

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr James Brennan, a prisoner at HMP Manchester, on 1 March 2021

**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 Brennan died in hospital on 1 March 2021, while a prisoner at HMP Manchester. He was 51 years old. The cause of Mr Brennan's death was COVID-19 pneumonitis. I offer my condolences to his family and friends.
4. In spite of the infection prevention measures in place at Manchester, Mr Brennan appears to have contracted COVID-19 at the prison, as he had not left for any reason.
5. The clinical reviewer highlighted deficiencies in monitoring Mr Brennan's condition; recognising early signs of deterioration; recording clinical decisions; and obtaining updates from the hospital after his admission. She concluded that although Mr Brennan's clinical care at Manchester was satisfactory before he contracted COVID-19, his management when he became unwell was not equivalent to that he could have expected to receive in the community.
6. We found that there were conflicting records about Mr Brennan's shielding status.
7. We are particularly concerned that when Mr Brennan's mother contacted the safer custody helpline with concerns about her son's health, the prison withheld the fact that he was seriously ill in hospital, without justification. By the time prison staff disclosed this information, Mr Brennan had been placed in a medically induced coma and did not recover. The handling of his mother's concerns does not reflect well on HMP Manchester and impairs the credibility of the helpline.

## Recommendations

- The Governor should ensure that prisoners who are shielding, or in protective isolation, are clearly identifiable and known to wing staff.
- The Head of Healthcare should ensure that healthcare staff review patients who test positive for COVID-19 at least daily and provide them with a pulse oximeter, to help detect early deterioration in their condition.
- The Head of Healthcare should ensure that staff are trained to recognise signs of clinical deterioration.
- The Head of Healthcare should ensure that all healthcare staff follow professional guidance for record keeping, including making clear, prompt and accurate entries in medical records.

- The Head of Healthcare should ensure that healthcare staff obtain regular updates on a prisoner's condition when he is admitted to hospital as an inpatient.
- The Governor should ensure that a prisoner's next of kin is informed immediately if he becomes seriously ill, in line with Prison Rule 22.
- The Governor should ensure that if a next of kin contacts the prison helpline about a prisoner's wellbeing, full and accurate details are given, unless there are justifiable and documented grounds for withholding information.

## The Investigation Process

8. NHS England commissioned an independent clinical reviewer to review Mr Brennan's clinical care at HMP Manchester.
9. The PPO investigator investigated the non-clinical issues, including aspects of the prison's response to COVID-19 and shielding prisoners; Mr Brennan's location; the security arrangements for his journey and admission to hospital; liaison with his family; and whether early release was considered.
10. In May 2021, the investigator and clinical reviewer jointly interviewed three healthcare staff and a prison manager from the COVID-19 command and information team. The interviews were conducted by telephone because of the COVID-19 restrictions in place.
11. The Ombudsman's family liaison officer wrote to Mr Brennan's next of kin, his mother, to explain the investigation. She asked for the following matters to be considered:
  - Why was Mr Brennan's medication not taken to his cell if he was shielding?
  - Did Mr Brennan have the COVID-19 vaccination by choice and was it compatible with his medication?
  - What follow-up care did he receive after he tested positive for COVID-19?
  - Why did the prison not tell her that Mr Brennan was in hospital and when did they intend to tell her?
  - Why did the prison not give the hospital her contact details?
  - Why was Mr Brennan's family not consulted about him being sedated?
12. The issues within the remit of the investigation have been covered in either this report, or the clinical review. We cannot address the issue of sedation, as the policy and actions of the hospital are outside the Ombudsman's remit.
13. Mr Brennan's mother received a copy of the initial report. She made no comments.
14. The initial report was shared with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies and accepted our recommendations. The HMPPS action plan is annexed to the report.

### Previous deaths at HMP Manchester

15. Mr Brennan was the 11th prisoner at Manchester to die since March 2019. Six of the previous deaths were from natural causes (including one from COVID-19), one was self-inflicted and three were drug-related. There have since been four deaths (none were due to COVID-19). There are no similarities between the findings in this investigation and those of the previous deaths.

## COVID-19 (coronavirus)

16. COVID-19 is an infectious disease that affects the lungs and airways. It is mainly spread through droplets when an infected person coughs, sneezes, speaks or breathes heavily. On 11 March 2020, the World Health Organisation (WHO) declared COVID-19 a worldwide pandemic.
17. COVID-19 can make anyone seriously ill, but some people are at higher risk of severe illness and developing complications from the infection. People at high risk (clinically extremely vulnerable) include those who have had an organ transplant; have severe lung or kidney disease; or are having certain types of cancer or other treatment which significantly increases the risk of infection. Examples of those at moderate risk (clinically vulnerable) are people over 70; people under 70 with an underlying health condition, such as diabetes, or chronic respiratory, heart, liver or kidney disease; those with a weakened immune system; or who are very overweight. (These lists are not exhaustive.)
18. In response to the initial pandemic outbreak, HM Prison and Probation Service (HMPPS) introduced several measures to try and contain the outbreak - to be implemented at local level, depending on the needs of individual prisons. (An outbreak is defined as two or more prisoners, or staff, who are clinically suspected, or have tested positive for COVID-19 within 14 days.) A key strategy is 'compartmentalisation' to cohort and protect prisoners at high and moderate risk; isolate those who are symptomatic; and separate newly-arrived prisoners from the main population. Other measures include social distancing and the use of personal protective equipment (PPE).
19. HM Inspectorate of Prisons carried out a scrutiny visit of Manchester in February 2021. Inspectors found that following the outbreak of COVID-19 in December 2020, partnership working between the prison, healthcare provider and Public Health England had been effective, with good communication about the restrictions in place to help prevent the spread of the infection.

## Key Events

20. Mr James Brennan had been sentenced to six years and two months imprisonment in 2015, for sexual offences and was released in December 2018. After breaching a sexual harm prevention order, Mr Brennan was recalled to prison and taken to HMP Manchester on 24 July 2019. (He was later sentenced to 26 weeks imprisonment.)
21. Mr Brennan had a history of asthma and chronic obstructive pulmonary disease (COPD), as well as mental health and substance misuse problems. In 2020, he was diagnosed with high blood pressure and angina.

### COVID-19 pandemic

22. The prison's healthcare department wrote to Mr Brennan on 8 April 2020, informing him that he was at high risk of complications from COVID-19. (Another term for high risk is clinically extremely vulnerable.) A wing officer discussed the letter with Mr Brennan the next day and he agreed to shield. The mental health team created a COVID-19 care plan.
23. On 4 May, an application was considered under the End of Custody Temporary Release scheme (early release to help manage the spread of COVID-19), but Mr Brennan did not meet the criteria.
24. On 2 July, a wing manager was concerned that Mr Brennan's mental state was deteriorating due to feelings of isolation and minimal contact with other people while shielding. He referred Mr Brennan to the mental health team for a welfare check and they reviewed him the next day.
25. On 25 November, Mr Brennan gave consent to receive the COVID-19 vaccine.
26. Healthcare staff sent another letter on 7 January 2021, advising Mr Brennan to shield. He said that he did not want to shield, as he was bored in isolation and wanted to work. Although the risks to his health were explained, he insisted and signed a disclaimer the same day. The Head of Residence added him to the list of non-shielding men and notified the Head of Healthcare on 8 January.
27. Entries in Mr Brennan's NOMIS personal records on 13, 14 and 15 January, indicated that he was shielding and part of a separate regime. An entry on 2 February noted that he was working.
28. On 10 February, Mr Brennan received the AstraZeneca vaccine for COVID-19.
29. Mid-February, Manchester had an outbreak of COVID-19 and Mr Brennan took part in prevalence testing. He was confirmed as positive on 18 February. He was placed in protective isolation, only allowed out of his cell to take showers and exercise at the same time as a cohort of other prisoners who had tested positive on the same day.
30. On 22 February, Mr Brennan was short of breath and fatigued. A nurse recorded that his blood oxygen saturation level (92%) was within the normal range for a patient with COPD. She gave him advice and noted that she would ask the prison GP if any treatment was needed. The outcome was not recorded.

31. On 23 February, Mr Brennan vomited blood and was finding it difficult to breathe. Two nurses checked him and administered oxygen to try and stabilise his very low oxygen saturation level. They consulted the prison GP, who provisionally diagnosed COVID-19 and sent him to hospital. Two prison officers escorted Mr Brennan, using single handcuffs. The security risk assessment said that his family should not be informed. No reason was recorded.
32. Mr Brennan arrived at the hospital at 1.00pm and the handcuffs were removed at 1.30pm, to allow for tests and X-rays. Just after 2.00pm, one of the escort officers told a prison nurse that doctors were struggling to stabilise him and were concerned that he would go into cardiac arrest. (The handcuffs were not replaced, as Mr Brennan was initially in a COVID-19 sealed unit and moved to the intensive care unit (ICU) at around 7.30pm.)
33. The prison assigned a family liaison officer (a prison chaplain) shortly after Mr Brennan left the prison. At around 3.00pm, Mr Brennan's mother telephoned the safer custody helpline, concerned that she had not heard from her son as they usually spoke twice a day. The message was passed to the family liaison officer, who consulted the duty governor and the security team. He was instructed not to disclose that Mr Brennan was in hospital. He informed Mr Brennan's mother that Mr Brennan could not speak to her due to treatment. When she asked if her son was in hospital, he was non-committal but agreed to update her the next day. (She telephoned a hospital where he had previously been an inpatient and hospital staff told her he was there.)
34. At 10.50am on 24 February, Mr Brennan was sedated. That morning, his mother again telephoned the prison's helpline about her concerns. Just after 11.30am, the family liaison officer rang to inform her that Mr Brennan had been placed in a medically induced coma and was on a ventilator. He gave the hospital's details and the password to get information from the clinicians. Members of Mr Brennan's family later visited him.
35. Mr Brennan died at 4.52pm on 1 March. The family liaison officer telephoned Mr Brennan's mother to offer condolences and help with the funeral arrangements. He kept in touch and led the funeral service, which was held on 30 March. In line with national policy, the prison contributed to the funeral expenses.
36. Notices were issued to staff and prisoners informing them of Mr Brennan's death and reminding them of the support mechanisms.

### **Cause of death**

37. No post-mortem examination was held as the Coroner accepted the hospital's clinical certification that Mr Brennan's cause of death was COVID-19 pneumonitis.

# Findings

## Clinical Findings

38. The clinical reviewer considered that the standard of Mr Brennan's clinical care was variable. She found that his long-term conditions and risks associated with COVID-19 were appropriately managed and monitored and were equivalent to that he could have expected to receive in the community. However, after Mr Brennan was diagnosed with COVID-19 on 18 February, he was not monitored; and possible signs of clinical deterioration were not recognised when he reported symptoms. The clinical reviewer concluded that these aspects of Mr Brennan's care were not equivalent.
39. The clinical reviewer also found weaknesses in record keeping and healthcare liaison with hospital staff. Her findings are set out in detail in the clinical review report. We summarise them below and make similar recommendations.

## *Management of Mr Brennan's risk*

40. Manchester facilitated shielding within two of the larger wings. (Additionally, throughout the pandemic, prisoners in any area of the prison who wanted to shield but did not meet the clinical criteria were permitted to do so in their own cell.) The cells of those shielding were marked, and they were allowed out separately for access to regime activities, such as showers. All cleaning was completed by designated wing cleaners and those who had contact with shielding men were required to wear PPE. Once the prison became an outbreak site, prisoners were allowed out in cohorts of 10 at a time.
41. While shielding, Mr Brennan's meals were delivered to his cell door and he was unlocked, individually, twice a day to collect his medication. These arrangements ended when Mr Brennan stopped shielding, but staff tried to ensure social distancing was maintained when he attended the medication area.
42. We are satisfied that, generally, Manchester implemented appropriate protective measures to minimise the risk of infection across the prison. However, we are concerned that, after Mr Brennan opted not to shield on 7 January, there were four entries by three different wing staff between 13 and 15 January indicating that Mr Brennan was on the shielding regime. It is unclear whether this was due to poor communication between operational staff, or weaknesses in the cell marking system, but the lack of clarity casts doubt on the effectiveness of the cohorting arrangements at that time. We recommend:

**The Governor should ensure that prisoners who are shielding, or in protective isolation, are clearly identifiable and known to wing staff.**

43. Mr Brennan's refusal to shield meant he was exposed to a limited, but larger group of men. As he had not left Manchester for any reason in the weeks leading to his positive diagnosis, it seems that he contracted COVID-19 within the prison.

### *Monitoring Mr Brennan's COVID-19 infection*

44. The clinical reviewer found that there was no process in place at Manchester to routinely check clinically vulnerable prisoners who had tested positive for COVID-19. After confirmation on 17 January that Mr Brennan had tested positive, there were no clinical checks until 22 January, when he reported symptoms. Although increased observations might not have altered the outcome, his deterioration might have been noticed sooner, leading to earlier medical intervention.
45. The clinical reviewer was also concerned that on 22 January, Mr Brennan's symptoms of fatigue, difficulty breathing and a raised temperature were not recognised by staff as possible early deterioration. Therefore, no follow up was planned.
46. Since Mr Brennan's death, the Head of Healthcare has circulated information to staff on recognising deterioration in patients. He has also implemented new processes for COVID-19 positive patients, including daily welfare checks and issuing pulse oximeters to measure blood oxygen saturation levels. We are pleased to note these improvements and make a recommendation to ensure these changes are properly embedded. We recommend:

**The Head of Healthcare should ensure that healthcare staff review patients who test positive for COVID-19 at least daily and provide them with a pulse oximeter, to help detect early deterioration in their condition.**

**The Head of Healthcare should ensure that staff are trained to recognise signs of clinical deterioration.**

47. Neither the nurse who assessed Mr Brennan on 22 January, nor the prison GP she consulted, documented the details of their discussion. Good record keeping is vital for continuity and shared understanding of decisions. We recommend:

**The Head of Healthcare should ensure that all healthcare staff follow professional guidance for record keeping, including making clear, prompt and accurate entries in medical records.**

### *Obtaining updates on prisoners in hospital*

48. During Mr Brennan's stay in hospital, healthcare staff only contacted the hospital twice for updates. Regular communication with hospital staff is important as this can inform decisions on risk and discharge plans. We recommend:

**The Head of Healthcare should ensure that healthcare staff obtain regular updates on a prisoner's condition when he is admitted to hospital as an inpatient.**

### *Contacting Mr Brennan's next of kin*

49. Prison Rule 22 states that prisons should inform the next of kin immediately if a prisoner becomes seriously ill. In March 2020, this obligation was reinforced in national Prison Service guidance on family liaison and communicating with prisoners' families during the pandemic. This also said that if a prisoner is diagnosed with COVID-19, they should be asked if they want to inform anyone.

50. Mr Brennan was a category C prisoner. Manchester's risk assessment form has two options for informing prisoners' families – immediately, or in 48 hours. Mr Brennan's risk assessment stated, 'no', meaning that his family should not be told. It is unclear whether this meant not before 48 hours, or not at all. No reason for this decision was recorded at the time and no explanation was given during the investigation.
51. A prison manager said that they had introduced the 48-hour policy following criticisms of the previous policy where families were not told for seven days unless the condition was life-threatening. He thought there might have been a breakdown of communication between the escort officers and the security team in reporting Mr Brennan's deterioration.
52. Despite following best practice by quickly assigning a family liaison officer, Manchester did not comply with the requirement in these circumstances to notify Mr Brennan's next of kin. We are concerned that there seems to have been a blanket application of the local policy. We are also concerned that the local policy does not comply with Prison Rule 22 or with the national COVID-19 guidance.
53. We are particularly concerned that the prison withheld, without any recorded reason, the information that Mr Brennan had been admitted to hospital, when his mother had twice called the prison helpline and had asked the family liaison officer outright. It was clear that Mr Brennan was acutely unwell, or in a life-threatening condition, as when he arrived at the hospital on 23 February, he went directly from assessment to the ICU. It was particularly incongruous to have maintained the line when the prison had already recognised the severity of Mr Brennan's illness by early removal of his restraints.
54. We acknowledge that the family liaison officer was acting on the direction of senior staff and was very supportive after Mr Brennan's death. Our concerns are therefore about the rationale and decisions taken by prison managers. We consider it unacceptable that Mr Brennan's mother had to press the prison for information. We are concerned that the delay in providing this information possibly deprived her of contact with her son before he was sedated. The treatment of Mr Brennan's mother following her legitimate and reasonable request for information degrades the purpose and value of the helpline and does not reflect well on the prison. We recommend:

**The Governor should ensure that a prisoner's next of kin is informed immediately if he becomes seriously ill, in line with Prison Rule 22.**

**The Governor should ensure that if a next of kin contacts the prison helpline about a prisoner's wellbeing, full and accurate details are given, unless there are justifiable and documented grounds for withholding information.**

**Elizabeth Moody**

**Deputy Prisons and Probation Ombudsman**

**December 2021**

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