

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Joseph Leigh a prisoner at HMP Manchester on 10 January 2018

A report by the Prisons and Probation Ombudsman

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 Joseph Leigh died on 10 January 2018 of pneumonia and lung disease, while a prisoner at HMP Manchester. He was 85 years old. I offer my condolences to Mr Leigh's family and friends.

I am satisfied that Mr Leigh received responsive and timely care, of a good standard and equivalent to that he could have expected in the community.

I am concerned that the prison staff did not notify Mr Leigh's next of kin of his admission to hospital until the day before his death, and then only because doctors requested contact. This denied his family the opportunity of visits and input to decisions about his medical care. After the family were informed, the prison's liaison officers provided them with a very high standard of support.

I am concerned that, given his age, poor health and poor mobility, Mr Leigh was inappropriately restrained on some of his outpatient and inpatient visits to hospital. I am pleased to note, however, that in assessing Mr Leigh's risk for his final journey to hospital, staff appropriately took account of his weakened condition and reduced mobility and used no restraints.

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

May 2019

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Summary

Events

1. On 3 January 2017, Mr Joseph Leigh was sentenced to six and a half years in prison for sexual offences and sent to HMP Manchester.
2. Health screens identified that Mr Leigh had type 2 diabetes, raised blood pressure and mobility problems. Staff referred him to clinics to manage his conditions, re-prescribed his medications and provided mobility aids. Prison carers assisted with social care. During the course of the year, Mr Leigh developed several additional medical conditions. Staff referred him to specialists and facilitated outpatient appointments. He also spent periods as an inpatient in hospital, as well as in the prison's healthcare unit.
3. On 28 December, Mr Leigh was unwell and short of breath. After discussion of the symptoms with a hospital doctor, a prison GP sent him to hospital for further assessment. Staff initially planned to use prison transport, but his condition worsened and, at 2.01am, they called an ambulance, which arrived at 4.28pm. Mr Leigh remained in hospital. On 9 January, hospital staff asked to speak to his family and the prison contacted them. Mr Leigh died on 10 January.

Findings

4. Healthcare staff treated and monitored Mr Leigh's health conditions and provided a good standard of care, equivalent to that he could have expected in the community.
5. Prison staff did not comply with the Prison Rule 22, which requires a prisoner's next of kin to be informed immediately of serious illness. There was an excessive delay in informing Mr Leigh's son that he was in hospital, which meant he was unable to participate in decisions about his care, or visit him sooner. Once contact was made, there was a very high standard of family liaison.
6. While waiting for an ambulance on the day Mr Leigh was sent to hospital, a nurse asked prison staff to give the ambulance service updates on Mr Leigh's deteriorating condition. There is nothing in either the prison's or ambulance service records to indicate this was done. There appears to have been miscommunication, but this did not impact on Mr Leigh's death.
7. Mr Leigh was handcuffed for many of his hospital visits in 2017. However, for his final journey to hospital, a risk assessment took full account of his age, infirmity and reduced mobility and concluded that no restraints should be used.

Recommendation

- The Governor should ensure, in line with Prison Rule 22 and PSI 64/2011, that prison staff inform the next of kin of seriously ill prisoners immediately when they are admitted to hospital.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Manchester informing them of the investigation and asking anyone with relevant information to contact her. A prisoner wrote to the investigator.
9. The investigator obtained copies of relevant extracts from Mr Leigh's prison and medical records.
10. NHS England commissioned a clinical reviewer to review Mr Leigh's clinical care at the prison.
11. Our investigation was suspended between 17 April 2018 and 14 January 2019, while waiting final reports relating to the cause of death. This report was delayed as a result.
12. We informed HM Coroner for Manchester City of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
13. One of the Ombudsman's family liaison officers contacted Mr Leigh's son, his next of kin, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. Mr Leigh's son said he had received very good support from prison staff while his father was in hospital and after his death. He raised some concerns about decisions in hospital that were outside the remit of this investigation.
14. Mr Leigh's son received a copy of the initial report. He made no comments.
15. We shared the initial report with HM Prison and Probation Service (HMPPS) and they found no factual inaccuracies.

Background Information

HMP Manchester

16. HMP Manchester operates as both a high security prison and a local prison serving the courts of the Greater Manchester area. It can hold more than 1,200 men. Greater Manchester Mental Health Foundation Trust provides 24-hour nursing care and the healthcare centre includes an inpatient unit.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Manchester was conducted in June and July 2018. Inspectors reported that there was a good range of primary care clinics and some secondary care was available. Patients with long-term conditions were generally well managed and monitored and same day appointments were available. Non-attendance for appointments was a problem, but had improved. Inspectors observed professional interactions with patients and record keeping was very good.

Independent Monitoring Board

18. 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 the prison continued to deliver a range of excellent healthcare. However, nearly a quarter of medical appointments were cancelled and there were delays in booking new appointments. The Board was concerned that insufficient priority was given to getting prisoners to appointments.

Previous deaths at HMP Manchester

19. Mr Leigh was the sixth prisoner to die of natural causes at Manchester since January 2017. There have been eight further deaths from natural causes. We have made previous recommendations about notification to prisoners' families.

Key Events

20. On 3 January 2017, Mr Joseph Leigh was sentenced to six years and six months imprisonment for sexual offences and sent to HMP Manchester. It was his first time in prison.
21. At his initial health screen, a nurse noted that Mr Leigh had type 2 diabetes and referred him to the diabetic clinic, as well as the general clinic to check his feet for ulceration and to recheck his raised blood pressure. The nurse also referred to him to a physiotherapist as he had mobility problems and used a walking aid. A prison doctor then assessed him and re-prescribed his medications.
22. On 6 January, Mr Leigh attended the older prisoners' clinic for a comprehensive health review and, the next day, he had a falls assessment. Following a social care assessment on 17 February, he was given disability aids, such as a walking frame to help him move around the prison, a shower chair and high back chair for his cell. Prison carers were assigned to help Mr Leigh obtain meals, escort him to the showers and other areas of the prison and assist him to clean his cell.
23. During 2017, Mr Leigh had frequent contact with healthcare staff. He was treated for several medical conditions, including high blood pressure, high cholesterol, Bowen's disease (early skin cancer), cellulitis (skin infection), foot ulcers, peripheral vascular disease (progressive circulation disorder), pneumonia, deep vein thrombosis, arthritis, kidney disease and osteomyelitis (inflammation of the bone due to infection). Mr Leigh was referred to hospital specialists and attended outpatient appointments. In August 2017, he was twice admitted to hospital as an inpatient, for pneumonia. He also spent periods in the prison's inpatient unit.
24. Early morning on 28 December, Mr Leigh had a dizzy spell and fell over. At around 7.00am, a nurse examined him, took clinical observations and assessed him using the National Early Warning Score (NEWS - a tool to assess clinical deterioration). It was a 0 - a low score, but he referred Mr Leigh to the prison GP.
25. At 9.47am, a locum GP assessed Mr Leigh, who reported that he had felt weak and short of breath over the previous three days. On examination, the doctor found that Mr Leigh was unable to stand without help. He was unsure of the cause of Mr Leigh's symptoms, so discussed the options with doctors at a hospital, who advised that he should be admitted to hospital.
26. As it was not an emergency, staff planned to use prison transport. While waiting for this to be arranged, Mr Leigh's condition significantly deteriorated and the prison called an ambulance at 2.01pm. The ambulance service assigned it as a category 2 priority and an ambulance was expected within 30 minutes. Healthcare staff gave Mr Leigh emergency treatment, including oxygen. A nurse said that she asked wing staff several times to ring the control room to find out the expected arrival time and to tell the ambulance service that the NEWS score had increased to 7, but was told the ambulance service was very busy. At 4.19pm, the ambulance service called to give an expected arrival time of six minutes. The ambulance arrived at 4.28pm and Mr Leigh was taken to hospital at 5.27pm, with two escorts and no restraints.

27. Hospital doctors diagnosed pneumonia and an upper gastrointestinal bleed. Healthcare staff regularly checked Mr Leigh's progress. After initial improvement, on 8 January he began to deteriorate and died on 10 January.

Contact with Mr Leigh's family

28. At around 5.00pm on 8 January 2018, one of the escort officers reported to the prison that Mr Leigh had had a seizure and might be moved to the critical care unit. A hospital consultant had asked for Mr Leigh's family to attend the hospital for a discussion about his care. A Supervising Officer (SO) asked the Safer Custody team to assign a family liaison officer to contact Mr Leigh's family and liaise with the hospital.
29. In the early hours of 9 January, the hospital contacted the prison for details of Mr Leigh's next of kin as they believed he only had a few hours to live. They also said he would not be resuscitated if his heart or breathing stopped. A prison chaplain was assigned as the prison's family liaison officer (FLO). At lunchtime, the FLO and an officer visited Mr Leigh's son, his next of kin. They told him that his father was in hospital in a serious condition, arranged for him to visit later that day and gave him key information and contact numbers.
30. The next morning, the FLO informed Mr Leigh's son that his father's condition had worsened. She went to the hospital and was with members of Mr Leigh's family when he died. His funeral was held on 9 February. In line with national policy, the prison contributed to the funeral expenses.

Support for prisoners and staff

31. The prison arranged for a member of the care team to speak to the escort staff at the hospital immediately after Mr Leigh's death, to ensure they had the opportunity to discuss any issues arising and to offer support.
32. The prison posted notices informing staff and other prisoners of Mr Leigh'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 Leigh's death.

Post-mortem report

33. The report of the post-mortem examination and a subsequent histopathology report concluded that Mr Leigh's death was due to: 1a) bilateral bronchopneumonia; 1b) pulmonary fibrosis; 2) ischaemic heart disease (inflammation and scarring of the lungs, with underlying narrowing of the arteries).
34. The pathologist noted that Mr Leigh had developed pneumonia in hospital and become septic. The pulmonary fibrosis was possibly caused by exposure to asbestos and the presence of ischaemic heart disease was likely to have decreased Mr Leigh's cardiac reserve (the heart's ability to increase the amount of blood pumped through the cardiovascular system).

Findings

Clinical care

35. When Mr Leigh arrived at Manchester, he had the appropriate health screens and his existing medical conditions and health needs were managed effectively. He developed several other medical conditions during the year. Healthcare staff assessed and diagnosed him promptly and referred him to specialists, as necessary. Healthcare staff were responsive and created appropriate care plans.
36. We agree with the clinical reviewer that Mr Leigh's care was of a good standard and equivalent to that he could have expected to receive in the community.

Notifying Mr Leigh's next of kin that he was in hospital

37. Prison Rule 22 instructs that prisons should inform the next of kin immediately if a prisoner becomes seriously ill. Prison Service Instruction 64/2011, about safer custody, sets out the expectation that if a prisoner suffers an unpredicted or rapid deterioration in their physical health an appropriate member of prison staff should engage with their next of kin to provide information and support.
38. Mr Leigh was admitted to hospital on 28 December. There is no record of any attempts to inform his son, his next of kin, until hospital staff asked to speak to him on 9 January, 12 days after Mr Leigh's admission and the day before his death. Although the nature of Mr Leigh's illness might not have been immediately clear when he was first admitted, an unplanned admission of more than a day or two for an elderly person suggests a serious illness. We are concerned that the prison did not comply with this requirement, so Mr Leigh's son lost the opportunity to visit sooner, if he wished.
39. One of the concerns stated by Mr Leigh's son was that he had not been consulted about the hospital's decision to implement a "Do not attempt cardiopulmonary resuscitation" order. While this issue is outside of our remit, it is an example of how a prisoner and their family can be disadvantaged by a delay, or failure in notifying them of serious illness or admission to hospital. We make the following recommendation:

The Governor should ensure, in line with Prison Rule 22 and PSI 64/2011, that prison staff inform the next of kin of seriously ill prisoners immediately when they are admitted to hospital.

40. We are satisfied that after the prison informed Mr Leigh's son of the situation, the prison's family liaison officers provided a very high standard of family liaison.

Requesting an ambulance on 28 December

41. Mr Leigh's transfer to hospital on 28 December was not initially urgent, so he was due to be taken by prison transport. However, when his condition worsened, prison and healthcare staff decided to call an ambulance. The priority level was two, but the ambulance service was very busy and unable to attend within the 30-minute response time specified. An ambulance arrived around two and a half hours after the request.

42. While waiting for the ambulance, Mr Leigh continued to deteriorate. A nurse asked prison staff several times for updates on the expected time of arrival and asked them to convey Mr Leigh's revised NEWS score to the ambulance controller. Each time, she was told that the ambulance service was busy.
43. The control room requested the ambulance promptly and documented events in detail. There is no record on the incident log of the update calls requested by a nurse and the ambulance service had no records of such calls. The ambulance service said that the NEWS score might not have raised the category, as there were high levels of demand at that time, but it might have triggered a clinician intervening in the ambulance service control room.
44. Given there was no trace of these calls, it seems that there was a breakdown in communication between wing staff and the control room. It is a concern that the nurse's requests were not communicated to the ambulance service. However, as this did not directly affect Mr Leigh's condition or death and it is unlikely that the ambulance service would have given the call greater priority, we make no formal recommendation on this matter. The Governor will wish to satisfy himself that there is effective communication between healthcare and prison staff.

Risk assessments and use of restraints

45. 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.
46. Mr Leigh had several outpatient and inpatient visits to hospital. We are concerned that, despite his advanced age, poor health and restricted mobility, he was restrained for some of these visits. However, for his final journey to hospital on 28 December, the risk assessment acknowledged all these factors and his low risk and concluded restraints were not necessary.

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