

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr James Gavin a prisoner at HMP Manchester on 4 February 2020

**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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## 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 James Gavin, who was 83 years old, died of old age on 4 February 2020, at HMP Manchester. I offer my condolences to those who knew him.
4. The clinical reviewer concluded that the clinical care Mr Gavin received at Manchester was equivalent to that he could have expected to receive in the community. She made one recommendation but as it was not directly related to Mr Gavin's death, we have not included it in our report.
5. We found no non-clinical issues of concern. We make no recommendations.

## The Investigation Process

6. NHS England commissioned an independent clinical reviewer, to review Mr Gavin's clinical care at HMP Manchester. The clinical reviewer's report is attached as Annex 1.
7. The PPO investigator has investigated non-clinical issues, including Mr Gavin's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
8. One of the PPO's family liaison officers, wrote to Mr Gavin's next of kin, a friend, to explain the investigation. She did not respond.
9. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

## Previous deaths at HMP Manchester

10. Mr Gavin was the 14<sup>th</sup> prisoner to die at Manchester since February 2018. Of the previous deaths, five were from natural causes, six were self-inflicted, one was drug-related and one was from an unknown cause. There are no similarities between our findings in the investigation into Mr Gavin's death and our investigation findings for the previous deaths.

## Key Events

11. On 17 May 2018, Mr James Gavin was remanded in custody, charged with sexual offences, and sent to HMP Manchester. He was later sentenced to 17 years in prison.
12. Mr Gavin arrived at Manchester with several long-term health conditions, including heart failure and diabetes. He told staff that he had been under the care of the palliative care team in the community and had been given a life expectancy of six months. He had signed a Do Not Attempt Resuscitation (DNAR) order stating that he did not want to be resuscitated if his heart or breathing stopped.
13. In June, Mr Gavin was admitted to hospital for treatment for unstable angina (chest pain caused by reduced blood flow to the heart). When Mr Gavin was returned to the prison on 6 June, staff decided that he should be located in the prison healthcare unit so that he could get extra support and assistance. Mr Gavin told staff that he did not feel he would benefit from future hospital admissions and that he wanted his heart condition to be managed by prison healthcare staff.
14. On 23 December 2019, a prison GP saw Mr Gavin, because there had been a general decline in his health. He had fallen on five occasions since 1 December, and had lost weight. Mr Gavin told the doctor that if his health deteriorated further he did not want to be treated at hospital. He said that he was happy with the treatment that he was receiving at the prison.
15. In January 2020, Mr Gavin's health deteriorated further so he was moved to a palliative care suite, where he was given end of life care.
16. On 4 February at 2.17pm, healthcare staff found that Mr Gavin had stopped breathing. At 2.36pm a prison GP confirmed that Mr Gavin had died.

### Cause of death

17. The Coroner accepted the cause of death provided by the prison GP and no post-mortem examination was carried out. The GP gave Mr Gavin's cause of death as old age with ischaemic heart disease (reduction in blood flow to the heart caused by the build-up of fatty deposits in the coronary arteries), congestive heart failure (where the heart is unable to pump blood round the body properly) and type 2 diabetes (a condition that causes the level of glucose in the blood to become too high) as contributing factors.

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

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