Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Johnstone, a prisoner at HMP Manchester, on 2 January 2019

A report by the Prisons and Probation Ombudsman

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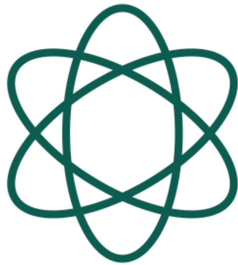
Our vision

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

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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.

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

Mr Paul Johnstone died on 2 January 2019 at HMP Manchester. The post-mortem examination was unable to establish Mr Johnstone's cause of death but the pathologist considered it likely that his past drug use caused his collapse. Mr Johnstone was 37 years old. I offer my condolences to his family and friends.

Mr Johnstone had been at Manchester for only seven days when he died. He had a long history of substance misuse and was placed on a drug detoxification programme the day after he arrived at Manchester. He was monitored twice daily.

The clinical reviewer was satisfied that Mr Johnstone's clinical care, including the care he received for his substance misuse issues, was good and at least equivalent to that he could have expected to receive in the community.

However, there were failings in the emergency response when Mr Johnstone was found unresponsive. The officer who found him failed to call a medical emergency code, which meant that the nurse who attended did not bring the appropriate equipment and an ambulance was not called immediately. There was a delay of 10 to 15 minutes before staff started cardiopulmonary resuscitation. The clinical reviewer was unable to say whether the delay affected the outcome for Mr Johnstone, but we know that in emergency situations a delay of a few minutes may be critical.

I am concerned that this office has repeatedly made recommendations to Manchester about ensuring staff call a medical emergency code when they find a prisoner unresponsive. I have asked the Prison Group Director responsible for overseeing Manchester to set out what he is doing to satisfy himself that meaningful action is being taken to improve Manchester's response to medical emergencies.

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

Sue McAllister CB
Prisons and Probation Ombudsman **December 2019**

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Summary

Events

1. On 27 November 2018, Mr Paul Johnstone was released on licence from HMP Forest Bank. On 27 December, he was recalled to prison after failing to comply with his licence conditions. He was sent to HMP Manchester.

2. Mr Johnstone had a long history of substance misuse. At his reception screening at Manchester, Mr Johnstone told a prison GP that he had been using heroin and crack cocaine daily. He was placed on the prison's drug treatment wing and the next day, he was put on a drug detoxification programme using methadone (an opiate substitute). He was monitored by healthcare staff twice daily.

3. On 31 December, a nurse recorded that Mr Johnstone's oxygen saturation level (oxygen in the blood) was 92% (a normal level is typically 95-100%). The nurse noted he had a GP appointment the next day. Mr Johnstone did not attend.

4. At around 1.45pm on 2 January, Mr Johnstone's cellmate rang the emergency cell bell because he was concerned about Mr Johnstone. When an officer attended, he found Mr Johnstone unresponsive. The officer asked the nurse on the wing for assistance but she said she was a substance misuse nurse and told him to radio Hotel 1 (the call sign for the first emergency responder for healthcare). The emergency response nurse attended and found Mr Johnstone lying on the top bunk. She asked officers to move him to the floor so she could start cardiopulmonary resuscitation (CPR) but they said they could not move him without permission, in case they injured him. The nurse radioed for an ambulance and for healthcare assistance. More staff arrived who helped to move Mr Johnstone to the floor. Staff started CPR which they continued until ambulance paramedics arrived at 2.25pm. The paramedics were unable to resuscitate Mr Johnstone and at 2.46pm, they pronounced him dead.

5. The post-mortem examination was unable to establish Mr Johnstone's cause of death. However, the pathologist considered it likely that Mr Johnstone's prolonged cocaine use was likely to have affected his heart and caused his collapse.

Findings

6. The clinical reviewer was satisfied that Mr Johnstone's clinical care, including the care he received for his substance misuse, was of a good standard and was equivalent to that he could have expected to receive in the community.

7. There were failings in the emergency response.

8. The officer who found Mr Johnstone unresponsive did not call a medical emergency code, which meant that the nurse who attended did not take the appropriate equipment with her and an ambulance was not called immediately.

9. Officers wrongly believed that they were not allowed to move Mr Johnstone from the top bunk. This led to a delay in starting CPR, which did not begin until more staff arrived and they moved Mr Johnstone to the floor.

10. The clinical reviewer noted that the delay in starting CPR amounted to 10 to 15 minutes. She could not say whether the delay affected the outcome for Mr Johnstone, but we know that in an emergency situation a delay of a few minutes may be critical.

11. The healthcare staff who attended the emergency response did not feel supported after the incident. A hot debrief took place before medical staff had finished treating Mr Johnstone and before he was declared dead.

Recommendations

- The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including that staff promptly use an emergency code to effectively communicate the nature of an emergency.
- The Governor should ensure that all relevant staff, including healthcare staff, are invited to the debrief following a death in custody.
- The Prison Group Director for Long Term High Security North should write to the Ombudsman setting out what he is doing to satisfy himself that meaningful action is being taken to improve Manchester's response to medical emergencies and the holding of debriefs.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Manchester informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

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

14. The investigator interviewed nine members of staff at Manchester on 6 March and 11 April 2019.

15. NHS England commissioned a clinical reviewer to review Mr Johnstone's clinical care at the prison. The clinical reviewer conducted joint interviews with the investigator.

16. We informed HM Coroner for Manchester of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

17. One of the Ombudsman's family liaison officers contacted Mr Johnstone's father to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not have any questions.

18. Our investigation was suspended between 2 January and 20 June 2019 while we waited for the cause of death and toxicology reports. The completion of this report was delayed as a result.

19. Mr Johnstone's family received a copy of the draft report. They raised one question, which did not impact on the factual accuracy of this report and has been addressed through separate correspondence.

20. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies. This report has been amended accordingly.

Background Information

HMP Manchester

21. HMP Manchester operates as both a high security prison and as a local prison serving the courts of the Greater Manchester area. It can hold more than 1,200 men. Greater Manchester Mental Health NHS Foundation Trust provides 24-hour nursing care and the healthcare centre includes an inpatient unit.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Manchester was in June and July 2018. Inspectors reported that compared to their last inspection in 2014, when the prison achieved reasonably good outcomes against their healthy prison tests, there had been a deterioration on most outcomes. However, the inspectors observed professional interactions between healthcare staff and prisoners, and clinical records and care plans were very good. Continuity of care was also good with most locum GPs and agency nurses working at the prison regularly. A dedicated nurse provided annual health checks and age-related screening.

Independent Monitoring Board

23. In its latest annual report, for the year to 28 February 2018, the IMB reported that healthcare provision at Manchester was excellent. However, they noted that prisoners failed to attend around 25% of the medical appointments booked. The Board had concerns that getting prisoners to healthcare appointments was not seen as a priority, and then prisoners experienced further delays while they waited for new appointments to be made.

Previous deaths at HMP Manchester

24. Mr Johnstone was the 13th prisoner to die at HMP Manchester since January 2017. Seven of the previous deaths were from natural causes and five were self-inflicted. There have been two self-inflicted deaths, two deaths from natural causes and one death caused by Spice (PS) toxicity since. We have made a recommendation about using the correct medical emergency code in three previous investigations. We have also made a recommendation about holding a hot debrief for all staff involved in the emergency response in four previous investigations.

Key Events

25. On 27 November 2018, Mr Paul Johnstone was released from HMP Forest Bank on licence after serving eight years in custody for wounding with intent. On 27 December, Mr Johnstone breached the terms of his licence and was recalled to prison. He was sent to HMP Manchester.

26. Mr Johnstone had hepatitis C, non-specific personality disorder, post-traumatic stress disorder and paranoid schizophrenia. He had a history of substance misuse, including benzodiazepines, heroin, crack cocaine, psychoactive substances ('Spice') and alcohol. He also had a history of self-harm and aggression to others.

27. During Mr Johnstone's reception health screen, a prison GP noted Mr Johnstone had been prescribed olanzapine (for schizophrenia) and mirtazapine (for depression). Mr Johnstone told the prison GP that before he was recalled to prison, he used heroin and crack cocaine daily.

28. The prison GP referred Mr Johnstone to the prison's mental health in-reach team and the substance misuse team. Mr Johnstone was placed on I Wing, the prison's drug treatment wing.

29. The following day, a prison GP saw Mr Johnstone and noted he had no complications with his physical health. He prescribed a titration dose of methadone, in accordance with the Methadone Integrated Drug Treatment Strategy (IDTS) protocol at Manchester. He prescribed 10mls on day 1 increasing up to 40mls on day 5. Mr Johnstone was reviewed for detoxification symptoms twice daily.

30. A mental health nurse saw Mr Johnstone later that day. She ordered an electrocardiogram (ECG) because of the potential side effects of olanzapine, which can cause an irregular heartbeat. (This was a routine referral and Mr Johnstone did not have an ECG before he died.) She put Mr Johnstone onto a list of patients for discussion at the next multidisciplinary team meeting.

31. On 30 December, a nurse noted that Mr Johnstone "appeared slightly drowsy but not intoxicated" and his oxygen saturation levels had dropped from 94 to 92 (a normal range is typically 95-100%). She noted that this might be a side effect of olanzapine and that he had a GP appointment the next day. Mr Johnstone refused to attend his GP appointment.

32. On 1 January 2019, a nurse took Mr Johnstone's observations, which appeared to have improved. However, he was unkempt and seemed tired. He asked Mr Johnstone if he had been taking anything other than his prescribed dose of medication. Mr Johnstone told him he had not and showed him the rest of his medication packets. There were no further concerns but the nurse made Mr Johnstone a further GP appointment.

Events of 2 January 2019

33. On the morning of 2 January, Mr Johnstone had his fifth day review with a psychosocial team leader. Mr Johnstone appeared tired but engaged well in conversation.

34. At around 1.45pm, Mr Johnstone's cellmate pressed their emergency cell bell. An officer responded. When he got to the cell, Mr Johnstone's cellmate said he was concerned about Mr Johnstone's welfare. The officer entered the cell but was unable to get a response from Mr Johnstone. He shouted down to a second officer, who was on the floor below, for assistance and the officer joined him. Neither could get a response from Mr Johnstone but thought they could feel a pulse. The first officer ran down two floors to the ground floor to ask one of the nurses to assist, but she said she was a substance misuse nurse and told him to call Hotel 1 (the call sign for the first emergency responder for healthcare). At 2.00pm, the officer used his radio to ask for Hotel 1 to attend.

35. A nurse (Hotel 1) arrived at the cell at 2.05pm. Mr Johnstone was lying on the top bunk. Officers had placed him in the recovery position. The nurse assessed Mr Johnstone and noted he had purple lips, was blue in colour, had dilated pupils and had no pulse. The nurse radioed for an emergency ambulance and for medical assistance.

36. The nurse asked the officers to take Mr Johnstone down from the bed so she could start cardiopulmonary resuscitation (CPR). They said they needed permission to move Mr Johnstone as there was a risk they might injure him. The nurse tried to administer CPR on the bed but this was difficult. A second nurse responded to the nurse's call for assistance. The nurse asked her to get the emergency resuscitation bag and the oxygen. When the second nurse returned, Mr Johnstone was on the floor and CPR had started. A third nurse was in attendance and requested a needle and a syringe. A prison GP attended and assisted with CPR. The defibrillator did not advise to shock and healthcare staff rotated CPR.

37. At 2.25pm the ambulance paramedics arrived and took over Mr Johnstone's care. After 40 minutes of attempted resuscitation with no response, a joint decision was made to stop treatment. At 2.46pm, paramedics pronounced that Mr Johnstone had died.

Contact with Mr Johnstone's family

38. At 3.30pm, a prison chaplain was appointed to act as the prison's family liaison officer (FLO). The FLO and an officer arrived at the home address of Mr Johnstone's next of kin at 4.00pm. They told him that Mr Johnstone had died and offered their support.

39. The FLO visited Mr Johnstone's next of kin on several occasions offering support and conducted the funeral service at the request of the family.

40. Mr Johnstone's funeral was held on 6 February 2019. The prison offered a financial contribution towards the cost of the funeral in line with national guidance.

Support for prisoners and staff

41. After Mr Johnstone's death, a prison manager debriefed the operational staff who were involved in the incident giving them the opportunity to discuss any issues arising, and to offer support. However, this was completed before medical staff had finished administering life support to Mr Johnstone and before he was declared dead. Medical staff were therefore not in attendance and did not have the opportunity to discuss any concerns or access support.

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

Post-mortem report

43. The post-mortem report concludes that the cause of Mr Johnstone's death is unascertained. The pathologist says, "In strictly pathological terms, the cause of Paul Johnstone's death is unascertained. However, given the circumstances of his death, and in the absence of a more plausible cause, in my opinion, the most likely reason he collapsed was because of a chronic cardiotoxic effect of his prolonged heavy cocaine abuse. Cannabis use may have contributed to this, and possibly even the use of (prescribed) methadone, although I cannot state, even on the balance of probability, that either or both must have done so. There are no pathological features of a physical assault."

Findings

Clinical care

44. Mr Johnstone arrived at Manchester with a long history of substance misuse. The clinical reviewer considered that he received a good level of input from healthcare, drug treatment services and the mental health in-reach team during the seven days he spent at Manchester. There was a streamlined approach with regards to mental health and substance misuse with medication prescribed in a timely manner, referral to appropriate services and substance misuse monitoring.

45. The clinical reviewer found that healthcare staff prescribed a titration dose of methadone in accordance with the Methadone Integrated Drug Treatment Strategy and an ECG was ordered due to Mr Johnstone being on olanzapine, which can cause side effects including irregular heartbeat. This was good practice.

46. The clinical reviewer concluded that the physical and mental health care Mr Johnstone received while at Manchester was equivalent to that he could have expected to receive in the community.

Emergency response

47. Prison Service Instruction (PSI) 03/2013, *Medical Response Codes*, requires prisons to have a two-code medical emergency response system. Manchester's local policy instructs staff to use a code blue to indicate when a prisoner is unconscious or having breathing difficulties, and a code red when a prisoner is bleeding. Calling an emergency medical code should automatically trigger the control room to call an ambulance, and for healthcare staff to attend with the appropriate emergency equipment.

48. However, the officer who found Mr Johnstone unresponsive did not call a medical emergency code as he should have done. An officer said that he decided to ask a nurse on a lower landing for assistance. However, the nurse was a substance misuse nurse, who did not carry a radio or respond to emergency situations. She advised him to call Hotel 1, which he did, but he did not call a code blue emergency and several staff at interview said there was no sense of urgency in his request. This resulted in the nurse attending alone and without the correct medical bag to respond to a prisoner not breathing.

49. Officers refused to move Mr Johnstone from the top bunk, which delayed the starting of CPR. Officers told the nurse that it was against prison policy to move a prisoner without permission in case of injury. During interview it became apparent that there was no such policy. However, Mr Johnstone was a large man and it would have been difficult to move him with two officers. During inspection of the cell and the bed, it was noted that the side rail was broken and it would have been difficult to lift Mr Johnstone over it without further assistance. However, had a code blue been called, more staff would have responded who could have moved Mr Johnstone.

50. The first officers on the scene did not start CPR. Not all officers were trained to administer CPR but acknowledged at interview that they should have called a code blue. This would have triggered healthcare staff to attend with the correct emergency

equipment and an emergency ambulance would have been called. The clinical reviewer noted that with this and other delays with the wrong equipment and lack of urgency, there were approximately 10 to 15 minutes of delays before CPR was started. Although the clinical reviewer found that the delay may not have changed the outcome for Mr Johnstone, we know that in emergency situations a delay of a few minutes may be critical.

51. We have made recommendations to Manchester previously about ensuring that staff call a medical emergency code when they find a prisoner unresponsive, and that they use the correct code. We have been told that Governor's Orders were issued in February 2017, November 2017 and September 2018 reminding staff, and pocket-sized ERIC (Emergency Response in Custody) cards were issued to staff in May 2018. However, we continue to find that staff at Manchester do not follow the correct medical emergency procedures. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including that staff promptly use an emergency code to effectively communicate the nature of an emergency.

The Prison Group Director for Long Term High Security North should write to the Ombudsman setting out what he is doing to satisfy himself that meaningful action is being taken to improve Manchester's response to medical emergencies.

Staff support

52. A prison manager conducted a hot debrief for the prison officers involved but there was no record. The prison staff interviewed could not recall who conducted the debrief but felt supported after Mr Johnstone's death and were seen by the care team.

53. However, a prison GP alongside other healthcare staff, said at interview that the hot debrief took place before medical treatment had ceased and before Mr Johnstone was declared dead. Healthcare staff therefore did not have the opportunity to attend the debrief or discuss the incident. The prison GP offered support to the healthcare staff in attendance after Mr Johnstone was declared dead, but healthcare staff did not feel supported by the prison.

54. Conducting a staff debrief before a prisoner is declared dead and not giving all staff the opportunity to attend is poor practice. All staff should have access to support after a traumatic event. We make the following recommendations:

The Governor should ensure that all relevant staff, including healthcare staff, are invited to the debrief following a death in custody.

The Prison Group Director for Long Term High Security North should write to the Ombudsman setting out what he is doing to satisfy himself that meaningful action is being taken to improve Manchester's response to medical emergencies and the holding of debriefs.

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