

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Michael Walsh, a prisoner at HMP Manchester, on 10 October 2019

**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*



© Crown copyright 2020

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit [nationalarchives.gov.uk/doc/open-government-licence/version/3](https://nationalarchives.gov.uk/doc/open-government-licence/version/3) or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: [psi@nationalarchives.gsi.gov.uk](mailto:psi@nationalarchives.gsi.gov.uk).

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

## Summary

1. 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.
2. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr Michael Walsh, who was 52 years old, died of metastatic bowel cancer on 10 October 2019, at HMP Manchester. We offer our condolences to Mr Walsh's family and friends.
4. The clinical reviewer concluded that the care Mr Walsh received was equivalent to that which he could have expected to receive in the community. She made no recommendations.
5. We are concerned that there is no record of a compassionate release application being made on Mr Walsh's behalf.
6. We are also concerned that Mr Walsh's family were not informed of his deteriorating condition in a timely manner which meant that they were unable to spend time with him before he died.

## Recommendations

- The Governor should ensure that when a prisoner is diagnosed with a terminal illness with a short time left to live, the possibility of compassionate release is fully considered and documented.
- The Governor should ensure that next of kin are promptly informed as soon as it becomes clear that a prisoner is seriously ill, or is suffering from an unpredicted or rapid deterioration in their physical health.

## Investigation Process

7. NHS England commissioned an independent clinical reviewer to review Mr Walsh's clinical care at HMP Manchester.
8. The PPO investigator has investigated the non-clinical issues in Mr Walsh's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
9. We wrote to Mr Walsh's next of kin to explain the investigation and to ask if she had any matters she wished the investigation to consider. She raised concern that the family were not informed of the seriousness of Mr Walsh's condition until thirty minutes before he died, which meant they were unable to visit him in prison. We have addressed her concerns in this report.
10. We have considered the matter in this investigation and found Mr Walsh's condition deteriorated much faster than was expected by healthcare staff. We

are satisfied that the family liaison officer contacted Mr Walsh's next of kin as soon as the seriousness of his condition became apparent.

### **Previous deaths at Manchester**

11. Mr Walsh was the seventh prisoner to have died from natural causes at HMP Manchester in the last two years. There are no similarities between our findings in the investigation of Mr Walsh's death and the other deaths.

## Key Events

12. On 24 October 2014, Mr Michael Walsh was remanded into custody charged with sexual offences. He was sent to HMP Manchester. On 1 May 2015, he was sentenced to 23 years imprisonment.
13. On 6 June 2018, healthcare staff noted Mr Walsh was short of breath, pale and appeared generally unwell. They suspected he had developed anaemia (a condition in which the red blood cells in the body do not carry enough oxygen). Blood tests were carried out and the results sent to North Manchester Hospital for review.
14. Hospital staff noted the results of his blood tests were abnormal and that his haemoglobin levels were very low (haemoglobin is the substance which carries oxygen around the body), confirming the diagnosis of anaemia. They considered that Mr Walsh required an urgent blood transfusion and he was admitted to hospital as an inpatient.
15. While an inpatient, hospital staff carried out a number of further tests. The results of which indicated Mr Walsh had developed colon cancer. Hospital staff planned to treat his cancer with a surgical procedure and chemotherapy treatment.
16. However, on 2 November 2018, further tests revealed the cancer had spread to his kidneys. Mr Walsh was told his condition was terminal and any further treatment would be palliative. A family liaison officer was appointed to support Mr Walsh and his family following his diagnosis.
17. Following his diagnosis, Mr Walsh was reviewed regularly by both healthcare, and hospital, staff. His medications and treatments were reviewed and adjusted as his condition deteriorated. On 3 October 2019, Mr Walsh told staff he did not wish to be resuscitated in the event of his death, and signed a DNACPR to that effect (do not attempt cardiopulmonary resuscitation).
18. Mr Walsh's condition continued to deteriorate and at 3.00pm on 10 October, he agreed to move to the palliative care suite in the prison's healthcare inpatient unit.
19. At 4.00pm, Mr Walsh's condition deteriorated further. At 4.42pm he died.
20. A post-mortem examination gave Mr Walsh's cause of death as metastatic bowel cancer (bowel cancer that spread to other parts of the body).

## Non-clinical Findings

### Family Liaison

21. Mr Walsh's family raised concern that they were notified of his deteriorating condition half an hour before he died. As a result, the family were unable to visit Mr Walsh before he died. We consider that the family could have been notified of his deteriorating condition much sooner, particularly when the decision was made to move Mr Walsh to the palliative care suite in the prison's inpatient unit. We therefore make the following recommendation:

**The Governor should ensure that next of kin are promptly informed as soon as it becomes clear that a prisoner is seriously ill, or is suffering from an unpredicted or rapid deterioration in their physical health.**

### Compassionate release

22. 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.
23. There is no evidence in Mr Walsh's medical or custodial records to indicate that, despite his extremely poor health, an application for early release on compassionate grounds (ECRG) was considered. We therefore make the following recommendation:

**The Governor should ensure that when a prisoner is diagnosed with a terminal illness with a short time left to live, the possibility of compassionate release is fully considered and documented.**

**Lisa Burrell  
Assistant Ombudsman**

**June 2020**