.

36. On 12 August, Mr King told the occupational therapy assistant that he still had hip pain, and was afraid to use the stairs. A week later, Mr King told him that another prisoner had been appointed as a carer to help him, and that he was negotiating with wing staff for a move to a cell on a lower landing. On 24 August, the occupational therapy assistant noted that Mr King had been moved to a cell on the second-floor landing but that he still struggled with the stairs due to his ongoing hip and back problems.

37. On 7 September, the occupational therapy assistant saw Mr King who told him that he was unable to attend the day care clinic that day, because no staff were available to escort him. He noted that Mr King then became agitated and said that his cellmate carer was treating him negatively and not supporting him. He also said some of his mirtazapine medication had gone missing, but he was afraid of accusing his cellmate. Mr King's prescription was changed from monthly to weekly. On 19 September, he told the occupational therapy assistant that the problems with his carer had been resolved.

The deterioration in Mr King's condition

38. At the beginning of December, Mr King's cellmate expressed concerns to officers about Mr King's behaviour as he was shouting out in the night. On 12 December, the occupational therapy assistant saw Mr King in his cell, and noted that he appeared low in mood, was unkempt and had poor personal hygiene. Mr King said he did not recall shouting at his cellmate and had no thoughts of self-harm. The next day, a prison GP reviewed Mr King at a planned consultation. He noted that Mr King had had a single episode of excess sleep, but that he was well otherwise.

39. On 15 December, a prison GP saw Mr King after wing officers became concerned about him. Mr King told him that he had felt dizzy that morning, had a sore throat and a temperature but he now felt better. He suspected an upper respiratory tract infection, and prescribed soluble paracetamol with a planned review in two weeks or sooner if Mr King's condition deteriorated.

40. On 21 December, Mr King told the occupational therapy assistant that he was hearing voices in his head that were negative, but he could not identify them. His cellmate told him that Mr King was neglecting himself, not showering, spending more time in bed, shouting out during the night and muttering to himself. The following day, psychiatrist, reviewed Mr King, and noted that he had no thoughts of self-harm or suicide, no psychotic symptoms or signs of paranoia. The psychiatrist diagnosed a relapse of his depressive disorder, due to his non-compliance in taking his mirtazapine. The psychiatrist decided to keep Mr King on mirtazapine but to take it out of his possession and instructed staff to monitor his compliance.

41. On 28 December, an officer informed a nurse that she was concerned about Mr King's mental health. The nurse reviewed Mr King's medical notes and noted that he had missed his mirtazapine for two days and his tramadol for three days. Later that day, the occupation therapy assistant visited Mr King to discuss his non-compliance. Mr King's cellmate told him that he had not collected his medication for two days, but that he had that morning. Mr King's cellmate also expressed his concern that Mr King had not showered for three weeks, eaten for

three days and was talking in his sleep. The following day, at a multidisciplinary team meeting, it was decided that Mr King should be monitored on the wing for the next week, but that if there was no improvement he would be admitted to the healthcare unit as an inpatient for closer observations.

42. On 3 January, a mental health nurse and the occupational therapy assistant saw Mr King and devised a care plan to improve his low mood. Mr King agreed to take his medication as directed and to work on his personal hygiene. Three days later, a nurse and the occupational therapy assistant reviewed Mr King and observed that he appeared relaxed and brighter in his mood. He was taking his medication daily, and had improved his personal hygiene. Mr King reported hearing voices of three to four men and women he did not recognise but said he did not find this distressing.

43. On 11 January, a nurse saw Mr King at the medications hatch. She noted that he had not collected his medication for a few days, and that his cellmate and wing staff were concerned about him. Mr King told her that "his voices are getting worse and he feels violent." She advised Mr King's cellmate to encourage him to take fluids and to get him to provide a urine sample to test for a urinary tract infection. Later that day, a prison GP saw Mr King and requested blood tests to go with the urine sample he had provided. He diagnosed a urine infection, and prescribed antibiotics.

44. On 12 January, the psychiatrist saw Mr King and noted that his mood was better, he was eating and sleeping well, and was regularly taking his medication. Mr King told the psychiatrist that he was distressed by the voices he was hearing, and that this affected his level of functioning. The psychiatrist prescribed aripiprazole to treat the psychotic episodes, and planned to review him in a few weeks.

45. Over the next few days, Mr King failed to collect his medication several times. On 16 January, the mental health nurse reviewed him and noted that he was reasonably well kempt and clean shaven, but smelt unpleasant. He reiterated the importance of taking his medication on a regular basis. Mr King continued to neglect his medication and, on 24 January, the mental health nurse saw Mr King and became concerned by his deteriorating condition and failure to comply with his medication. Later that day, Mr King was admitted to the healthcare unit as an inpatient for a period of mental health observation.

46. On 26 January, a prison GP reviewed Mr King, who told him that he had felt dizzy for the past two weeks. The prison GP examined him and noted that he had mild lower abdominal pain. He recorded that Mr King had been confirmed with a urinary tract infection on 18 January, which had not been treated, so he gave him antibiotics.

47. On 30 January, a psychiatrist, reviewed Mr King and noted that he appeared extremely downcast and flat. Mr King told him that he was hearing voices and had a low appetite but his sleep was normal. The psychiatrist doubled his aripiprazole medication and recommended a period of convalescence to recover from his urinary infection.

48. Over the next few weeks, Mr King was monitored regularly on the healthcare unit, and his condition improved. On 13 February, the psychiatrist reviewed Mr King and recorded that "outwardly he appeared much brighter … and that the increase in his aripiprazole appeared to be working well". He noted that Mr King complained of being physically weak and unable to eat properly due to feelings of nausea and dysphagia (difficulty in swallowing). The psychiatrist recorded in his medical notes that Mr King needed to be reviewed by a GP. In interview, the psychiatrist said that there was a meeting each Monday, where patients' needs were discussed.

49. Mr King continued to be monitored by physical and mental health nursing staff, but did not have a GP review over the next two weeks, and none was arranged. On 27 February, he examined Mr King following recent episodes of dizziness and falling. Mr King told him that he experienced light headedness and dizziness similar to vertigo. The prison GP noted he had no physical injuries, his blood pressure and pulse rate were unremarkable and neurological examination results were normal. He requested blood tests and for an ECG to be performed. On 2 March, the prison GP reviewed Mr King. He noted that his blood test results were abnormal and that his ECG revealed an abnormal heart rhythm, with a repeat test showing the same. The prison GP consulted a cardiologist at the hospital, who advised further blood tests to check for heart damage. As these results failed to disclose the issue being investigated, Mr King remained under observation at Manchester.

50. The following day, a nurse saw Mr King following reports that he was unwell. Mr King was pale and ashen. He said he felt dizzy and had experienced pain in his chest for two hours. She noted that his observations were abnormal, and arranged for a GP to review him. Mr King had an ECG which was shared with the hospital, which advised that he be admitted as an emergency. Mr King was taken to hospital but discharged back to Manchester later that day. The hospital did not provide a discharge summary.

The events of 4 March

51. On 4 March, at approximately 10.15am, a nurse manager, a nurse and a healthcare assistant made a routine visit to Mr King's cell. They observed that he was lying on his mattress on the floor, which had been placed there due to his risk of falling. They tried to sit Mr King up but were unable to do so. The nurse noted that Mr King "was moving his arms in the air as if he was responding to unseen stimuli." She asked Mr King a series of questions but he gave only confused answers. She recorded that a medical officer was required for a further assessment and continued to monitor Mr King.

52. Shortly afterwards, another nurse assessed Mr King and noted that his observations were abnormal and that he required further clinical assessment. At 10.57am, the nurse recorded that Mr King had an ECG which showed significant changes. An ambulance was requested. A prison GP arrived shortly afterwards, having been asked to attend as an emergency. He confirmed the observations and irregular ECG scan, and reiterated the need for a full clinical assessment at the hospital. The prison GP noted that Mr King's right leg was slightly shorter

than his left one, and that he could not actively move his hip. He remained with Mr King until the ambulance arrived.

53. The prison GP recalled that he had a disagreement with the ambulance's senior paramedic, who was reluctant to take Mr King to hospital. In a belated entry in Mr King's medical records, the prison GP noted that the senior paramedic told him that Mr King did not want to go to hospital and that he had the mental capacity to make this decision. He also informed the prison GP that Mr King would not have been discharged by the hospital the day before if there was anything wrong with him. The prison GP stated that, in Mr King's confused state, he was not in the position to make a rational decision, and with his adverse ECG scan, abnormal observations, and hip problem, he could not be adequately managed at the prison.

54. Due to Mr King's position, hip problem and size, a specialist team was sent to lift him from the floor into the ambulance. Mr King was taken to hospital, under prison escort and restrained. He arrived at 1.15pm, and at 6.05pm escort staff recorded that his double cuffs could be removed.

55. Initial tests at the hospital revealed that Mr King did not have an immediate brain injury but a brain infection was suspected. His condition deteriorated quickly. On 10 March, the governor authorised the removal of his restraints.

56. On 14 March, Mr King was transferred to the intensive care unit. Specialists at the hospital suspected that he might have Guillain-Barré syndrome and, on 15 March, he was transferred to another hospital for further tests. On 25 April, doctors made a working diagnosis of Bickerstaff's brainstem encephalitis.

57. Mr King's condition continued to deteriorate and on 30 May at 7.55am, he was pronounced dead.

Contact with Mr King's family

58. Mr King's wife was listed on his prison record as a contact but not his next of kin. On 11 March 2017, the governor tried to contact her but was unable to do so on the number listed. He spoke to an officer from the Greater Manchester Police who later told him that Mr King's wife had passed away a year earlier. This was incorrect. The officer also stated that Mr King was restricted from contacting his wife. He was also restricted from contacting his two daughters because they were the victims of his offending behaviour.

59. On 13 March, the prison appointed a chaplain as Mr King's family liaison officer (FLO). The prison FLO spoke to a member of staff from victim support to ask whether any of his daughters would be prepared to act as Mr King's next of kin. Later that day, Mr King's wife called the FLO, and asked about being able to visit him. He checked with security and later informed her that this would not be possible due to the restrictions of a court order on contact.

60. Over the next couple of months, the FLO updated Mr King's wife about her husband's health, but did not go into detail about his condition. She was still unable to visit him due to the court order. Mr King's daughter enquired about removing these restrictions. In early May, Mr King's wife became very ill and was admitted to hospital. On 29 May, the FLO spoke to the duty governor and

arranged for Mr King's wife to visit her husband. Later that day, the FLO met Mr King's wife at the hospital and escorted her to visit her husband at his bedside.

61. On 30 May at 10.15am, the FLO visited Mr King's wife at the hospital to inform her of her husband's death. He informed her that the chaplaincy and nursing staff were available for support.

62. Mr King's funeral was held on 19 July 2017. The prison contributed to the cost, in line with national policy.

Support for prisoners and staff

63. After Mr King's death, the governor debriefed the staff involved in his care to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

64. The prison posted notices informing other prisoners of Mr King'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 King's death.

Post-mortem report

65. The post-mortem concluded that Mr King's cause of death was sepsis as the clinical diagnosis, with the additional presence of Guillain-Barré syndrome and Bickerstaff's brainstem encephalitis.

66. The pathologist recorded that Alzheimer's disease and cardiac enlargement were contributory factors to his death, but he noted that these were unlikely to have been major factors.

Findings

Clinical care

67. The clinical reviewer concluded that the care Mr King received at Manchester was of a reasonable standard, and at least equivalent to that which he could have expected in the community. Mr King had complex health concerns, and developed a rare condition which ultimately caused his death.

68. We agree that for the most part, healthcare staff provided excellent care for Mr King, and kept his conditions under close review. We also recognise the prison GP's robust conversation with the paramedic which ensured that Mr King was taken to hospital on 4 March. However, we consider that healthcare staff should have been more proactive at times, which would have resulted in improved care for Mr King.

69. We share the concerns of the clinical reviewer that staff failed to monitor Mr King's compliance with his medication appropriately. On 22 December 2016, the psychiatrist, recognised that Mr King's failure to take his anti-depressant medication regularly was causing his mood to decline. He instructed staff to monitor this but, by 28 December, a nurse noticed that he had failed to take his medication for two days. While there is no suggestion that this impacted on his death, we would expect staff to have followed this direct instruction.

The Head of Healthcare at Manchester should ensure that there are effective processes to ensure that prisoners take their medication, and that staff monitor this, as instructed by clinical professionals.

70. We are also concerned that despite a psychiatrist, requesting a GP review for Mr King on 13 February, this was never processed. At that time, Mr King was being monitored as an inpatient on the healthcare wing at Manchester, so we would have expected this review to have happened as a matter of urgency. However, it appears not to have been scheduled at all.

The Head of Healthcare at Manchester should ensure that there are effective systems in place to ensure that medical appointments are processed when requested by clinical professionals.

71. We also share the concerns of the clinical reviewer that there was no evidence of any falls risk assessments ever being conducted for Mr King. In December 2015, Mr King was prescribed strong opioid pain killers for injuries he sustained following a fall, with a known side effect being increased dizziness. He was subsequently diagnosed with osteoarthritis, and his mobility continued to decline. In the summer of 2016, he stated that he was struggling to cope with stairs, and was moved to a cell on a lower landing. Following his admission to the healthcare unit in January 2017, he was also noted as suffering with dizziness similar to vertigo, and falls. We also note that his mattress was placed on the floor during his last few days at Manchester, due to him being at risk of falling. Given these circumstances, we would have expected staff to have assessed Mr King's risk of falling, and to have implemented measures to address this.

The Governor and Head of Healthcare at Manchester should ensure that staff complete risk assessments for prisoners who are at risk of falls.

Mr King's location

72. We are concerned that despite the progressive deterioration in Mr King's mobility from the end of 2015, he was still accommodated in an upstairs cell until he was admitted to the healthcare unit in January 2017. He originally sustained a hip injury in December 2015, which was diagnosed as osteoarthritis early in 2016. In August 2016, officers agreed to transfer Mr King from a cell on the third floor to one on the second floor, but he was still struggling to manage the stairs and was reliant on his cell mate to assist him. While we accept that ground floor cells may be in high demand, we would have expected Mr King to have been considered for one as a matter of priority.

The Governor at Manchester should ensure that prisoners with mobility issues are considered for ground floor cells as a matter of priority.

Family contact

73. We consider that the prison acted appropriately in their contact with Mr King's family, in what were complex and difficult circumstances. Mr King was not in contact with his immediate family during his time in prison. When he became ill and went to hospital, prison staff located his family, and were successful in establishing contact with his wife. However, a court order was in place which prevented Mr King from contacting either his wife or their daughters. Despite Mr King's wife having initiated this order, the prison could not ignore it even though she wanted to now visit him. Correspondence from the prison confirmed that Mr King's wife would need to seek a further order of the court to re-establish contact. She was in the process of doing this but then became ill herself and was unable to continue this process.

74. Despite these complications, the FLO liaised with Mr King's wife throughout, and kept her updated on his condition. The FLO also managed to facilitate a visit for Mr King's wife on the day before he died. He also visited her in person to break the news of her husband's death, and to offer support.

75. While we understand Mr King's wife's frustration that she was unable to see her husband sooner, we consider that the prison did everything they reasonably could in their contact with her.

Escorts, restraints and security

76. 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.

77. We are concerned that when Mr King first went to hospital on 4 March 2017, he was restrained despite clearly having mobility issues. That evening, escort staff removed his double cuff to enable nurses to administer fluids but, apart from during medical treatment, Mr King remained subject to restraints until 10 March,

when their removal was authorised by the governor following input from a hospital doctor.

78. The prison considered Mr King a security risk on the basis of his index offence but all other risks were assessed as low. He had significantly limited mobility, had to be physically lifted from the ground before being sent to hospital and was in very poor and deteriorating physical condition. Even if the initial decision to use restraints was justified in the circumstances, that decision to restrain him should have been reviewed much sooner.

The Governor 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.

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Independent Investigations

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