Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Gerard Thompson, a prisoner at HMP Manchester, on 20 November 2020

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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.

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 Gerard Thompson died on 20 November 2020 while at HMP Manchester. Mr Thompson's cause of death is unascertained. He was 29 years old. I offer my condolences to Mr Thompson's family and friends.

When Mr Thompson was found unresponsive on the morning of 20 November, there were signs that he had been dead for some time. I am concerned that no early welfare check was made when staff first started their shift that day.

When staff did find Mr Thompson, there were slight delays in radioing a code blue emergency and calling an ambulance. While it made no difference to the outcome for Mr Thompson, any delay in a future medical emergency could be critical. I also note that officers attempted to resuscitate Mr Thompson despite signs that he had been dead for some time.

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 **September 2021**

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Summary

Events

1. On 6 January 2020, Mr Gerard Thompson was recalled to custody for theft and was sent to HMP Altcourse.

2. On 11 September, Mr Thompson reported to a nurse that he had been suffering with chest pain since the previous evening. He continued to complain about chest pain over the following days but tests, including an electrocardiogram (ECG), proved normal.

3. Mr Thompson transferred to HMP Manchester on 25 September.

4. In a telephone conversation with his partner on 19 November, Mr Thompson told his partner that he had had severe chest pain the previous night but that he felt okay by the morning.

5. Mr Thompson was seen lying in an awkward position when he was checked in the early morning of 20 November. When an officer unlocked Mr Thompson's cell at around 9.00am, he was found to have no pulse. The officer called for medical assistance over his radio and he and another officer started cardiopulmonary resuscitation (CPR). When a nurse arrived, she found that Mr Thompson had rigor mortis so she told the officers to stop CPR.

6. The post-mortem examination found that Mr Thompson had a slightly enlarged heart and quetiapine (antipsychotic medicine) was found in his blood, although he was never prescribed it. However, the pathologist was unable to ascertain his cause of death.

Findings

Welfare checks

7. We accept that it was reasonable for the officer who checked Mr Thompson in the early morning of 20 November to consider that he was asleep, even though he was lying in an awkward position.

8. We are, however, concerned that Mr Thompson was not checked when the day staff arrived as standard morning welfare checks were no longer being made. (Checks were reinstated after Mr Thompson's death.)

Emergency response

9. The officer who found Mr Thompson unresponsive should have immediately radioed a medical emergency, rather than calling a colleague.

10. There was a two-minute delay in calling an ambulance following the call of a medical emergency: this delay would not have affected the outcome for Mr Thompson but could be crucial in future medical emergencies.

11. Finally, we are concerned that officers tried to resuscitate Mr Thompson even though there were signs he had been dead for some time.

Recommendations

- The Governor should ensure that all staff are made aware of, and understand their responsibilities during medical emergencies, including that:
    - staff radio a medical emergency without delay; and
    - an emergency ambulance is called immediately.
- The Governor should ensure that staff are given clear guidance and understand the circumstances, in line with European Resuscitation Council Guidelines, when they should not try to resuscitate prisoners.
- The Governor should share a copy of this report with the officers who tried to resuscitate Mr Thompson and arrange for a senior manager to discuss the Ombudsman's findings with them.

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 him. No one responded.

13. The investigator obtained copies of relevant extracts from Mr Thompson's prison and medical records. He interviewed ten members of staff and one prisoner from Manchester during January 2021. All the interviews were conducted by telephone due to revised working practices during the COVID-19 pandemic.

14. NHS England commissioned a clinical reviewer to review Mr Thompson's clinical care at the prison.

15. We informed HM Coroner for Manchester City of the investigation. The Coroner gave us Mr Thompson's post-mortem report. We have given the Coroner a copy of this report.

16. One of the Ombudsman's family liaison officers contacted Mr Thompson's partner to explain the investigation process and to ask if she had any matters that she wanted us to consider. She asked to receive a copy of our report but did not ask us to consider any particular issues.

Background Information

HMP Manchester

17. HMP Manchester is a high security prison which holds more than 1,200 men. Greater Manchester Mental Health NHS Foundation Trust provides 24-hour nursing care.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Manchester was in June and July 2018. Inspectors reported that they observed may positive interactions between staff and prisoners although they also noted that a small but influential number of operational staff were disengaged and distant. Inspectors noted that there was a wide range of primary and secondary care services with improved waiting times and some good practices in systematic assessment of patients.

Independent Monitoring Board

19. 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 2020, the IMB reported a number of positive developments during the year, including progression of the key worker scheme showing evidence of closer engagement between officers and prisoners and the provision of in-cell telephones which was a major enhancement for prisoners allowing contact with friends and family throughout the day.

Previous deaths at HMP Manchester

20. Mr Thompson was the 13th prisoner to die at HMP Manchester since November 2018. Of these deaths, eight were from natural causes, two were self-inflicted and two were drug related. In one of the deaths, staff attempted to resuscitate the prisoner even though it was clear he was already dead. Manchester accepted our recommendation about this. In a more recent case there was a slight delay in radioing a code blue emergency and in calling an emergency ambulance.

Key Events

21. On 24 May 2019, Mr Gerard Thompson was released on licence from HMP Liverpool where he was serving a ten-year sentence for burglary, conspiracy to commit burglary and assault occasioning actual bodily harm.

22. On 6 January 2020, Mr Thompson was recalled to custody for theft and was sent to HMP Altcourse.

23. On 11 September, Mr Thompson reported to a nurse that he had been suffering chest pain since the previous evening. Mr Thompson was reviewed by other nurses during the morning and he was given pain killers. At 10.29am, Mr Thompson reported that the pain had settled, but that he was anxious as his father had died of a heart attack.

24. A nurse reviewed Mr Thompson on 15 September. She noted that he was presenting with muscular chest pain but that he looked well and had a good skin colour.

25. On 16 September, Mr Thompson was referred for an ECG (electrocardiography: a check of the rhythm and electrical activity of the heart). The ECG results showed that Mr Thompson's heart was functioning normally.

26. On 25 September, Mr Thompson transferred to HMP Manchester. During a healthcare reception interview, Mr Thomson told a nurse that he had not used alcohol or drugs in the last three months. He said that he was not receiving any prescribed medication and that there was no significant family history of heart disease. (This contradicted what he said on 11 September about his father's death.)

27. On 28 September, a substance misuse worker visited Mr Thompson to tell him about the support her team could offer for any substance misuse problems. Mr Thompson told the support worker that he was not using drugs and that he did not need support.

28. On 5 October, Mr Thompson complained to officers that he had a headache and felt hot. A nurse examined him and found that all his clinical observations were within normal limits and that he did not need any treatment.

19 November

29. At 3.45pm on 19 November, Mr Thompson made the first of several telephone calls to his partner that day and they spoke for ten minutes. Mr Thompson said that he had had severe chest pain in the night and he could not feel his right leg. He said that by the morning he was feeling okay (Mr Thompson did not speak to a nurse about the chest pain that he mentioned to his partner). Their final conversation was at 8.15pm, and he did not talk about his health again. In response to our initial report, Mr Thompson's partner said that she believed his final call to her was at around 10.00pm.

30. At around 7.30pm, an Operational Support Grade (OSG) made a roll check of I Wing, where Mr Thompson lived. The OSG told the investigator that she had

checked Mr Thompson several times that week, although she could not recall having any conversations with him. When she checked Mr Thompson on the evening of 19 November, he was lying on his bed watching television. She thought that was the last time she saw him.

20 November

31. At around 5.00am on the morning of 20 November, an officer carried out the early morning roll check. The officer told the investigator that she had not previously met Mr Thompson and when she checked him, she noticed that his left leg was sticking out of the bed. She said that there was nothing else about him to cause her to feel concern for his welfare so she did not try to get a response from him, which she would have done if she were concerned. However, after completing her count, she spoke to another officer who told her that Mr Thompson had a longstanding leg injury so he slept in an awkward position.

32. The second officer confirmed at interview with the investigator that the first officer did speak to him about Mr Thompson and he told her that he did sleep in an apparently awkward position with one leg out of the bed.

33. At just after 9.00am, another officer unlocked Mr Thompson's cell to ask if he wanted a shower or wanted to clear rubbish from his cell. Mr Thompson's left arm and left leg were both half in and half out of the bed. He stepped closer to Mr Thompson and then saw that his eyes were half open. He called out to a Supervising Officer (SO) who was on the landing and then checked Mr Thompson for a pulse. There was no pulse and Mr Thompson's body was cold. At 9.02am, the officer radioed a medical emergency code blue (to indicate a prisoner is unconscious or having breathing difficulties). The officer estimated that 30 to 60 seconds elapsed from the time of going into Mr Thompson's cell and the time he radioed a code blue emergency.

34. Another officer was on the landing above and he responded to a combined shout for staff assistance and to the code blue alarm. He went to Mr Thompson's cell and the two officers moved Mr Thompson from his bed to the cell floor. One of the officers started chest compressions and as he began to tire, the other officer took over giving chest compressions.

35. A nurse arrived at 9.04am. She examined Mr Thompson and found that he had no pulse, that his eyes were fixed and dilated, that he was cold to the touch, that rigor mortis was present in his fingers, his arm was locked and blood pooling was evident in his back and calves. She told the officers that Mr Thompson was dead and that they should stop giving chest compressions. Ambulance paramedics arrived at 9.25am and one of the prison doctors officially certified Mr Thompson's death at 9.29am.

Contact with Mr Thompson's family

36. Mr Thompson had named his sister as next-of-kin. In line with Government advice on COVID-19 working practices, one of Manchester's family liaison officers (FLOs) telephoned Mr Thompson's sister at 10.15am, but her mobile telephone was switched off. The FLO made further calls through the morning, but again without success. At just before 12.30pm, Mr Thompson's partner telephoned the prison to

say that she had heard that her partner was dead. The FLO confirmed the news of Mr Thompson's death.

37. Manchester contributed to the cost of Mr Thompson's funeral in line with national instructions.

Support for prisoners and staff

38. The Duty Governor debriefed the staff who responded when Mr Thompson was found. The staff care team also offered support.

39. The prison posted notices informing other prisoners of Mr Thompson'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 Thompson's death.

Other matters

40. Later on 20 November, an officer overheard a conversation between several prisoners, where one prisoner made a comment on the lines of "Well I don't know what he's had". At interview with the investigator, the prisoner said that he did not know Mr Thompson very well and he had no knowledge of him using or trying to obtain drugs.

Cause of death

41. Toxicological tests found the presence of unprescribed quetiapine in Mr Thompson's blood. The toxicologist wrote that quetiapine is an antipsychotic medicine, only available on prescription, that can be subject to abuse. The toxicologist noted that the concentration of quetiapine found could be consistent with typical therapeutic dosage rather than recent overdose.

42. The pathologist found that Mr Thompson's heart was slightly enlarged, which could have increased the risk of cardiac arrhythmia (abnormal heart rhythm) and of sudden death. The pathologist noted that several studies have found an association between quetiapine use and sudden death secondary to fatal cardiac arrhythmias. The pathologist wrote that it was possible that the use of quetiapine in conjunction with the changes in Mr Thompson's heart could have further increased the risk of fatal heart arrhythmia. However, the pathologist noted that Mr Thompson's death could also have been caused by an adverse reaction to another substance not detected by post-mortem tests.

43. The pathologist concluded that his opinion was that a definitive cause of death could not be provided and he recorded cause of death as unascertained.

Findings

Morning roll and welfare checks

44. Manchester's local instruction on roll checks states that the night staff should complete a roll check at around 6.00am before handing over to the day staff. The purpose of a roll check is to confirm that all prisoners are present and correctly accounted for, that they have not escaped, and are not ill or dead. An officer said that she checked Mr Thompson at around 5.00am and she noticed that he was lying in an awkward position.

45. Rigor mortis had begun to set in when Mr Thompson's death was discovered which indicates he had been dead for some time. We cannot be sure when Mr Thompson died and it is not possible to say whether he was dead when the officer checked him at 5.00am. Roll checks are an important opportunity to check prisoners' wellbeing and we would expect officers who are conducting roll checks to try to obtain a response from a prisoner if there is reason to be concerned about his health. However, we accept that it was reasonable for the officer to consider that Mr Thompson was asleep when she checked him. We do not consider that it would have been reasonable or decent for her to have woken him up at 5.00am simply because his leg was sticking out of the bed in an awkward position. (We note too, that she spoke to a colleague who confirmed that Mr Thompson usually slept in an awkward position.)

46. Between 7.15am to 8.15am, the day staff were required to complete a welfare check on prisoners. The investigator was told that the welfare check was not being carried out at the time of Mr Thompson's death: he was told that some prisoners would be offered the chance to exercise at around 8.00am, but as Mr Thompson always declined exercise staff had ceased to ask him and the first time staff would speak to him was when he would be offered the chance to shower at around 9.00am. As we cannot be sure when Mr Thompson died, we cannot say whether he was dead at around the time that the welfare check should have been made.

47. We are surprised and disappointed that Manchester had ceased to carry out morning welfare checks on prisoners. However, we have been told that since Mr Thompson's death, Manchester has reintroduced these checks, so we make no recommendation.

The emergency response

48. Prison Service Instruction (PSI) 03/2013 Medical Emergency Response Codes and Manchester's Local Instruction sets out the actions staff should take in a medical emergency. The PSI includes mandatory instruction on efficiently communicating the nature of a medical emergency to ensure that medical staff are called promptly and to ensure there is no delay in calling an emergency ambulance.

49. When the officer unlocked Mr Thompson's cell, he found him unresponsive and noticed that his eyes were half open. The officer called out first for the SO to help him check Mr Thompson. The officer then checked Mr Thompson for a pulse and on finding he had no pulse, he radioed a code blue emergency. We consider that

the officer should have radioed a code blue emergency at the point he called for assistance from the SO.

50. There was also a delay in calling an emergency ambulance. The control room incident log shows that the code blue call was made at 9.02am and that an emergency ambulance was called at 9.04am. We acknowledge that the delays in making the code blue call and then in calling an emergency ambulance were not lengthy, but in other circumstances, even slight delays can make a difference in the outcome for the prisoner. We make the following recommendation:

The Governor should ensure that all staff are made aware of, and understand their responsibilities during medical emergencies, including that:

- **staff radio a medical emergency without delay; and**
- **an emergency ambulance is called immediately.**

Resuscitation

51. In September 2016, the National Medical Director at NHS England, wrote to the Heads of Healthcare for prisons in England and Wales introducing new guidance to support staff on when not to perform cardiopulmonary resuscitation. This guidance was designed to address the issue of inappropriate resuscitation after a sudden death in prison and was taken from the European Resuscitation Council Guidelines 2015 which state: "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile". The European Guidelines were updated in November 2017, but the same principles apply.

52. The officer who found Mr Thompson believed that he was already dead and the other officer who responded also thought from his appearance that he was dead. However, both officers wanted his death to be confirmed by a nurse so they delivered chest compressions until a nurse arrived and told them to stop as Mr Thompson was dead.

53. We understand why staff might want to attempt resuscitation until death has been formally recognised, but staff should understand that they are not required to carry out resuscitation in these circumstances. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. We therefore make the following recommendation:

The Governor should ensure that staff are given clear guidance and understand the circumstances, in line with European Resuscitation Council Guidelines, when they should not try to resuscitate prisoners.

The Governor should share a copy of this report with the officers who tried to resuscitate Mr Thompson and arrange for a senior manager to discuss the Ombudsman's findings with them.

Cell bell anomaly

54. The original records obtained by the investigator included Mr Thompson's cell bell log. This indicated that he pressed his cell bell at 11.00pm on 19 November, and the call was reset at 11.01pm (which would require an officer to visit the cell). The

log also indicated that Mr Thompson pressed his cell bell at 8.04am on 20 November, and the call was reset at 8.05am. The investigator was unable to identify any officer who answered a cell bell at these times.

55. Due to COVID-19 working practices the investigator was unable to visit Manchester to view the CCTV, but asked instead for a copy of the CCTV footage to be sent to him. Unfortunately, the software used by Manchester was incompatible with the investigator's computers and was also incompatible with the systems of prisons close to the investigator's home which might have allowed him to view the footage at their establishments.

56. The investigator asked Manchester to view the CCTV footage on his behalf and they informed him that there was no sign of officers going to Mr Thompson's cell at the times in question. Manchester then further interrogated the cell bell system and sent the investigator a print-out of cell bell activity for the whole of I Wing which indicated that Mr Thompson did not press his cell bell at any time on either 19 or 20 November. Without being able to view the CCTV ourselves, we can reach no definitive conclusion on this matter.

Clinical care

57. The clinical reviewer found that Mr Thompson's care at Manchester was of a good standard and was equivalent to that which he could have expected to receive in the community.

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