Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Philip Birch, a prisoner at HMP Manchester, on 26 March 2020

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*

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. On 26 March 2020, Mr Philip Birch, who was 66 years old, died in hospital while a prisoner at HMP Manchester. The cause of death was given as COVID-19. We offer our condolences to Mr Birch's family and friends.

4. In September 2019, Mr Birch had been diagnosed with lung cancer which had spread to his brain, and was given a life expectancy of a few months. His condition deteriorated over the next few months.

5. On 18 March 2020, he was admitted to hospital for treatment for a skin infection. On 20 March, he tested positive for COVID-19 in hospital.

6. The clinical reviewer concluded that the clinical care that Mr Birch received in prison was good and equivalent to that which he could have expected to receive in the community. She made one recommendation to ensure the process for completing DNACPR documents is more robust.

7. Mr Birch had not shown symptoms of COVID-19 while in prison and we cannot say when or where he contracted the virus. The investigation found that Manchester had responded quickly and effectively in following national guidance on COVID-19 and implemented all possible measures advised at the time.

8. We found family liaison officer (FLO) arrangements were an example of best practice. A FLO was promptly appointed when Mr Birch received his terminal diagnosis and was proactive in supporting Mr Birch to re-establish links with his next of kin. The FLO facilitated visits funded by the prison, and ensured Mr Birch's next of kin was updated regularly as guidance on managing COVID-19 evolved.

9. We were, however, concerned that the prison did not consider an application for compassionate release when Mr Birch was diagnosed with terminal cancer.

Recommendations

- The Head of Healthcare should ensure that DNACPR forms are completed accurately and revise the current process to include an accuracy check by the healthcare manager.

- The Governor should share this report with an officer and ensure she is aware of the Ombudsman's findings.

Investigation Process

10. NHS England commissioned an independent clinical reviewer to review Mr Birch's clinical care at the prison, including his diagnosis and treatment. The PPO investigator and the clinical reviewer spoke to the healthcare manager to clarify aspects of Mr Birch's care. The clinical reviewer's report is attached as Annex 1. Notes from a discussion with the healthcare manager are attached as Annex 2.

11. The investigator investigated non-clinical issues, including the prison's response to COVID-19 and shielding prisoners, the security arrangements for his hospital escorts, liaison with his next of kin and whether compassionate release was considered.

12. The Ombudsman's family liaison officer contacted Mr Birch's next of kin to explain the investigation. They did not have any specific issues for the investigation to consider.

13. The prison received a copy of the report and did not identify any factual inaccuracies. An action plan for the recommendations is attached to the report as Annex 3.

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

Previous deaths at Manchester

15. Mr Birch was the 16th prisoner to die at Manchester since February 2018. Of these deaths, seven were from natural causes, six were self-inflicted, one was drug-related and in one death the cause was unascertained. There have been no other deaths from COVID-19.

16. We have previously identified the need for Manchester to ensure they make a timely application for compassionate release, which was also identified in this investigation, although we do not repeat the recommendation.

COVID-19 (coronavirus)

17. COVID-19 is an infectious disease that affects the lungs and airways. On 11 March, the World Health Organisation (WHO) declared COVID-19 as a worldwide pandemic.

18. COVID-19 can make anyone seriously ill, but the risk is higher for some people. People at high risk include those who have a severe lung condition; are having certain types of treatment for cancer; or have a condition with a very high risk of getting infections. Those at moderate risk include people over 70; people with a lung condition or a chronic medical condition, such as diabetes, heart, liver, or chronic kidney disease; or those who are very obese (this list is not exhaustive).

19. To reduce the spread of the virus, the Government introduced voluntary and mandatory actions, such as 'social distancing' and 'lockdown' (on 16 and 23 March, respectively). Public Health England (PHE), HM Prison & Probation Service (HMPPS) and NHS England worked together to devise measures to contain the outbreak, achieve social distancing, reduce the risk to the most

vulnerable in prisons in England and protect the NHS (by reducing the number of people requiring specialist care in community-based hospitals).

20. On 13 March, PHE's National Health and Justice team issued an interim notice providing advice on preventing and controlling outbreaks of COVID-19 in prisons. HMPPS issued further instructions over the following weeks with guidance on the appropriate use of personal protective equipment (PPE), hygiene, cleaning schedules and stock checks. The guidance set out the importance of effective preventative measures and that methodical cleaning would help prevent infection spread.

21. From 24 March, HMPPS took further measures to contain COVID-19 but, by this time, Mr Birch had been admitted to hospital and did not return to prison.

Early 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. In addition, End of Custody Temporary Release on licence (ECTR) was introduced in response to the COVID-19 pandemic, to enable risk-assessed prisoners, who are within two months of their release date to be temporarily released from custody, as part of the national approach to managing public services. In deciding which prisoners should be eligible for early release, a number of factors have been taken into account, these include:

    - The need to minimise the risk to public protection, so those assessed as a high risk of serious harm or convicted of sexual or violent offences are excluded.
    - The need to maintain public confidence in the justice system, so only those who are already close to release and who have already served at least half of their time in prison are considered
    - The need to comply with Government directions on COVID-19 will mean that only those who have suitable accommodation and whose healthcare needs (including Covid-related ones) can be safely managed on release are eligible.
    - Some groups of prisoners have separate processes governing their release so those serving a recall to custody have been excluded.

Key Events

24. On 4 August 2017, Mr Philip Birch, was remanded into custody charged with attempted rape and indecent assault, and later sentenced to five years and six months in prison. He was due to be released on 4 May 2020.

25. Mr Birch had several long-term physical health conditions, including chronic obstructive pulmonary disease (COPD - lung disease), Type 2 diabetes, and a history of alcohol misuse which had resulted in pancreatitis. He had poor hearing and was partially sighted. Mr Birch also had poor mobility and required assistance, so he was located in the prison's healthcare unit.

26. In September 2019, hospital doctors diagnosed Mr Birch with lung cancer, which had spread to his brain. His condition was considered terminal and he was given a life expectancy of a few months. Prison staff made contact with Mr Birch's next of kin and arranged visits.

27. Over the next few months Mr Birch's condition deteriorated. On 6 March 2020, he went to hospital for an ultrasound investigation of a lump in his arm and it was agreed that he would receive radiotherapy sessions at the hospital from 17 to 23 March. He had his first session on 17 March. However, on 18 March the hospital advised prison healthcare staff that he should not attend for any more sessions until further notice as a prisoner at Manchester had tested positive for COVID-19. Mr Birch had not been in direct contact with him but the prison could not be certain that there had been no indirect contact.

28. On 18 March a prison GP, assessed that Mr Birch required intravenous antibiotics for cellulitis, a potentially serious skin infection, and he was admitted to hospital. He was not restrained but was accompanied by two prison officers.

29. Prior to his transfer to hospital, Mr Birch had not been showing any symptoms of COVID-19, but he tested positive in a routine test in hospital on 20 March. He was moved to the hospital's infectious disease unit. Mr Birch experienced respiratory difficulties and was treated with high levels of oxygen over the next week but his condition deteriorated.

30. On 26 March, at 2.51am, Mr Birch was pronounced dead. Prison staff were present at the hospital, but not in the room.

31. An application for ERCG was initiated on 19 March 2020, but Mr Birch died before the application was processed. Mr Birch was not eligible to be considered for ECTR because of the nature of his offences.

32. There was no post-mortem examination as the coroner accepted the cause of death provided by the hospital. The hospital doctor recorded the cause of death as COVID-19.

Findings

Clinical Findings

33. The clinical reviewer concluded that the clinical care that Mr Birch received in prison was good and equivalent to that which he could have expected to receive in the community.

Management of Mr Birch's risk of catching COVID-19

34. Mr Birch had been located in a single cell in the inpatient unit since he arrived at Manchester in August 2017. At the outbreak of the pandemic, the prison identified Mr Birch as at high risk of contracting the COVID-19 virus and he was required to shield. He was not mobile and the clinical reviewer was satisfied that staff attending to his clinical needs always wore the correct PPE.

35. Until Mr Birch was routinely tested when admitted to hospital on 20 March, he showed no signs of COVID-19. We cannot say where or when he acquired the virus.

36. The investigation found that Manchester had responded quickly and effectively in following national guidance on COVID-19 and implemented all possible measures, as outlined in the compartmentalisation initiative.

Non-clinical Findings

Early release

37. There is no evidence in Mr Birch's medical or custodial records to indicate that an application for early release on compassionate grounds was considered when he received his terminal diagnosis and short prognosis in September 2019. An application for compassionate release was initiated on 19 March 2020, but Mr Birch died before the application was processed.

38. We highlighted the lack of compassionate release consideration following the death of another prisoner at Manchester in October 2019. We recommended that 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 considered and documented.

39. Manchester accepted our recommendation and provided an action plan on how they would improve the compassionate release process, and said:

> "All considerations for compassionate release (due to terminal illness) will be considered in line with National guidance and a record of the outcome of this type of application, noting the decision maker, will be held by the Offender Management Unit (OMU) Manager."

40. Given that this action plan in response to an earlier death was received after Mr Birch died, and that Manchester had followed the correct procedure for compassionate release after he was admitted to hospital in March, we do not make a further recommendation.

41. Mr Birch was not eligible to be considered for ECTR because of the nature of his offences.

Liaison with Mr Birch's next of kin

42. We found that an officer undertook the family liaison officer (FLO) role in line with PSI 64/2011 and the new HMPPS instructions in response to COVID-19. Despite the restrictions of the new instructions (which provide that FLOs should not make home visits), we consider that the prison provided a high level of support for Mr Birch's next of kin. The officer should be commended for her duties as the prison FLO. We therefore make the following recommendation:

The Governor should share this report with the officer and ensure she is aware of the Ombudsman's findings.

Sue McAllister CB **September 2020**
Prisons and Probation Ombudsman