

**Investigation into the death a man
whilst in the custody of HMP Manchester in April 2010**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

February 2011

This is a report into the death of the man who died at North Manchester General Hospital, whilst in the custody of HMP Manchester. The man was 68 years old when he died of natural causes. A post mortem concluded that he had died of bronchopneumonia and heart failure.

I offer my sincere condolences to his family and friends for their loss. One of my family liaison officers contacted the man's family to inform them about the investigation and to provide them with an opportunity to raise any issues about the care the man received in custody. I hope that my report addresses their concerns and gives them a greater understanding of the events leading to his death. I am sorry that it has been delayed and regret any additional distress this may have caused.

The investigation was carried out on my behalf by my colleague. Both she and I would like to thank the Governor of Manchester and his staff, for their co-operation during the course of our enquiries. In particular, I would like to thank the liaison officer. Manchester Primary Care Trust were commissioned to provide a clinical review into the care provided for the man, and I would like to thank the clinical reviewer for conducting the review.

As the man died from natural causes, the findings in the clinical review play an essential part in my report. The review shows that the standard of care the man received was equitable to that which he could have expected in the community and the clinical reviewer makes no criticism of the man's clinical care whilst at HMP Manchester. I do not make any recommendations as a result of this investigation.

The version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Jane Webb
Acting Prisons and Probation Ombudsman

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SUMMARY

The man was born in July 1941 and lived in Manchester prior to his conviction for sexual offences in 2006. He was sentenced to an Indeterminate Public Protection sentence (IPP) with a minimum tariff of 669 days at Manchester Crown Court on 31 July 2007.

On reception into prison, he was taking a number of medications for a heart condition, angina, high blood pressure, heart disease, high cholesterol, asthma, chronic obstructive pulmonary disease and skin complaints.

From the time he entered custody until his death, he had regular access to prison doctors and healthcare staff and also attended outside hospital for his heart condition to be monitored. His health and medication were reviewed regularly. However, there were many occasions when he did not go to medical appointments and refused to comply with the medication prescribed for him (or appeared to have over-used the medication).

His health progressively worsened and, at the beginning of 2010, he had occasional difficulty breathing, and his legs appeared swollen. He was seen by the prison doctor and agreed to start taking medication again to alleviate these symptoms.

Shortly afterwards, the man was admitted into the in-patient healthcare unit at the prison to enable him to be more closely assessed. The swelling in his legs was increasing and noted as 'significant'. Staff assisted him with personal hygiene and his legs were regularly cleaned and dressed. A review by a doctor on 31 March found that the man's heart was not beating effectively and so his medication was increased to control his heart rate.

Despite daily medical care, the man's health further deteriorated. On 3 April, he was admitted to North Manchester General Hospital. As a result of his worsening health, the security restraints were removed and his family were permitted to visit without prior arrangement with the prison.

On 12 April, the man's condition grew worse and he refused to eat or drink, so became dehydrated. The following day he had a parenteral line inserted in an attempt to provide nutrients. However, his health continued to decline and he died in the early hours of 15 April.

THE INVESTIGATION PROCESS

1. Following notification of the man's death, my colleague was appointed to conduct the investigation. HMP Manchester provided a copy of his prison records, including his medical records. Notices were issued to prisoners and staff inviting anyone who had information regarding his death to make themselves known to the investigator. No other witnesses came forward.
2. My colleague visited Manchester prison on 8 June. She met senior managers there, and conducted recorded interviews with four staff.
3. Manchester Primary Care Trust (PCT) was commissioned to provide a clinical review into the care provided for the man. A clinical reviewer was appointed to conduct the review.
4. My colleague contacted Her Majesty's Coroner to inform him of the nature and scope of the investigation and request a copy of the post mortem report. Upon completion, the investigation report will be sent to the Coroner to assist his enquiries into the man's death.
5. A member of the family liaison team contacted the man's daughter on 21 May, to inform her about the investigation and invite her to ask any questions or raise any concerns about the care her father received in prison. The man's daughter said that she was aware he wrote to healthcare at the prison saying that he did not always receive his medication for his heart condition in time, which was a cause of concern. As she asked, I have considered this issue in my report.

HMP MANCHESTER

6. HMP Manchester is part of the National Offender Management Service high security estate. It is a complex prison holding those remanded by the courts and prisoners convicted of serious offences, including category A prisoners and those serving a life sentence. The maximum prison capacity is 1269 men. There are two separate accommodation blocks.
7. There is a separate healthcare centre, incorporating inpatients, day care and pharmacy facilities. Healthcare at Manchester is provided by Manchester Primary Care Trust. The inpatient unit provides 24 hour nursing care for up to 20 patients.

Independent Monitoring Board

8. Each prison has its own Independent Monitoring Board (IMB), which is made up of volunteers from the community. The Board's role is to ensure that the prison is properly run and that prisoners are treated fairly. Each Board produces an annual report for the Secretary of State. The report covering the period of 1 March 2008 to 28 February 2010, is the latest report available. In their report, the IMB made the following comments:

“Patients requiring specialist health services attend by appointment at one of the local NHS Hospitals. As attendance at such appointments remains conditional on the provision of escort officers, this often results in the cancellation of the appointment for operational reasons.

“A specialist nurse for “older prisoners” has been appointed in the last year. This is an important development, recognising the particular needs of prisoners who are aged 55 or over. Patient visiting is conducted within the prisoner's own environment on the wings with a case load of approximately fifty individuals being visited on a monthly basis.”

HM Chief Inspector of Prisons

9. A report covering the period 27 July to 31 July 2009, published by the then Chief Inspector of Prisons noted that there was evidence of strong support from the Primary Care Trust. This was reflected by an improvement to services and greater access to a range of prison and specialist clinics. Pharmacy and dental services were judged to have improved and there was efficient management of external appointments to clinical services. Further comments included:

“Health services were commissioned by the Manchester Primary Care Trust (PCT). The prison was strongly supported by the PCT, and there were regular forums through which they met. The general manager for specialist services with responsibility for prison health provided the direct link with the prison; she had established excellent relationships with prison staff and provided robust support to the whole team. A comprehensive health needs analysis had been completed in 2008 and updated in 2009. The prison director of health was a member of several committees,

including the Prison Partnership Board and the Integrated Governance Subgroup. Overall, there was good access to health services, most of which were comparable to those found in the community. Health services were delivered from discrete areas in the prison; the main healthcare department was located adjacent to E wing, with treatment rooms on A, D, E and I wings. In addition, there was a healthcare room in the reception area.”

Previous deaths in custody

10. The man’s death was one of 32 to have occurred at Manchester since April 2004 when this office began investigating all deaths in prison custody in England and Wales. Twelve of the previous deaths were due to natural causes. There are no similarities between those deaths and that of the man.

KEY EVENTS

2006-2009

11. The man was born in July 1941 and prior to coming into custody lived in Manchester. He was convicted of sexual offences and sentenced to an Indeterminate Public Protection sentence at Manchester Crown Court on 31 July 2007 (IPP - IPP means that offenders can be sentenced to life but must have a minimum period of imprisonment specified at the time of sentence, which is known as the tariff. Prisoners can be considered for release once the tariff period has been served). His minimum tariff was 669 days. The man spent his entire sentence at HMP Manchester, although between 28 June and 31 July 2007 he was remanded to HMP Preston.
12. Following his arrest, he was medically assessed by Manchester Police as part of Operation Safeguard. (Operation Safeguard is put into place when there are very few prison cells, and prisoners are instead held in police cells.) These documents were available to HMP Manchester on his reception there on 1 December 2006. He said that he had a history of heart problems, angina, bronchitis, chronic obstructive pulmonary disease (COPD) and was a smoker.
13. On reception, the man's medical record listed his medication as: clopidogrel bisulfate (used for heart conditions to stop clotting of the blood), digoxin (for heart conditions), folic acid (a nutrient), furosemide (a diuretic), glyceryl trinitrate spray (GTN) (for angina), quinine sulphate (to prevent heart arrhythmia), ramipril (for high blood pressure and heart disease), simvastatin (to address high cholesterol), salbutamol (for COPD), Quvar (an asthma inhaler), atrovent (for COPD), Dioralite (a mineral replacement drink) and emulsify ointment (for skin conditions).
14. From 1 December 2006 to January 2010, the man had regular access to prison doctors and healthcare staff and also went to hospital when his heart condition was monitored. On 4 April 2007, however, while at court, he was suspected of having a heart attack and was taken to Rochdale Infirmary. He discharged himself the next day, and was taken to HMP Preston, where he remained for the rest of his trial.
15. After being sentenced, he returned to Manchester. In reception, he was seen by the first prison doctor, who did not assess him fully as there was no transfer information. The first prison doctor arranged for some blood tests to be done, and the man was seen the next day by a second prison doctor. The second prison doctor undertook further observations and arranged for medication to be prescribed.
16. The man's medication was reviewed at appropriate intervals and he also had blood tests taken, during which he was compliant with the treatment. There were many instances when the man refused to take his medication, accept treatment or attend healthcare and hospital appointments despite proactive encouragement from healthcare staff. On each occasion that the man refused

treatment, he signed a disclaimer stating that his refusal was against the advice of the healthcare staff.

17. On one occasion, on 14 August 2009, the man requested a new supply of furosemide a week before his previous supply should have run out. (Furosemide is a diuretic which is often used to treat the symptoms of heart failure by preventing water retention.) The pharmacy raised this issue with a doctor, who decided that the man should no longer have this medication in possession. (In possession medication is held by the prisoner; otherwise, each dosage is dispensed by healthcare staff when required and is taken in front of the member of staff.)

2010

18. On 22 January 2010, the first nurse who saw the man recorded that he refused to collect his simvastatin medication, as he wanted to take it later in the evening. He declined the opportunity to discuss this with a doctor. The man raised this concern again with a third prison doctor on 9 February, when it was agreed he could have the medication dispensed daily, to enable him to take it later in the evening.
19. The first nurse recorded that, on the following two days, the man still refused to collect his medication. The third prison doctor offered another appointment to discuss the reasons. On 17 February, a second nurse recorded that the man again refused to collect his medication. The clinical reviewer reports that, because the man refused to attend medical appointments or collect his medication, his prescription was stopped.
20. On 3 March, the first nurse recorded that the man's blood pressure was 123/88 (The normal range for blood pressure is 100/70 to 140/90, although the pressure varies throughout the day depending on the individual's activities. A blood pressure reading of greater than 140/90 is classed as high and a reading of 90/60 or below is classed as low.) He was seen on the wing by healthcare staff at the request of wing staff, as he had said he was unable to go to the segregation unit due to being 'constipated but having diarrhoea'. He was observed by the first nurse to be breathing heavily and having trouble speaking, although he was able to walk without assistance. His breathing became easier and he was shown breathing exercises to calm himself. He was subsequently able to walk to his cell.
21. The healthcare centre received another request from discipline staff at 6.45am on 15 March. They were asked to assess the man, whose legs were swollen, and a third nurse attended. She noted that the man was sitting in his chair smoking, had swelling to both feet and legs and recorded his blood pressure as 129/81. The man confirmed that he had not been taking his medication, having said that he was unable to access the treatment room on the 1's landing (this is the ground floor) as he was located on the 2's (the first floor). He told the third nurse that he did not believe his legs were any worse than they had been. It was agreed that he should be moved to the ground floor to encourage him to

collect his medication. An appointment was made for the man to be assessed by the doctor later the same morning.

22. The man refused to attend this appointment. A further appointment was made for the afternoon and the third prison doctor recorded that the man also refused to attend this assessment. Instead, the doctor went to assess the man in his cell, recording that he had occasional shortness of breath and swollen ankles since stopping his medication. He sometimes slept propped up to help his breathing. The man agreed to start taking his digoxin, ramipril, clopidogrel, furosemide and simvastatin.
23. On 18 March, The second nurse recorded an improvement in the man's appearance and that he was walking better. Four days later, a telephone call from discipline staff was received by healthcare, advising that the man was having difficulty walking and his legs were swollen. He was unable to access the showers, which are on the first floor, and he wanted to be admitted to healthcare as an in-patient. A fourth nurse recorded that, following consultation with the second prison doctor the man would not be admitted as an in-patient. This would reduce his independence and was not comparable to the care he would receive in the community (where he would not be treated as an in-patient). However, consideration would be given to transferring him to a different establishment with better facilities to meet his needs. In the interim, it was proposed that the man should be transferred back to the first floor landing to enable him to access the showers. Healthcare staff would take his medication to him to further promote his cooperation and ensure that his condition was regularly reviewed
24. However, following further concerns about the man's health, it was agreed to admit him to healthcare for a period of assessment. A fifth nurse recorded the man's blood pressure as 80/40. The swelling to his legs was recorded as significant, but he was not suffering from shortness of breath and was lucid. He was closely monitored throughout the day and provided with information to help reduce the swelling and stiffness in his feet and knees. He was encouraged to stay as mobile as possible as fluid was oozing from his feet and legs. The man's diuretics (which helps ease fluid retention) were increased and, later the same evening, his blood pressure was recorded as 85/50.
25. The next morning, a sixth nurse recorded that the man had an unsettled night as his legs continued to ooze fluid and remained swollen. His blood pressure was recorded by the nurse as 100/60. The man was assisted to bathe, and his legs were dressed as they were still oozing fluid. The man continued to eat and drink independently, was able to move around his cell and made no complaint of pain or discomfort.
26. On 26 March, The fifth nurse recorded that his blood pressure was 90/55. The care plan was reviewed and was consistent with his medical needs. His lower legs and feet remained swollen and oozing fluid, but the man was able to wash independently and move around his cell. Later the same day, the second prison doctor recorded that the man had lost two kilograms in weight in the three days since he was admitted to in-patients. His legs remained swollen and

while the man said that he experienced no shortness of breath, the prison doctor recorded that there were reduced breath sounds and crackles in his chest.

27. Over the following four days, healthcare staff recorded that the man was assisted with his personal hygiene, his legs were regularly dressed and he was encouraged to raise his legs when sitting. On 31 March, a fourth prison doctor reviewed the man. The doctor recorded that his heart was not beating effectively and increased the digoxin medication to control the heart rate. The fourth prison doctor consulted the medical registrar at North Manchester General Hospital, to discuss changes in his medication as blood tests had shown that the man had reduced sodium levels, which could result in an admission to hospital. The Care Plan was reviewed and remained relevant. The man remained in the healthcare centre overnight.
28. The man's blood pressure was recorded as 92/67 on 1 April. He reported that he slept intermittently and was again encouraged to elevate his legs. The second prison doctor assessed the man and recorded that he felt weak. The doctor noted that the increased digoxin had improved his heart rate but there remained concerns regarding the diuretics affecting sodium levels. An electrocardiogram (ECG, a test to measure the electrical output of the heart) was requested and blood tests were taken and sent for urgent review. The fifth nurse recorded that, when she contacted the Oldham biochemistry laboratory, they reported not receiving the blood sample. A second medical registrar at North Manchester General Hospital, was consulted and advised that a further blood sample should be taken the following morning.
29. On 2 April, the man's blood pressure was recorded as 83/60. He was moved to a different cell that provided more space. He was also given a hospital bed, where he was able to elevate his legs, which were redressed. The second prison doctor reviewed the ECG results from the previous day and was not unduly concerned. He noted that the man's breathing had improved as had the swelling to his legs. Later the same day, the blood test results revealed that the man's sodium level had dropped slightly. Following consultation with a third medical registrar at North Manchester General Hospital, the second prison doctor agreed to stop the furosemide and increase the ramipril.
30. The next day, the man reported that he slept well during the night and was sitting up in bed watching the television. Later the same morning, his blood pressure was recorded by a seventh nurse as 74/59. An hour later it was recorded as 81/51 and further blood tests were taken. The man's condition deteriorated, he became very drowsy and less responsive and he was admitted to North Manchester General Hospital.
31. A risk assessment must be completed when prisoners go to hospital appointments. This determines the level of escort and the restraints (handcuffs) required for the safe custody of the prisoner. Restraints are applied if the risk assessment states they are necessary, and prison staff are allocated to escort for the prisoner. When a prisoner is admitted to hospital, prison staff carry out a bed watch duty and complete a log of activities. A regular

management check of the bed watch is carried out by a duty governor. Visits from the family may be allowed but they are closely monitored to ensure that they do not impinge on the security of the bed watch.

32. The risk assessment will consider the following:
 - The prisoner's medical condition. When there is doubt, the prison's medical officer will be asked to advise on any medical objections to the use of restraints.
 - The prisoner's behaviour in prison.
 - Home circumstances.
 - The nature of the offence (criminal history), the risk to the public and hospital staff, including the risk of hostage taking.
 - The prisoner's motivation to escape, likelihood of outside assistance and their conduct whilst in custody.
 - The physical security of the hospital.
 - There will also be an assessment of visits restrictions.
33. According to the policy for performing hospital bed watches in force when the man was in hospital, the following options were available to the Governor:
 - Escort and bed watch with two officers or more, with restraints.
 - Escort and bed watch with two officers or more, without restraints.
 - Escort and bed watch with one officer, without restraints.
34. Following this risk assessment, the Duty Governor authorised that the man would be escorted by two prison officers and an escort chain used. (The escort chain allows one of the escorting officers to be handcuffed by wrist to the prisoner's wrist via a chain and allows greater access of treatment and comfort.)
35. Over the next few days, the man's ramipril was discontinued in order to try to regulate his blood pressure. He also received intravenous anti-biotics for cellulitis (skin infection) in his legs. Healthcare staff reported that he did not cooperate with taking oxygen and also refused to eat. On 9 April, the third nurse from HMP Manchester healthcare centre visited North Manchester General Hospital and was advised that the man was very unwell. A consultant advised the nurse that they had requested an urgent oesophagogastroduodenoscopy (OGD, a procedure in which a camera is inserted into the oesophagus) and that the man had refused to be fed via a tube.

36. The man was visited by the third nurse again at 10.45am, who obtained his authority to retain a copy of his medical record. The chaplaincy department were alerted to the man's condition and contacted his next of kin. The man was encouraged to have a feeding tube, but despite several attempts to get him to agree, he declined and was placed on an intravenous drip. At 1.50pm, the man was visited by the Operations Governor. Permission was given for all restraints to be removed due to his deteriorating medical condition. Visits from the man's family would be allowed, although they had to be arranged with the prison. The man's daughter visited later that day, and stayed for approximately 90 minutes. She was given permission for the man's son to visit from Cyprus.
37. Over the next few days, the man continued to receive medical care and encouragement to eat. He also received further visits from his family. On 12 April, the man's condition continued to deteriorate and he refused to eat and drink and became dehydrated. An eighth nurse recorded that the hospital were considering returning the man to the prison for nursing care. There was no significant improvement or decline in the man's condition the following day. He was taken to theatre where a parenteral line (which provides nutrition through a vein) was inserted.
38. On 14 April at 8.55am, the man's daughter was contacted and advised to visit because of her father's continuing decline. The officer who was performing bedwatch duties, contacted Senior Officer (SO) at the prison who confirmed that visits were unrestricted and did not need to be booked through the prison. The man received a visit from his daughter and son at 11.55am. They were advised of his condition and life expectancy and stayed for much of the day. At 2.55pm, the Security Governor visited.
39. Following a continuing decline, at 2.29am the next morning, the man was pronounced dead. An officer rang the prison control room to inform them of the man's death. A second prison governor, was contacted at home and told that the man had died. He attended the prison as possible, to ensure that the prison's contingency plans for a death in custody were adhered to correctly and support staff present when the man had died.
40. A prison chaplain who had spoken to the man's family in the preceding few days was also contacted at home and told that he had died. The chaplain contacted the ward sister at the hospital who confirmed that she had already contacted the man's family.
41. The second prison governor carried out a de-brief with the staff who had been with the man when he died and ensured that they were aware of on-going support available to them.
42. The prison contributed towards the funeral costs and staff from the prison attended.

ISSUES

First reception health screening

43. The man was transferred to Manchester from Preston in July 2007. He did not undergo an initial assessment at Manchester, as he was transferred there from another prison, and had been at Manchester only a few months previously. (The man had been moved to Preston after being taken to hospital after suffering a suspected heart attack at court.) However, he did see a doctor the day after he arrived and had his medication reviewed at that stage.
44. Current guidance on the reception of prisoners is contained in Prison Service Instruction (PSI) 52/2010, "Early Days in Custody". This replaced the previous Prison Service Order 0500, which dealt with reception. PSI52/2010 states, at paragraph 2.36, that:

"Prisoners spending their first night in the current prison following transfer from another establishment may undergo the detailed medical assessment on the following day, (or if this is not possible, no later than one week after arrival) *unless there are urgent health issues that must be addressed on the day of arrival.*" (The italics in the quote mean that this section is mandatory.)

It is clear that, given the current instruction, it was appropriate for the man not to see medical staff when he returned to Manchester, assuming that he had no immediate medical needs. At the time, it was not local practice to re-screen when a prisoner was transferred from another prison. Although he had only gone to Preston after being taken to hospital with a suspected heart attack, he had discharged himself the next day. In the circumstances, I believe that he was treated appropriately when he returned to Manchester.

The man's non compliance with treatment

45. Throughout his time in custody, the man often did not take his medication or chose not to attend appointments with healthcare staff. Despite advice to the contrary, the man remained a heavy smoker. Overall, from the medical record, it seems that the man was offered advice on many occasions, but he often declined to accept it. I believe that healthcare staff acted appropriately when trying to encourage the man to comply with his medical regime, but that he chose not to do so.

Whether the man was refused appropriate medication

46. The man's daughter told my investigator that she had seen a copy of a letter he wrote to healthcare saying that he did not always receive medication for his heart condition in time. There does appear to have been one occasion, in August 2009, when the man requested furosemide but was refused as he had already received it. As a result, he was no longer allowed to hold his medication in his own possession.

47. In 2010, the man continued to refuse to take his medication. As a result, his prescription was stopped in February, after he refused to attend several appointments with medical staff. The medication was prescribed again on 16 March, after the second prison doctor went to see the man (the man had, again, refused to attend an appointment).
48. I believe that these might be the occasions that the man's daughter is referring to. While these events have been noted by the clinical reviewer in her clinical review, she has not made any recommendations or made any adverse comment on this issue. I accept that staff at Manchester acted appropriately in their dealings with the man and his medication.

Overall assessment of the care provided to the man

49. The clinical reviewer has found that, despite continual attempts, healthcare staff found it difficult to engage the man and help him maintain a routine. She judged that he was treated appropriately when he was an in-patient. The clinical reviewer has not made any recommendations as a result of her review.

The man's time in hospital

50. When a prisoner is escorted to hospital, a risk assessment is made as to the level of restraint and escort that is used. I am pleased to note that the assessment was reviewed regularly, and that restraints were removed at an appropriate time.
51. I am also pleased to note that contact was established with the man's family, through the chaplaincy department, soon after he was taken to hospital. Again, I believe there was a good reassessment of his condition, leading to the decision to allow unrestricted visits that did not have to be booked through the prison.

CONCLUSION

52. The comprehensive clinical review found that while the man was in prison he chose to take responsibility for managing his medical condition. However, his compliance with medical advice and taking medication was inconsistent.
53. The man had a progressive chronic condition which was managed by healthcare staff within the constraints of his compliance. He failed to attend many doctor's and hospital appointments. Of course, as in the community, the man had the right to choose to do so. He was made aware by staff of the consequences of not accepting treatment.
54. I believe the man received a great deal of medical input during the final weeks of his life. Prison healthcare remained in contact with the hospital, and were therefore able to provide him with up to date and appropriate care for the management of congestive cardiac failure. When eventually he was admitted to hospital, the risk assessment was revised and, as he deteriorated, the restraints were completely removed. I am sure that seeing her father without restraints and being allowed open visits made the circumstances easier for the man's daughter.
55. The Prison Service received the draft report. They commented that they had identified no issues or inaccuracies in the report.