

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lenford White, a prisoner at HMP Manchester, on 19 March 2020

A report by the Prisons and Probation Ombudsman

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE



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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 Lenford White died in hospital on 19 March 2020 of small intestine failure, while a prisoner at HMP Manchester. This was caused by surgical complications for the treatment of an inflammation of the lining of the abdominal wall. He also had prostate cancer and heart disease, which did not cause but contributed to his death. Mr White was 65 years old. I offer my condolences to his family and friends.

The clinical reviewer found that the clinical care that Mr White received at Manchester was not equivalent to that which he could have expected to receive in the community. I am concerned that Mr White's missed hospital urology appointment just before he went to prison was not identified when he arrived at HMP Forest Bank, nor when he later transferred to HMP Manchester. I am also concerned that staff at Manchester did not notify Mr White's next of kin when he became seriously ill and was admitted to hospital in August 2019.

Our investigation has been delayed for various reasons arising from the COVID-19 pandemic. I am sorry for the additional distress this is likely to have caused Mr White's family.

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

July 2022

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Summary

Events

1. On 17 August 2018, Mr Lenford White was remanded to HMP Forest Bank, charged with sex offences. He had missed a scheduled urology appointment for an ultrasound prostate scan in the community a few days earlier.
2. On 15 November, he was sentenced to 10 years in prison and sent to HMP Manchester. Healthcare staff at Forest Bank and Manchester did not identify the outstanding appointment when they completed initial health screens.
3. In May 2019, Mr White was admitted to hospital twice, both times for urinary infections. During the second admission on 21 May, Mr White became increasingly unwell, and a scan of his stomach identified a small bowel obstruction. He had surgery to remove it.
4. On 12 June, Mr White returned to Manchester. His discharge summary noted that he had prostate cancer.
5. On 15 July, when Mr White attended hospital for a routine appointment, a nurse noted that he seemed unaware that he had prostate cancer. The nurse completed prostate cancer blood tests and arranged a follow-up appointment. Mr White was unable to attend this appointment because he had been readmitted to hospital.
6. On 15 August, Mr White attended a scheduled hospital appointment for blood tests, and was admitted to hospital because his blood test results showed that he had kidney failure and prostate cancer.
7. He remained in hospital, where he died on 19 March 2020 as a result of small intestine failure caused by complications of surgical treatment.

Findings

8. The clinical reviewer concluded that the care Mr White received at Manchester was not equivalent to that which he could have expected to receive in the community.
9. Forest Bank and Manchester failed to identify that Mr White had an outstanding urology appointment which he should have attended just before he was taken into custody. This potentially contributed to longer term uncertainty about his prostate cancer diagnosis.
10. The clinical reviewer made several recommendations about healthcare administration which the Head of Healthcare will need to address.
11. We are concerned that Manchester did not inform Mr White's next of kin when he became seriously ill and was admitted to hospital in August 2019.
12. Mr White's next of kin was concerned that the prison suddenly prohibited family meals that were taken to him in hospital after his surgery in May 2019. Although we found no evidence that Manchester stopped Mr White's family taking meals to him, we are satisfied that doing so would have been in line with Manchester's local security policy.

Recommendations

- The Heads of Healthcare for Forest Bank and Manchester should ensure that a dedicated clinician updates SystemOne with a summary of all information about newly arrived prisoners, recording appropriate diagnoses, community appointments and GP updates.
- The Governor of Manchester should ensure that staff notify a prisoner's next of kin as soon as possible if he becomes seriously ill and is admitted to hospital, and that the local family liaison policy reflects this position in line with Prison Rule 22.

The Investigation Process

13. 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/her. No one responded.
14. The investigator did not visit HMP Manchester due to the COVID-19 pandemic. She obtained copies of relevant extracts from Mr White's prison and medical records.
15. NHS England commissioned a clinical reviewer to review Mr White's clinical care at the prison. The clinical reviewer conducted joint interviews with the investigator via video link on 3 June 2020.
16. We informed HM Coroner for Manchester of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
17. Our family liaison officer contacted Mr White's daughter to explain the investigation and to ask if she had any matters she wanted us to consider. She asked for a copy of our report. She also asked about the care Mr White received in relation to his prostate cancer and about family visits. We have addressed her questions in this report and in the clinical review where they fall within the PPO's remit. We have explained that the care Mr White received in hospital is outside the PPO's remit and questions about this should be directed to the hospital.
18. Mr White's daughter received a copy of the draft report. They did not make any comments.
19. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Manchester

20. HMP Manchester is a high security and training prison and holds up to 750 prisoners. Greater Manchester Mental Health NHS Foundation Trust provides primary care and mental health services.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Manchester was in June and July 2018. Inspectors reported that there had been a deterioration for most 'healthy prison' outcomes since their last inspection in 2014. However, the inspectors noted that interactions between healthcare staff and prisoners were professional, and clinical records and care plans were very good. They noted that continuity of care was also good, with most locum GPs and agency nurses working at the prison regularly. They also noted that a dedicated nurse provided annual health checks and age-related screening.

Independent Monitoring Board

22. 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 that Manchester delivered an excellent healthcare service to prisoners.

Previous deaths at HMP Manchester

23. Mr White was the thirteenth prisoner to die at Manchester since March 2018. Of those deaths, seven (including Mr White's) were from natural causes, four were self-inflicted, one was drug-related and the cause of one death was unascertained. There are no similarities between our findings in the investigation of Mr White's death and those of the previous deaths.
24. Since Mr White died, there have been nine more deaths at Manchester, six from natural causes, one drug-related, one self-inflicted and the cause of another was unascertained.

Key Events

25. On 17 August 2018, Mr Lenford White was remanded to HMP Forest Bank, charged with sexual offences. A nurse completed his initial health screen. She recorded his history of osteoarthritis (a condition that causes joint pain) and that he had had urinary retention (a sudden inability to pass urine).
26. On 15 November, Mr White was sentenced to ten years in prison and transferred from Forest Bank to HMP Manchester. A nurse completed his initial health screen. Mr White said that he had had urinary retention. He declined a secondary health screen but was seen in the prison's over-50s clinic on 4 January 2019.

Physical health

27. The day after Mr White's arrival at Manchester, healthcare staff sent a letter Mr White's community GP practice requesting a summary of his community medical record. The GP practice replied with a summary of Mr White's significant medical history and included a letter from the urology department at Manchester Royal Infirmary dated 31 July. The letter said Mr White had experienced an episode of acute urinary retention. It noted that he had been temporarily catheterised (a procedure to drain urine into an attached collection bag). While being treated for urinary retention, it was identified that he had a nodular (lumpy) prostate gland. He was given an appointment at the hospital's urology clinic for blood tests and an ultrasound scan to test for prostate cancer. Mr White was also prescribed tamsulosin, a medicine to help with prostate problems. The GP practice noted that days before he went to prison, Mr White had not attended his scheduled urology appointment on 14 August.
28. On 20 November, a prison GP reviewed the community medical history summary and referred Mr White to hospital to review his arthritis. However, no one identified or followed up the proposed investigations for prostate cancer. The GP told the investigator that there was no standard approach to identifying missed community appointments for new prisoners or new diagnoses that a prisoner received in hospital when they returned to prison.
29. The prison GP said she did not recall Mr White's case due to the passage of time but that she usually reviewed the month or two before a prisoner's arrival at the prison and chased up anything that was missing within that timeframe. She said that prison GPs generally assumed that prisoners had the mental capacity to inform healthcare staff of any outstanding community appointments.
30. On 3 January 2019, a prison GP reviewed Mr White because he had symptoms of urinary urgency (a sudden and urgent need to pass urine) and dysuria (pain, burning or discomfort when passing urine). The GP prescribed antibiotics for a urinary tract infection.
31. On 17 January, Mr White attended a GP consultation with a prison GP. His osteoarthritis and anti-inflammatory medication were discussed and changed from naproxen to ibuprofen. He was also prescribed omeprazole (a medication that protects the lining of the stomach from becoming irritated through taking regular

anti-inflammatory medication). The GP requested blood tests to check Mr White's general blood count, cholesterol levels and liver and kidney function.

32. On 29 January, Mr White attended a routine NHS health check in prison.
33. On 7 February, a prison GP reviewed the results of Mr White's health check and noted his cholesterol was high and that his liver and kidney function results were slightly outside the normal range. He recorded he discussed Mr White's blood results with him and that he needed to repeat blood tests in a few months. Mr White had repeat blood tests in February, March and April to check his liver and kidney functions.

Hospital admission – 2 May

34. On 2 May, a prison GP reviewed Mr White because he had urinary symptoms again. This time, he also had worsening abdominal pain, a swollen abdomen and bladder, and was unable to retract his foreskin. He arranged for him to go to hospital straightaway, where he was treated with oral antibiotics and was catheterised. The next day, Mr White was discharged from hospital and returned to prison with a catheter in place.
35. On 7 May, Mr White complained that the catheter was rubbing against his foreskin, causing soreness. A prison GP reviewed him. Mr White told him about his recent hospital visit but that he did not know about his treatment plan. The GP asked administrative staff to chase up Mr White's hospital discharge letter.
36. Mr White's hospital discharge letter explained that he was catheterised and given oral antibiotics. The letter did not mention symptoms caused by problems with the prostate gland and it said a follow-up was not needed. Mr White's prison medical record about his return to Manchester is very brief, with no reference to a catheter nor any catheter care plan.

Hospital admission – 21 May

37. On 20 May, a prison nurse removed Mr White's catheter, without difficulty. Later, at 10.41pm, prison staff informed healthcare staff that he was in pain. At 1.05am the next day, prison staff told healthcare staff that Mr White was sweating and wanted to go to hospital. At 1.45am, a nurse saw Mr White in his cell. He told her that he had not passed urine since his catheter was removed the previous day. She recorded Mr White's vital signs and noted that his National Early Warning Score (NEWS2, a tool to detect and respond to clinical deterioration) was 1, indicating a low clinical risk and arranged for a prison GP to review Mr White the following morning.
38. On the morning of 21 May, a prison GP reviewed Mr White and noted his abdomen was tender and his bladder distended. The GP sent him to hospital straightaway for re-catheterisation. At hospital, Mr White was treated for a urinary infection. He became increasingly unwell with a raised temperature, disorientation and confusion. A CT scan of Mr White's abdomen showed that he had a small bowel obstruction for which he had surgery on 23 May.

39. While in hospital, Mr White developed supraventricular tachycardia (an extremely fast heart rate) and was transferred to the coronary care unit for monitoring. He was given adenosine, an intravenous drug to slow his heart rate. He also developed a sub-splenic collection (a collection of fluid between the spleen and the left kidney) which was treated with intravenous fluids and antibiotics.
40. Mr White's daughter said that after his surgery in May, his family took him meals to help his recovery. She said that the prison stopped this suddenly, without explanation.
41. On 12 June, Mr White returned to Manchester, with a small surgical wound. His discharge summary noted that he had prostate cancer. It was also noted that a cystoscopy (a procedure to examine the inside of the bladder) had been arranged, as well as a follow-up appointment with the general surgical team.
42. On 15 July, Mr White attended hospital for his cystoscopy. A Macmillan urology nurse specialist also completed prostate cancer blood tests as she had noted that a previous discharge letter said that Mr White had prostate cancer. (Mr White seemed unaware of this.) She arranged an outpatient, follow-up appointment for two to four weeks' time. She wrote to prison GPs informing them of the tests and follow-up plan. However, Mr White was unable to attend the follow-up appointment because he was re-admitted to hospital on 15 August.
43. Between 15 July and his readmission to hospital on 15 August, Mr White's medical record shows that he continued to report difficulty in passing urine and was only passing small amounts. Records show that although Mr White's surgical scar was dressed frequently, a scar lesion formed. Mr White had abdominal pain and dysuria and in July, his scar began to open. Healthcare staff continued to dress his scar and examine him.
44. On 29 July, a Healthcare Assistant (HCA) saw Mr White and noted his difficulty passing urine, constipation and abdominal pain. A prison GP reviewed him and recorded that he had had these symptoms for a week. Mr White's urine was tested and found to contain white blood cells and blood, indicating a possible urine infection. The GP prescribed antibiotics and noted Mr White's upcoming urology and general surgery appointments. He also recorded that he should be medically reviewed if he became unwell or his condition worsened.
45. On 5 August, the HCA saw Mr White again and noted that he had abdominal pain, that liquid was coming out of his surgical scar and he had a burning sensation when passing urine. She noted that he was due to see a prison GP. A prison GP reviewed Mr White and recorded that the consultation focussed on a lump on Mr White's thigh and his urinary symptoms were not discussed.
46. On 9 August, Mr White complained of pain and difficulty passing urine. A nurse booked a GP review for the next day and noted that Mr White's NEWS2 was 1, indicating a low risk of clinical deterioration. Mr White did not see a doctor the next day because there were no officers available to take him to the healthcare department. On 12 August, a prison GP recorded in Mr White's medical record that neither nursing staff nor Mr White had raised concerns over the weekend.

15 August 2019 – 19 March 2020

47. On 15 August, Mr White attended a scheduled hospital appointment for blood tests, after which he went back to Manchester. Later that day, the hospital requested Mr White return to hospital because of his blood test results. He travelled to hospital by ambulance, unrestrained and escorted by two officers.
48. At 10.14pm, it was recorded that Mr White had been re-admitted to hospital because he had kidney failure. It was also recorded that his blood test results suggested he had prostate cancer and that urgent scans were being arranged.
49. Between 22 November and 4 December, Mr White was managed under suicide and self-harm prevention procedures because he kept removing his stoma (an opening in the abdomen with a bag over it to collect faeces) which caused hospital staff serious concern. ACCT procedures were closed on 4 December.
50. Mr White remained in hospital, where he died on 19 March.

Contact with Mr White's family

51. Mr White's daughter and her uncle had scheduled a visit to see Mr White in hospital on 19 January 2020. She told us that when they arrived, an officer and a nurse told them that Mr White was no longer allowed visitors and a visit was not scheduled.
52. On 16 February, Manchester appointed a family liaison officer (FLO) as Mr White's health had deteriorated and the usual family liaison officer was away. She contacted Mr White's daughter that day, told her about Mr White's deterioration and arranged to meet her at hospital. Mr White's daughter told her that the hospital had informed her on 14 February that Mr White had advanced prostate cancer. She asked her if the prison healthcare team also knew, when was he diagnosed and why she, as his next of kin, had not been informed sooner. The FLO explained that she was unable to discuss Mr White's health with her for confidentiality reasons and that she should speak to hospital staff about his health. She also told her that she would check with the prison's Head of Healthcare for them to speak to her.
53. On 17 February, the FLO noted in the family liaison log that she had informed Mr White's daughter that the 19 January visit had been cancelled for medical reasons because a hospital nurse had said that Mr White had an infection and was not allowed visits as he risked infecting others. The nurse had said that visits could be reassessed once Mr White had moved to another ward.
54. Just after Mr White's death, hospital staff telephoned his daughter and broke the news of his death to her. The FLO travelled to hospital and met Mr White's daughter and extended family. She offered her condolences and support.
55. The prison contributed to the costs of the funeral in line with national instructions.

Support for prisoners and staff

56. The prison posted notices informing other prisoners of Mr White'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 White's death.

Post-mortem report

57. The post-mortem report established that that Mr White died from small intestine failure. This was caused by complications of surgical treatment for an intra-peritoneal inflammatory collection (an inflammation of the lining of the abdominal wall). He also had prostate cancer and coronary artery atheroma (a build-up of fatty deposits and plaque on the walls of the arteries around the heart) which did not cause but contributed to his death.

Findings

Clinical care and cancer diagnosis

58. The clinical reviewer found that the overall care that Mr White received at Manchester was not equivalent to that which he could have expected to receive in the community. She found that despite a number of identified examples of good practice, Mr White's outstanding urology appointment was not identified when he arrived at Forest Bank nor when he transferred to Manchester. She said that, although this did not lead directly to his death, it might have contributed to a longer term uncertainty about his prostate cancer diagnosis. We make the following recommendation:

The Heads of Healthcare for Forest Bank and Manchester should ensure that a dedicated clinician updates SystmOne with a summary of all information about newly arrived prisoners, recording appropriate diagnoses, community appointments and GP updates.

59. Although not directly related to Mr White's death, the clinical reviewer also made several recommendations about improving healthcare administration, which the Head of Healthcare will need to address.

Contact with Mr White's family

60. Prison Rule 22 says that when a prisoner becomes seriously ill, the Governor should "at once inform the prisoner's spouse or next of kin". This is reflected in PSI 64/2011, which requires prisons to contact the next of kin of prisoners who are seriously ill.
61. On 15 August 2019, Mr White was admitted to hospital because he had grossly abnormal blood results, which suggested he had prostate cancer. Despite this, the prison did not inform Mr White's daughter that he was in hospital. She only found out by chance on 6 September when she went to visit him in prison, and he was not there. We are very concerned that the prison told her that it would not normally inform a prisoner's family for at least seven days after hospitalisation. This is not in line with Prison Rule 22.
62. We are even more concerned that Manchester had still not told her that he was in hospital three weeks' after he was admitted. Again, this is not in line with the requirements of Prison Rule 22. Although we note from the family liaison log that prison staff apologised to Mr White's daughter for her wasted visit to the prison on 6 September, this could have been avoided if the prison had contacted her on 15 August when he was admitted to hospital. They could then have cancelled the prison visit booked for 6 September and arranged for a hospital visit instead.
63. We make the following recommendation:

The Governor of Manchester should ensure that staff notify a prisoner's next of kin as soon as possible if he becomes seriously ill and is admitted to hospital, and that the local family liaison policy reflects this position in line with Prison Rule 22.

Meals

64. Mr White's daughter said that after Mr White's surgery in May, his family took him meals to help his recovery. She said that the prison stopped this suddenly, without explanation.
65. The investigator found no record of family meals being stopped suddenly and asked Manchester for a copy of its policy on food when prisoners are in hospital. Security measures during hospital visits are generally very similar to those in place for prison visits. Manchester's local security strategy in such situations says, "Visitors may not bring any items with them to hand to the prisoner during a visit on a bedwatch. All food must be provided by the hospital canteen and products can be purchased by the visitors for their own consumption. All toiletries must be provided for personal use by the prisoner, prison and or hospital small items such as get well cards, etc. may be left for the prisoner (to be searched by staff) but no other property must be handed over to the prisoner during the visit."
66. We found no record that Manchester stopped the family bringing meals for Mr White. However, doing so would have been in line with prison security policy and we make no recommendation.

Inquest

67. The inquest, held on 3 May 2023, gave a narrative conclusion. It said, "Mr Lenford Lloyd White was admitted to North Manchester General Hospital on the 15 August 2019 due to abdominal discomfort. Complications during surgery, multiple co-morbidities and difficulties to maintain nutrition led to bronchopneumonia, which ultimately caused the death of Mr White."

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