Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Allan Rollisson a prisoner at HMP Manchester on 27 June 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.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Allan Rollisson died on 27 June 2017 of pneumonia at HMP Manchester. He was 82 years old. We offer our condolences to Mr Rollisson's family and friends.

Mr Rollisson suffered from a number of medical conditions and required a high level of support to manage his day-to-day activities when he arrived at Manchester.

The investigation found that Mr Rollisson received a good standard of care at Manchester. Healthcare staff managed a very complex case well, ensuring that he received a level of care that was equivalent to that which he could have expected to receive in the community.

We are not persuaded, though, that the decisions taken on restraints were appropriate.

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 **January 2021**

Contents

Summary

1. On 31 August 2016, Mr Allan Rollisson was sentenced to 32 months in prison and sent to HMP Manchester.

2. As a result of an accident in 1974, Mr Rollisson was paraplegic and had restricted mobility. He required assistance to undertake all daily activities. On entering prison, healthcare staff immediately located Mr Rollisson in an enhanced care suite within the healthcare unit to ensure that his daily care needs could be met.

3. Prison nurses and doctors created a number of care plans to support Mr Rollisson. His daily needs were managed effectively against the care plans put in place.

4. Mr Rollisson's pre-existing health problems put him at risk of developing leg ulcers. Prison healthcare staff created a robust pressure relief and monitoring care plan to support his risk. Throughout his time in prison, healthcare staff liaised with specialist clinical services to ensure that optimum treatment was delivered.

5. On 2 October 2016, it was noted that Mr Rollisson had developed a small broken area of skin on his left heel. His condition was treated in line with the pressure relief care plan. Even so, Mr Rollisson's condition deteriorated and he went to hospital for five days. Mr Rollisson saw vascular surgeons who diagnosed significant arterial disease (a narrowing of the blood vessels) and discussed possible surgical intervention. Mr Rollisson was unwilling to undergo surgery and returned to prison where, in line with advice from the vascular surgeon, his sores were managed.

6. Mr Rollisson's health remained stable until March 2017, with healthcare staff providing regular and effective wound care. On 7 March, Mr Rollisson vomited blood. A prison doctor made an urgent referral as there was a concern that this could indicate stomach cancer. Later that day, Mr Rollisson used his cell call bell to alert staff that he was unwell. He was taken to hospital as there was concern that he might have had a stroke. Doctors referred him for further tests and he was diagnosed as having vascular epilepsy which was controlled using medication. He returned to prison on 15 March.

7. On 18 June, care staff alerted nursing staff that Mr Rollisson was extremely lethargic, could not move his right hand and was having difficulty swallowing. Routine observations indicated that his blood pressure and oxygen levels were low and that he needed urgent care. He was taken to hospital by ambulance. On 27 June, Mr Rollisson died in hospital.

Findings

Clinical care

8. Mr Rollisson suffered from a number of medical conditions and required a high level of support to manage his daily activities when he entered prison. On reception, healthcare staff identified his needs and he was accommodated in an enhanced care suite. Healthcare staff created clear and effective care plans to manage Mr Rollisson's specialist needs and support his care.

9. Throughout his time in prison, Mr Rollisson was subject to regular health checks and had support to treat the leg ulcers which had developed as a result of pre-existing health problems. Using care plans, staff were able to provide Mr Rollisson with effective care and manage his leg ulcers and wounds. There was good coordination and collaboration between all the teams caring for Mr Rollisson.

10. Healthcare staff requested specialist support and advice from tissue viability nurses and the hospital vascular team. Good liaison between prison healthcare staff and hospital specialists ensured that Mr Rollisson was treated effectively.

11. During his time in prison, healthcare staff treated Mr Rollisson with dignity and compassion. He received a good standard of nursing care, his specialist needs were met and his personal comfort maintained. Healthcare staff ensured on a daily basis that Mr Rollisson received drinks and encouraged him to eat. It is therefore of some concern that Mr Rollisson did not have a nutritional assessment, the absence of which had the potential to negatively impact his health.

12. We are satisfied that healthcare staff managed a very difficult case well, ensuring that Mr Rollisson received a level of care that was equivalent to that which he would have expected to receive in the community.

Contact with Mr Rollisson's family

13. When Mr Rollisson was admitted to hospital in March 2017, a prison manager attended hospital to speak to the family. He regularly updated the family, facilitating visits and keeping them informed about Mr Rollisson's condition. On the morning of Mr Rollisson's death, he visited the family to offer condolence and provide support. We are satisfied that the prison acted appropriately in their contact with Mr Rollisson's family.

Restraints, security and escorts

14. Officers restrained Mr Rollisson with an escort chain when he attended hospital on 4 November. On 6 November, the duty governor reviewed the arrangements and authorised restraint removal. Although Mr Rollisson had committed the offences for which he had been imprisoned while he was paraplegic, the initial risk assessment, which recognised his limited mobility, might more appropriately have directed that no restraints be used. We recognise that restraints were removed after the first review and not used again during Mr Rollisson's times in hospital.

Recommendations

- The Head of Healthcare should ensure that all relevant information about a prisoner's health is appropriately recorded and actioned.

The Investigation Process

15. 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.

16. The investigator obtained copies of relevant extracts from Mr Rollisson's prison and medical records.

17. NHS England commissioned an independent clinical reviewer to review Mr Rollisson's clinical care at the prison

18. We informed HM Coroner for the City of Manchester District of the investigation. He gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.

19. The investigator wrote to Mr Rollisson's son to explain the investigation and to ask whether he had any matters he wanted the investigation to consider. One of the Ombudsman's family liaison officers spoke to Mr Rollisson's son and to a family friend. Mr Rollisson's son asked why his father was sent to hospital, and also about the care his father received when he was discharged from hospital back to prison. The family friend asked about Mr Rollisson's access to his regular medication, whether he was provided with pressure-relieving equipment and whether he was able to get out of bed on a daily basis, if he wished.

20. We shared the initial report with HM Prison and Probation Service. They found no factual inaccuracies.

21. We shared the initial report with Mr Rollisson's son and family friend. They found no factual inaccuracies.

Background Information

HMP Manchester

22. HMP Manchester operates both as a high security prison and as a local prison serving the courts of the Greater Manchester area. It holds 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

23. 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 further commented that staff on the inpatients' unit provided compassionate care for patients with complex needs.

Independent Monitoring Board

24. 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, given financial restraints, they believed that healthcare staff offered the best possible level of care to their patients.

Previous deaths at HMP Manchester

25. Mr Rollisson was the sixth prisoner to die of natural causes at Manchester since January 2016. There were no significant similarities between the circumstances of Mr Rollisson's death and the previous deaths at the prison.

Key Events

26. On 31 August 2016, Mr Allan Rollisson was sentenced to 32 months imprisonment for historic sex offences and was sent to HMP Manchester.

27. At an initial health screen, a nurse noted that Mr Rollisson had restricted mobility due to being paraplegic and would need assistance for all aspects of daily living. Given that Mr Rollisson had received full support from social services in the community, the nurse decided that a full assessment of his care needs was required. At the initial assessment, the nurse also noted Mr Rollisson's previous medical history which showed that he suffered from high blood pressure. This was controlled using ramipril and she noted that Mr Rollisson also took various other medications for pain relief and to help him sleep.

28. Given Mr Rollisson's immediate care needs, until a full assessment of his support and daily needs was undertaken, he was located in an enhanced care suite within the healthcare wing. (The enhanced care suite is equipped with a tracking hoist, en-suite shower area, hospital bed and a pressure-relieving mattress.)

29. On 1 September, a nurse saw Mr Rollisson and created a 'support with living' care plan to manage his daily hygiene and dressing needs. On the same day, a prison GP saw Mr Rollisson to discuss his bladder and bowel care and to review his medication. Mr Rollisson had a catheter and required manual evacuation of his bowels. To support Mr Rollisson with these needs, nurses created care plans to reduce the risk of infection and to ensure that there was regular and effective management of his bowels. Mr Rollisson was prescribed with the same pain-relieving medication that he had used in the past.

30. On 14 September, a nurse completed a Waterlow pressure sore risk assessment on Mr Rollisson. (This is an assessment of various risk factors scored to indicate a person's risk of developing pressure sores). Given Mr Rollisson's paraplegia, there was a high likelihood of his developing sores. He scored 21 points on the Waterlow scale, constituting a very high risk. The nurse created a pressure relief care plan which included a review of Mr Rollisson on a weekly basis, or more frequently if any deterioration was noted. The care plan also set out activity that care and nursing staff should undertake to reduce the risk of Mr Rollisson developing sores.

31. On 2 October, a nurse identified a small broken area of skin on Mr Rollisson's left heel. In line with his care plan, his wound was regularly dressed and he received a heel protector. On 17 October, another broken area of skin was noted on Mr Rollisson's first toe on his right foot and, on 20 October, a large area of discoloration was noted on his right calf. On 19 October, Mr Rollisson's Waterlow risk assessment scored 24 points.

32. Healthcare staff requested specialist support and contacted the tissue viability nursing team to seek advice on the best way to manage Mr Rollisson's broken areas of skin. Nursing staff also provided Mr Rollisson with the necessary equipment to reduce his risk of developing pressure sores. He had an airflow mattress, pressure-relieving cushions for his wheel chair and also heel protectors. Mr Rollisson also received regular advice from nurses on how to reduce his risk while sitting in his wheelchair and lying in bed. On some occasions he removed

his heel protectors as he said they were uncomfortable. Healthcare staff discussed the importance of using the equipment at the dressing clinics.

33. On 4 November, despite continuing treatment, Mr Rollisson's skin continued to deteriorate. A nurse noted that Mr Rollisson's leg ulcers had increased in size and were red and wet. The same day, Mr Rollisson saw a prison GP, who authorised his transfer to hospital for further assessment. Two prison officers escorted Mr Rollisson using an escort chain in the ambulance. (An escort chain is a long chain with a hand cuff at each end, one of which is attached to the prisoner and the other to an officer.)

34. In hospital Mr Rollisson received antibiotics for his necrotic and inflamed leg ulcers. (Necrotic tissue is dead tissue that can form at the edges of open wounds.) Hospital doctors also carried out an arterial lower limb duplex scan (a test to examine blood vessels in the legs). This identified significant arterial disease, preventing the supply of blood to the organs and tissue, in both Mr Rollisson's right and left lower legs. The hospital vascular team discussed possible surgical intervention with Mr Rollisson to treat the arterial disease, but Mr Rollisson indicated that he was unwilling to undergo surgery.

35. Mr Rollisson continued to be restrained with an escort chain until 6 November, when the duty governor agreed to remove his restraints after discussion with bedside officers who highlighted his lack of mobility. The initial risk assessment indicated that Mr Rollisson presented as a medium risk given the nature of his offences, but that due to his mobility issues handcuffs were not be used. A decision was made to restrain Mr Rollisson using an escort chain.

36. On 9 November, Mr Rollisson was discharged from hospital and returned to prison. On his return, Mr Rollisson's condition was well managed with healthcare staff providing regular treatment to address his wounds, undertaking regular dressing, and seeing to his personal hygiene and social care needs. Between November 2016 and March 2017, Mr Rollisson's health remained relatively stable.

37. On 7 March, Mr Rollisson saw a prison GP after vomiting blood. The GP was concerned that Mr Rollisson might be suffering from upper gastrointestinal cancer and made an urgent two-week referral appointment. She also prescribed Mr Rollisson with omeprazole to treat acid reflux as his symptoms could also be a result of a stomach ulcer.

38. Later that day, Mr Rollisson's condition deteriorated. At 9.05pm, he used his cell call bell to alert prison officers that he was feeling unwell. Prison officers requested immediate healthcare support. A nurse attended and found Mr Rollisson shaking vigorously and unable to communicate verbally or respond. The nurse also noted that Mr Rollisson might have right side facial droop, a symptom of a possible stroke. The nurse took observations and due to Mr Rollisson's poor levels of oxygen saturation, administered 15 litres of oxygen, and requested an ambulance. Mr Rollisson was taken to Salford Royal Hospital escorted by two prison officers. They did not use restraints.

39. In hospital, Mr Rollisson had a CT scan of his head that confirmed that he had multiple areas of longstanding infarction (old mini strokes) with moderate small

vessel cerebral vascular disease (a narrowing of the blood vessels in the deep brain). Mr Rollisson was also diagnosed as having vascular epilepsy. Further investigations into Mr Rollisson's vomiting blood were unable to identify a cause. A subsequent gastroscopy was performed on 24 March and Mr Rollisson was diagnosed as having Barrett's Oesophagus (a chronic reflux disease of the gullet). Mr Rollisson remained in hospital with a two prison officer escort. He was not restrained.

40. On 15 March, Mr Rollisson was discharged back to prison. Between March and June 2017, he was treated appropriately, in line with his pressure relief care plan, receiving pain-relieving medication and effective care. Despite this, Mr Rollisson's leg ulcers gradually deteriorated and, on 13 April, a prison GP referred Mr Rollisson back to the vascular team as an outpatient. Although Mr Rollisson had not been assessed by the team prior to his death, this did not breach the NHS 18-week waiting time for non-urgent consultant-led treatments.

41. From time to time, Mr Rollisson decided that he did not want to get out of bed and on some occasions, he did not attend regular wound-dressing appointments. There is no evidence that missing these appointments had a detrimental impact on the condition of Mr Rollisson's leg ulcers. Healthcare staff regularly supported Mr Rollisson on these occasions and ensured that he had access to food and liquids. However, nutrition plays a vital role in the prevention and treatment of ulcers. Despite Mr Rollisson's condition and his reduced dietary intake as a result of his loss of appetite, there is no evidence that a nutritional assessment was ever completed. Although there is no evidence that this failure had a detrimental impact, there was the potential to negatively impact Mr Rollisson's health.

42. Due to Mr Rollisson having a permanent catheter he was at an increased risk of urinary tract infections. Throughout his time in prison Mr Rollisson did suffer from a number of infections and healthcare staff ensured that he was effectively treated in line with guidance. In April 2017, Mr Rollisson had a urinary tract infection and a prison GP requested a detailed urine sample analysis. Results of the sample were delayed for 20 days and there is no evidence that these were pursued. A further sample was requested but there is no evidence that this was ever taken. Although there is no evidence that this failure had a detrimental impact, it may have had a negative impact on Mr Rollisson's health.

43. On 9 May, Mr Rollisson received the wrong medication. A prison GP immediately informed Mr Rollisson of the mistake and reviewed Mr Rollisson's temperature, blood pressure and pulse. All were within the normal range. On the direction of the GP, Mr Rollisson had hourly observations and tests. Throughout the day Mr Rollisson's results did not indicate any concerns and there was no evidence that this mistake had any impact on Mr Rollisson's health.

44. On 2 June, Mr Rollisson saw a prison GP as test results showed that Mr Rollisson's count for haemoglobin (a protein in red blood cells) was low. The GP asked Mr Rollisson whether he would be willing to go to hospital for further assessment but Mr Rollisson was reluctant. He did, however, agree to an urgent referral to the gastroenterology unit at Salford Royal Hospital. The GP

prescribed Mr Rollisson iron supplements. Mr Rollisson did not see any gastroenterology specialists prior to his death.

45. On 17 June, after concerns raised by healthcare staff that Mr Rollisson was exceptionally lethargic and that his right hand was slightly swollen, he was seen by a prison GP. The GP carried out a series of routine observations which were all within normal range. However, the GP noted that Mr Rollisson's catheter was leaking. When the catheter was changed, Mr Rollisson's urine was thick and cloudy and the GP considered that Mr Rollisson might have a urinary tract infection. He prescribed antibiotics.

46. On 18 June, at 8.15am, a nurse attended Mr Rollisson after care staff alerted her that he was very lethargic, was unable to move his right arm and was having difficulty swallowing. Mr Rollisson was able to respond to questions and did not appear confused but he told the nurse that he felt unwell. The nurse carried out some routine observations where she took Mr Rollisson's temperature which was normal, oxygen levels which were low, pulse which was normal and blood pressure which was very low. These results indicated that he needed urgent care and the nurse requested an ambulance. Mr Rollisson was taken to North Manchester General Hospital for further assessment. Two prison officers went with Mr Rollisson in the ambulance. He was not restrained.

47. On 25 June, a prison manager visited Mr Rollisson in hospital as his health had deteriorated and he indicated that he wanted to speak to his family. The manager spoke at length to Mr Rollisson's family and provided his contact details.

48. Mr Rollisson remained in hospital until he died on 27 June, at 7.21am.

Contact with Mr Rollisson's family

49. On 18 June, the prison appointed a prison manager as the prison's family liaison officer (FLO). The FLO had previously spoken to Mr Rollisson's son in March 2017, when his father was in Salford Royal Hospital. The FLO regularly updated the family and also arranged for the prison to provide taxis to allow the family to visit Mr Rollisson.

50. On the morning of Mr Rollisson's death, the FLO and a prison chaplain visited Mr Rollisson's son and other family members to offer condolences and support.

51. The FLO remained in contact with Mr Rollisson's family immediately after his death. Mr Rollisson was cremated on 14 July and the prison contributed towards the cost of the funeral in line with national policy.

Support for prisoners and staff

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

53. The prison posted notices informing other prisoners of Mr Rollisson's death, and offered support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected.

Post-mortem report

54. A post-mortem examination indicated the cause of Mr Rollisson's death was pneumonia, caused by underlying cerebro-vascular disease and peripheral vascular disease with leg ulcers Ischaemic heart disease was also a contributory factor.

Findings

Clinical care

55. Mr Rollisson suffered from a number of medical conditions and required a high level of support to manage his daily activities. On arrival at HMP Manchester, his previous medical history was noted and he was immediately accommodated in an enhanced care suite within the healthcare wing of the prison. Prison healthcare staff ensured that clear and effective care plans were developed and put in place to manage Mr Rollisson's specialist needs.

56. As a result of pre-existing health problems, Mr Rollisson developed leg ulcers. Healthcare staff developed and followed an extensive care plan to manage these, including regular dressing and cleaning. Healthcare staff also requested specialist support and advice from tissue viability nurses and the hospital vascular team.

57. Throughout his time in prison, Mr Rollisson was subject to various care pathway arrangements. These ensured that he was subject to regular health checks and observations. Through these care plans, staff were able to provide Mr Rollisson with effective care and support his daily needs. The development of care plans also resulted in effective coordination and collaboration between all the teams caring for Mr Rollisson. On occasions, when Mr Rollisson chose not to get out of bed or attend wound dressing appointments, healthcare staff proactively supported him and actively engaged with him in an attempt to keep his outlook positive.

58. The prison healthcare unit established effective points of contact with local hospitals. When Mr Rollisson was in hospital, prison staff maintained regular contact with the establishment, and visited him to check on his health and progress. Mr Rollisson might have benefited from having a formal nutritional assessment and nutritional support in line with relevant guidance. There is no evidence that the lack of nutritional support contributed to Mr Rollisson's death, but it had the potential to impact on the condition of his leg ulcers.

59. During his time in prison staff treated Mr Rollisson with dignity and compassion. Mr Rollisson received a good standard of nursing care, his specialist needs were met and his personal comfort maintained.

60. We agree with the clinical reviewer that the standard of care Mr Rollisson received was equivalent to that which he could have expected in the community.

Contact with Mr Rollisson's family

61. When Mr Rollisson became ill in March 2017, the prison made active efforts to contact and update members of his family. During Mr Rollisson's stays in hospital the prison facilitated visits for both Mr Rollison's son and family, and kept them informed of his condition throughout his time at Manchester.

62. We are satisfied that the prison acted appropriately in their contact with Mr Rollisson's family.

Compassionate release

63. Given the rapid deterioration of Mr Rollisson's condition it was not practical for the prison to consider an application for release on compassionate grounds. We are satisfied that, given this rapid deterioration, there was no opportunity for the prison to consider compassionate release.

Restraints, security and escorts

64. 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.

65. The initial risk assessment indicated that Mr Rollisson presented as a medium risk given the nature of his offences but that, due to his mobility issues, handcuffs were not to be used. However, a decision was made by a prison manager to restrain Mr Rollisson using an escort chain. We regard this initial assessment as over-cautious given that Mr Rollisson had highly limited mobility, was very unwell and was escorted by prison staff, but recognise that when staff alerted the duty governor of Mr Rollisson's situation he authorised the removal of restraints.

66. The initial risk assessment made a considered decision not to double-handcuff Mr Rollisson and the escort chain was removed very soon after admission into hospital. We also note that on the three further occasions Mr Rollisson went to hospital he was not restrained. We make the following recommendation:

    The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that risk assessments show clear justification on the use of restraints.

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