

**Investigation into the circumstances surrounding the
death of a man at HMP Manchester
in July 2009**

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

April 2010

This is a report into the circumstances surrounding the death of a man, a prisoner at HMP Manchester, in July 2009. He was 43 years old. The post mortem determined that his death had been caused by a cerebral abscess. He had been in custody at Manchester since January 2005.

I would like to offer my sincere condolences to the man's partner and family, and to all those who were touched by his passing.

One of my investigators conducted the investigation on my behalf. In addition, the local Primary Care Trust (PCT) commissioned a clinical review into the standard of healthcare the man received in custody. A clinical reviewer led this with the assistance of a psychiatrist who provided a review of the mental health care. I would like to thank them both for their assistance with my investigation. I would also like to thank the Governor of HMP Manchester and his staff for their help.

The man had a long history of complex mental health problems, the most severe of which was Tourettes Syndrome, an inherited neurological condition. He had also been diagnosed with Obsessive Compulsive Disorder (OCD). His conditions were identified as soon as he was first remanded to HMP Manchester. Once sentenced, he progressed well. With the advice of the man's partner, staff and other prisoners learnt to understand how his Tourettes Syndrome could manifest itself, and he received continued support.

Two days before his death, the man was admitted to the healthcare wing as a result of staff concerns about his appearance. Tests revealed that he had taken Subutex, a drug normally used in detoxification from heroin, and he was closely monitored. However, at 7.10pm, a nurse found him unconscious on his cell floor and efforts by staff and paramedics to resuscitate him failed.

I commend the prison for the actions taken in ensuring that a complex mental health problem was dealt with sensitively and that all staff and fellow prisoners were aware how Mr Hillard's condition could affect his daily life. I am satisfied that the man's care was managed appropriately and make no recommendations as a result of my investigation.

This 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.

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Prisons and Probation Ombudsman

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CONTENTS

Summary

The investigation process

HMP Manchester

Key findings

Issues

Good practice

SUMMARY

On 12 January 2005, the man was remanded into custody at HMP Manchester. He was 38 years old at that time. He suffered from complex mental health problems, most significantly Tourettes Syndrome. On reception at Manchester, he disclosed his mental health problems to medical staff who assessed him. In terms of his physical health, he was considered fit and well. However, he was given a place in the healthcare wing so that his mental health needs could be assessed by a doctor.

The man remained in the healthcare wing for the next seven months and had regular medication reviews. The 'tics' which he experienced as a result of his Tourettes Syndrome would often lead him feeling unable to interact with other prisoners. However, his general behaviour was considered to be good. During these seven months, he was also assessed by staff from a Mental Health Hospital with a view to being admitted for a period of assessment before sentencing, and in August 2005 he transferred to the hospital under the Mental Health Act. He remained there under the care of a doctor until May 2006 when he returned to court and was sentenced to life imprisonment, with a minimum term of one year and 231 days.

The man returned to HMP Manchester and was again located into the healthcare wing where he remained until June 2007. During this time, medical staff saw him and reviewed his treatment regularly. They also sought opinions on his care from staff at the Mental Health Hospital who worked closely with the prison. The man had prolonged periods where his 'tics' were particularly bad and these resulted in him causing self injury by hitting himself around the head and banging his head against walls. As a result, he was placed on Assessment, Care in Custody and Teamwork (ACCT) monitoring on a number of occasions. (ACCT is the Prison Service's process to monitor and support prisoners felt at risk of suicide or self-harm. The prisoner's movements and interactions with staff and others are closely monitored and recorded, and a care plan is put in place to reduce the level of distress.)

In June 2007, the man was considered well enough to be moved to a residential wing. It was considered that his complex mental health problems made him vulnerable and he was located on a wing for vulnerable prisoners – E wing. Staff were made fully aware of his problems and how these manifested in his behaviour. This information was shared with other prisoners on the wing. He appeared to settle in well and was well liked by both staff and prisoners. However, his time on E wing was not without problems, and his continued difficulties with his 'tics' meant that he was regularly moved back to healthcare for periods of assessment and to make changes to his medication.

During the weekend of 11 July 2009, staff became concerned that the man's appeared to be drowsy and was spending a lot of time in his cell. They contacted healthcare, and a nurse went to the wing, spoke with him, and arranged for him to be seen by the doctor. In turn, the doctor arranged for blood samples to be taken and agreed to review him again in two days.

The following day, the Senior Officer on E wing contacted healthcare again as staff continued to be concerned about him. After consultation with the doctor, he was admitted to healthcare for observation. On admission, he was assessed by a locum

doctor and denied taking any illicit drugs when asked. As his symptoms indicated that he might have ingested drugs that had not been prescribed, the doctor arranged for a urine test which subsequently found that he had Subutex in his system. (Subutex is the trade name of the drug buprenorphine. It is an opioid drug similar to heroin. It is prescribed to treat those suffering from addiction to opiates such as heroin.)

Although the man initially denied having taken anything illicit, he eventually admitted that he had taken Subutex two days earlier but could not be sure how much. As a precaution, all of his other medication was temporarily suspended. In addition, his temperature and pulse were checked hourly (the frequency was subsequently reduced).

At 6.44pm in July 2009, a nurse carried out a routine observation on the man and recorded that he was verbally unresponsive when prompted by staff. Around 25 minutes later, when she returned to check him again, she saw him lying on the floor. She immediately called to her colleagues for assistance, went into the cell and attempted to gain a response from him. No pulse or breathing could be detected and staff attempted CPR until the arrival of paramedics called by the prison's control room. With the assistance of nursing staff, the paramedics continued to attempt to revive him but, sadly, at 7.45pm they declared him dead.

There were initial concerns that the Subutex in his system had in some way contributed to his death. However, post mortem results concluded that he died as a result of a cerebral abscess.

This investigation found that HMP Manchester has procedures in place for the issuing of controlled medication such as Subutex. However, despite the security measures, illicit drugs are still finding their way into the prison. The investigation has also found that both medical and discipline staff acted well in ensuring that the man's complex mental health issues were dealt with sensitively.

THE INVESTIGATION PROCESS

1. HMP Manchester provided the man's prison and medical records for examination. Notices were issued to staff and prisoners to advise them of the investigation process and to give them the opportunity to speak with the investigator. No responses were received.
2. My investigator visited Manchester on 22 July and met with staff including the Head of Healthcare. He visited the residential unit where the man had lived and spoke with staff who had known him. He also visited the healthcare centre.
3. My investigator wrote to HM Coroner to inform him of the nature and scope of the investigation and to request a copy of the post mortem and toxicology reports.
4. A clinical reviewer was appointed by the local PCT to conduct the clinical review on their behalf. Given the man's history of mental illness, she sought the assistance of a psychiatrist who has experience of working with patients in a prison environment.
5. One of my family liaison officers (FLOs) telephoned the man's partner on 13 August. They discussed the investigation and her initial concerns. His partner said that she would welcome the opportunity to meet with the FLO and my investigator at a later date. In a further conversation on 25 August, they agreed to meet at her home on 9 September.
6. During the visit the man's partner talked about his mental health problems and how he had struggled to obtain the appropriate treatment in the community. She did not say anything critical about prison staff and recognised that they had done their best to help him. However, she was critical that there did not appear to be a psychologist based in the prison. The man had been in custody since 2005, but was eventually assessed by a psychologist just six months before he died. His partner asked whether a psychological assessment could have been made available earlier in his sentence. My investigator explained that the review of the man's medical care would look at the handling of his mental health needs. I hope that the report has helped the man's partner to understand better the circumstances of his death and provides some answers to the questions asked. She received and read the draft report, however, had not raised any specific comments in relation to the findings at the time of issuing the final version of my report.

HMP MANCHESTER

7. HMP Manchester is a local prison which takes people who are remanded into custody from courts in Greater Manchester. It has been part of the High Security Estate since 2003. The prison has nine wings with a mix of single and double cells.
8. Healthcare at the prison is commissioned by the local Primary Care Trust. The healthcare centre provides 24 hour nursing care and medical cover, and has beds for up to 20 patients.
9. Every prison in England and Wales has an Independent Monitoring Board (IMB). The members are volunteers who monitor the day-to-day life in their prison and ensure that proper standards of care and decency are maintained. The Manchester Independent Monitoring Board report for 2007-08 noted that a number of the beds in the healthcare centre were used for non-clinical use due to prison overcrowding. They also reported that at least half of the prisoners being monitored under the Assessment, Care in Custody and Teamwork procedure were located in healthcare.
10. Following the issue of the draft report, Manchester emphasised that since the publication of the IMB report, the number of beds on the healthcare has been reduced from 38 to 20 and patients are now admitted to the healthcare mainly on clinical need only.
11. HM Chief Inspector of Prisons published a report on Manchester in 2007. There has been a more recent inspection by her, the findings of which were published in December 2009. However, this report comments on the last report prior to the man's death. The inspection in 2007 found that a number of prisoners were inappropriately admitted to the healthcare centre, mirroring the concerns raised by the IMB. The Chief Inspector recommended that admission to the healthcare centre should be on the basis of clinical needs alone.
12. The man's death was one of 29 to have occurred at Manchester since April 2004 when I began investigating all deaths in prison custody in England and Wales. Ten of the previous 28 deaths were due to natural causes.

KEY FINDINGS

The man's reception at HMP Manchester

13. The man had spent several periods as an inpatient on psychiatric units since being diagnosed with Tourettes Syndrome and Obsessive Compulsive Disorder (OCD) as a teenager. While in the community, he struggled at times to take the medication prescribed to keep his condition under control. This often led to him committing offences that both his partner and his probation officer described as a "cry for help". The man's partner feels that he did not receive the appropriate care that he required while in the community.
14. In January 2005, he committed arson while he was again having trouble with his medication and was subsequently remanded into custody on the grounds of public safety. He arrived at HMP Manchester on 12 January. He was 38 years old at that time.
15. On his reception at Manchester, a health screen was completed. During the screen, the man said that he had previously been in custody and had been homeless in the last year. He said that he had not seen a doctor in the last few months but listed the medication that he was currently receiving. In addition to his mental health problems, he is recorded as saying that he suffered from asthma but had no concerns about his physical health. Other than his prescribed medication, he said that he did not use drugs and did not drink alcohol. The man's partner told my investigator and FLO that he would not drink alcohol as it reacted badly with his medication, and that he had never taken drugs other than those prescribed. He also told the nurse conducting the screen that he had been diagnosed as having Tourette's Syndrome and Obsessive Compulsive Disorder which had led to him spending time in psychiatric hospitals as well as receiving care in the community.
16. The nurse asked the man whether he had any history of self-harm and he replied that he had taken an overdose in 2002. However, he said that he did not have any current thoughts of self-harm or suicide. As a result of the information he gave and his previous history, the nurse referred him to the doctor and the mental health team, and he was admitted to the healthcare centre.
17. The following day, a doctor carried out a psychiatric assessment of the man. The doctor recorded that he was rational and coherent during the assessment and that he provided a very good insight into his previous mental health problems. The man told the doctor that he had been in prison in 2001/2002, and after this had spent time in a hostel, but he had not been employed. The doctor recorded that the man should continue with his current treatment and his community psychiatric nurse (CPN) in Blackpool should be contacted for further information.
18. During January, the man's CPN visited him in prison. The prison healthcare team also continued to try and obtain his previous psychiatric reports. As well as liaising with the CPN, the doctor contacted another doctor who had treated

him at a psychiatric hospital, to try to get him referred. In mid February, the second doctor's secretary advised the first doctor that the man would be considered for a bed placement once they received a referral.

19. The man's medical record indicates that his medication was kept under regular review and he was very aware of the medication that he felt worked for him and that which did not. A letter was sent to a third doctor at another psychiatric hospital to arrange for him to assess the man with a view to admitting him to the hospital. The prison continued to pursue this, and in May 2005 a nurse spoke to the man as there appeared to be some confusion whether he had been seen by the third doctor. After speaking with the man, the nurse recorded that two CPNs from the third doctor's clinic had seen him.
20. The man's 'tics' caused by his Tourettes Syndrome continued to be monitored. These were more severe at times and he would become very agitated and injure himself. When he was received into custody he had told nursing staff that he was HIV positive, but blood tests carried out in May indicated that this was not the case. On the healthcare unit he would attend education and associated with other patients, but at times when his 'tics' became difficult for him to control he would refuse to attend education or take part in the regime. Despite this, he was recorded as always remaining compliant and polite towards staff.
21. When he was feeling well, the man's reluctance to comply with his medication regime continued. Nursing staff spoke with him and explained the importance of adhering to the regime to maintain his mental well-being. As previously mentioned, he was very aware of the medication that he was prescribed and was vocal in telling the doctors what he felt worked for him and what did not. Throughout his time in custody, his medication was kept under regular review.
22. The third doctor reviewed the man on 27 June 2005 to provide an assessment report to the court on whether a hospital order could be made under the Mental Health Act. At his subsequent court hearing on 22 July, he was convicted of arson and an order was made under section 38 of the Mental Health Act for him to be admitted to a psychiatric hospital for a period of assessment prior to sentencing. Immediately after the court hearing, he returned to Manchester's healthcare wing until a bed became available at the hospital.
23. The man transferred to the psychiatric hospital on 16 August 2005 and remained there until 24 May 2006 when he returned to court for sentencing. He was sentenced to life imprisonment with a minimum term of one year and 231 days. The third doctor, who had been treating him at the hospital, provided a final report to the court. He indicated that the man's psychological needs were complex and unlikely to be met in the healthcare unit of a local prison. He added that, if the man transferred to a prison for those serving longer sentences, he might have the opportunity of engaging in a more constructive and stable therapeutic relationship with psychological services. The doctor confirmed to the court that arrangements had been made to

coordinate care planning initiatives with the Mental Health In Reach Team (MHIRT) at Manchester.

24. The team leader who had looked after the man at the psychiatric hospital also wrote a report for Manchester. She highlighted areas that the prison would need to be aware of in relation to how his 'tics' might affect his behaviour. She also mentioned issues that he had with taking his medication. She said that, on occasion, he would get ideas into his head that he wanted to change his medication. At these times, he had been known to hide his medicines. It is clear from her report that the man's partner had been involved in his care planning while he had been at the hospital.

The man's return to HMP Manchester, May 2006

25. Following his court appearance, the man returned to HMP Manchester. On arrival, a nurse assessed him and completed a health screen. The nurse again recorded all his previous medical history and noted that he appeared calm during the interview. Following the reception process and the health screening, he was again placed in the healthcare unit.
26. The day after he arrived back into custody, he was recorded as being up and down in mood and given reassurance by nursing staff. He was assessed later that day by a doctor who recorded that he had accepted his life sentence and there were no signs of him being at risk of self-harm.
27. During a review on 8 June, a doctor and the man discussed the possibility of him moving to a residential wing. He told the doctor that he would benefit from a change to a different medication, but the doctor advised to continue with his current regime. Following this consultation, a registered mental health nurse (RMN), who had known him for some time, arranged a meeting with the lifer officer to discuss how he could be best placed in the prison to meet the necessary targets in his sentence plan. (A lifer officer is an officer trained to deal with the specific needs of a life-sentenced prisoner. As part of their role, they speak with newly-sentenced prisoners, explain the life sentence process, and ensure that they are allocated to an appropriate prison to meet the requirements of their sentence plan.)
28. Sentence planning involves interviewing a newly sentenced prisoner and agreeing a plan which assesses their needs and risks and will assist in addressing offending behaviour. The sentence plan provides continuity during the entire sentence and is designed to reduce reoffending on release. The sentence plan is also used by the Parole Board in their decision making, providing information on a prisoner's progress.
29. The man settled in well to the regime on the healthcare unit and was recorded as being compliant. He also began to attend education. The Tourettes Society contacted healthcare staff, offered to provide the prison with fact sheets, and gave them a helpline number in case staff needed advice.

30. Regular meetings continued to take place to discuss the man's care, attended by staff from Guild Lodge to share advice on his treatment. Although he remained compliant with his medication regime, on a number of occasions he voiced concern that he felt it needed to be changed. In late July, his 'tics' began to get worse and this affected how he interacted with other prisoners. As a result, he chose to complete his education work in his cell. The escalation in his 'tics' was constantly monitored by both the nursing staff and MHIRT at Manchester, as well as practitioners who visited regularly from the psychiatric hospital.
31. During 2006, the man was recorded as having injured himself during "bad episodes" by banging his head on cell walls and punching himself. Because of this self-injury, he was placed on Assessment, Care in Custody and Teamwork (ACCT) monitoring in August 2006. Although he said that he was not suicidal, staff were concerned that his continued self-harm could lead to permanent injury. It was decided at a case review on 22 October to stop the monitoring.
32. The man remained in the healthcare centre during the first part of 2007 and continued to receive regular reviews of his treatment and support from staff. His medical record shows that during this period he attended education and the social discussion group held in the healthcare unit. He is said to have made a substantial contribution to the group in these sessions.
33. Staff tried to find a place in a residential wing for the man and he told them that he was looking forward to moving to E wing. On 3 May, the RMN recorded on his medical record that she had spoken with the doctor and the man was considered fit enough to move out of the healthcare unit. She wrote that she would need to liaise with the Senior Officer (SO) on E wing to arrange a place. She also recorded that when he moved to any wing the MHIRT would follow up to provide support. He remained in the healthcare unit until 8 June when he was moved to K wing, while he awaited a cell on E wing. When the RMN was told of his move, she emphasised to staff on K wing the importance of moving him to E wing quickly.
34. The man initially appeared to be settling well onto K wing. He attended education and mixed with other prisoners. The RMN recorded that she would contact his probation officer to discuss the next steps to refer him to other services.
35. On 26 June, the man was placed on ACCT monitoring again after he told staff that he had tried to hang himself with a pair of jeans. He said that he had not gone through with it because "it hurt". When staff asked him why he had taken this action he told them that he had been sexually assaulted by another prisoner. Staff asked him whether he wanted the police to investigate but he declined saying that he just wanted to return to the healthcare wing. Staff found no evidence to support his claims, no further action was taken, and the ACCT document was closed following the interview. No further concerns were raised by him in relation to this.

36. However, on 11 October the RMN was told by staff on E wing that the man had “smashed up his cell”. She went across to speak to him and discovered that he had actually smashed his radio. He told her that his ‘tics’ were becoming out of control and he was having compulsive thoughts. He said that he had been in contact with his partner. He denied any eating disorder problems, which were known to be trigger indicators for him becoming unwell. He told her that he had been compliant with his medication since arriving on the wing and that he had not had any altercations with either staff or prisoners. The RMN recorded that there appeared to have been a gradual deterioration in his mental state over the previous couple of weeks which had gone unnoticed. He agreed that he needed to be readmitted to the healthcare unit so he could be monitored for a short while.
37. Once the man returned to healthcare, his medication was reviewed and this appeared to reduce the severity of the ‘tics’ that he said had led him to smash his radio. It was recorded that he settled well and told staff that he was feeling all right and looking forward to returning to E wing. Towards the end of October, the RMN contacted his probation officer and staff at the psychiatric hospital to arrange a meeting to discuss his future care.
38. The man returned to E wing on 14 November. An entry in his wing history file made staff aware that his condition could make him say or do things involuntarily and that he should be monitored. He began to attend education again and took an active part. However, his ‘tics’ continued to be erratic and staff regularly updated healthcare staff on his condition and raised concerns.
39. In February 2008, the man refused the offer of a place at HMP Wymott, a category C prison. He explained that he would prefer to go to HMP Preston as he was familiar with it and it would be an easier journey for his partner.
40. The man was reluctant to return to healthcare for respite care. In June 2008, he told the RMN that he wanted to progress to another establishment where he would be able to complete courses. He felt that moving to healthcare would not benefit him in the long term. His ‘tics’ continued to get worse, and on 27 June staff on E wing asked an officer to speak with him as he was now having thoughts of hurting others. The officer and a nurse agreed that a couple of days in healthcare would be beneficial for him and would allow his medication to be reviewed. Staff on E wing kept his cell open so that he could be monitored easily while arrangements were made.
41. Later that day, the man was admitted to healthcare where he remained until 21 January 2009. A psychologist conducted a psychological assessment and in a letter dated 31 July 2008 said that the prison psychology team would be willing to arrange a further assessment. However, it was considered that this and other psychological treatment needs, including offence-related work, would not be effectively met while he remained in healthcare.
42. During his time in healthcare, he continued to struggle with controlling his ‘tics’ and injured himself on a number of occasions by punching himself and banging his head against walls and the floor of his cell. He became

particularly anxious in September 2008, and harmed himself when he found out there were plans to move him back to a residential wing. Staff provided a protective head guard which he wore at first, but then stopped using it as he thought it prevented him from feeling “relieved”. He was also placed on ACCT monitoring and spent time in a “safer cell” so that he could be monitored easily.

43. In October 2008, following an assessment by a doctor, it was decided that the man should be referred to the local hospital for a further examination of his eye that had become swollen as a result of his continued self-harm. However, he declined to go despite nursing staff advising him of the potential consequences for his health by not doing so. He signed a disclaimer to indicate that he had refused treatment.
44. Despite some earlier apprehension when the man returned to E wing in January 2009, he settled back into the regime quickly and began attending education on a daily basis where he received favourable reports. Staff and prisoners were fully aware of his condition and offered him support. He spoke to staff about how he was feeling, and would discuss with them any thoughts that he had about hurting himself. No further concerns about his ‘tics’ recorded.

The man’s progress with sentence plan

45. The man’s partner wrote to both the prison and her local Member of Parliament several times to highlight his condition and to enquire about his progress. He had been assessed early in his sentence as requiring psychological treatment to reduce his risk of re-offending. His partner asked whether he would receive the treatment that would enable him to progress with his sentence. She had been told by the prison that they did not have a psychologist.
46. The prison confirmed that the healthcare unit at Manchester does not have a dedicated psychologist as part of its team, although there are forensic psychologists who deliver offending behaviour courses in a different department. It is possible that, because the man’s need was seen as medical, a delay in a referral to the forensic psychology team occurred.
47. A parole review took place in April 2008 and again indicated that he would require psychology intervention if his level of risk was to be reduced. Following this a member of the forensic psychology team at Manchester was asked to work with the man. He is recorded as engaging well with her and, apart from a brief spell when he was having difficulties with his ‘tics’, he saw her regularly to complete one to one work. She completed her one to one work with him in April 2009 and a report on his progress was in the process of being written at the time of his death.
48. The man’s partner wrote to the prison asking for him to be moved to open conditions. The Governor responded and explained that, because he was a discretionary life sentence prisoner, the prison was unable to reduce his

security category any lower than C. He added that it would be for the Parole Board to make such a decision, and the next review was due to take place in April 2010.

49. The prison also made efforts, in consultation with the psychiatric hospital, to refer the man to a new Personality Disorder Unit. The Consultant Forensic Psychiatrist, who assisted the clinical reviewer, has outlined the steps taken. His report is attached as an annex.

Admission to healthcare in July 2009

50. Over the weekend of 11 July 2009, staff on E wing became concerned about the man as he appeared to be sleeping a lot during the day and had no energy. They reported this to healthcare staff and the doctor assessed him in his clinic on 13 July. He recorded that the man said he felt well mentally but was sleeping a lot. As he appeared drowsy and over-sedated, the doctor decreased his medication. He also asked for urgent blood samples to be taken and wrote that he would review him again in two days. The man's partner told the investigator that she had spoken to him on the telephone that weekend and was concerned that his speech appeared slurred.
51. A Senior Officer (SO) told the RMN on 14 July that staff were concerned about the man. She reassured the SO that the man was due to be seen again the following day by the doctor. She then relayed the staff concerns to the doctor and the decision was made for him to be admitted to the healthcare unit.
52. A locum general practitioner assessed the man and observed that he was tired, lethargic and not himself, but did not complain of any pain or breathing problems. He recorded the possibility that the man had either taken a drug on the wing or had been spiked with a drug, and asked for a urine test to be carried out.
53. The results of the urine test showed a positive reading for Subutex. (Subutex is the trade name of the drug buprenorphine. It is an opioid drug, prescribed to treat opiate addiction. At Manchester, all those prescribed Subutex are required to take their dose in sight of a nurse to prevent it being stored and used inappropriately.) When the results of the man's test came back, a nurse recorded that he was to have hourly observations, including blood pressure and temperature. If these remained within the normal range for four hours, they could be reduced to two-hourly. The nurse also noted that, if he remained physically well, the observations should be continued throughout the night at four-hourly intervals. Staff monitored him over the next couple of days. In view of the Subutex in his system, a decision was taken to temporarily withdraw his other medication, and he indicated that he understood this.
54. A doctor spoke to the man on the morning of 16 July. He initially denied taking Subutex but then admitted that he had taken some two days earlier but could not say how much. The doctor recorded that he appeared alert with a normal respiratory rate, and he was due to restart his normal medication the

following day. He also asked for observations on the man to be continued every two hours during the afternoon. Following an observation later that afternoon, his blood pressure was noted to be high but not excessively so.

55. A nurse recorded that, while carrying out the man's observations at 6.44pm, she asked him to respond to her verbally and he just smiled and nodded his head. She added that he continued to appear verbally unresponsive when prompted by staff. At 7.10pm, she went to check on him again and saw him lying on the floor of his cell. She immediately alerted an officer and a second nurse who were also on the healthcare landing. Together, they entered the cell.
56. The first nurse attempted to gain a verbal response from the man, before checking his pulse and breathing without success. She then ran to collect the emergency response bag from the treatment room. A call had also been made via the radio for further medical assistance and a third nurse went to the cell. The first nurse began cardio pulmonary resuscitation (CPR) while the third nurse assessed the man's airway. They attached a defibrillator to his chest. (A defibrillator is a machine that can restart the heart in some cases of cardiac arrest by giving an electric shock.) Staff continued to perform CPR rotating with one another to ensure that efforts were maintained. The defibrillator remained attached to the man and advised that no shockable rhythm had been detected. Paramedics arrived at 7.23pm and continued to work with nursing staff in the resuscitation attempts. Unfortunately, he remained unresponsive and at approximately 7.45pm paramedic staff pronounced him dead.

Actions following the man's death

57. HMP Manchester arranged for the man's partner to be notified of his death. The staff at the prison knew his partner, and that she had health concerns of her own, and were concerned that if the news was received late at night she might not have anyone to support her. As a result, the decision was taken to visit her the following morning. The RMN, who had been involved in the man's care and had known both him and his partner for some time, was asked to attend when the news was broken so that she could offer support to the partner.
58. At the prison, staff involved in attempting to resuscitate the man had a debrief and a record made to identify any immediate concerns with procedures. Prisoners on E wing were saddened by his death and they organised a collection. The monies raised were passed to the man's partner. She was very moved by the gesture and told my FLO that she intended to use the money to have a bench in memory of him placed in her local park.

ISSUES

Awareness of the man's condition

59. The prison consulted the Tourette's Society to gain more information on the condition and its symptoms. They were also open to advice offered by the man's partner and ensured that this was shared with staff on the residential wing. The information provided was laminated and displayed on the wing so that both staff and prisoners would know what to be aware of.

I commend the prison for its actions in ensuring that a complex mental health problem was dealt with sensitively, and that all staff and prisoners were made aware of how the man's condition could affect his daily life.

Use of Subutex

60. The man's partner told the investigator that he had always been adamant that he would not take any illicit or non-prescribed medication, as he felt that it would react badly with his prescribed medicine. For the same reasons, he did not drink alcohol when he lived in the community. The results of his routine drug tests in prison had all been negative. It is difficult therefore to understand why he would suddenly choose to take Subutex.
61. My investigator was told that Manchester issues Subutex under strict guidelines and prisoners are required to take it in sight of nursing staff. This process reduces the risk of Subutex being traded and taken illicitly. However, the prison acknowledged that some prisoners would still attempt to obtain Subutex and, although systems are in place to prevent this and other drugs entering the prison, inevitably some will get through.
62. The man clearly knew what he was taking as he later admitted to healthcare staff, but how he came by the Subutex and why he took it remains unknown. It is possible that he thought the Subutex would relieve his symptoms. There is no evidence to suggest that he took Subutex after having developed a drug habit.

Admission to healthcare in July 2009

63. When wing staff noticed changes in him, they quickly drew their concerns to the attention of healthcare staff who, in turn, followed them up. He was monitored closely by both wing and nursing staff and, following assessment by a doctor, was admitted to healthcare. A locum doctor who later examined him suspected he had used or been given illicit drugs, and tests taken after his admission subsequently revealed him to have taken Subutex.
64. The post mortem gives the cause of the man's death as a cerebral abscess. The symptoms for such a condition include those that he displayed: lethargy and speech difficulties. The doctors and healthcare staff would have had no reason to suspect this to have been the case and I judge that the course of action they followed was appropriate. A number of things can cause a

cerebral abscess. One cause is infection following head trauma, and this is significant in his case given that he would often hit his head on walls when experiencing a bad 'tic'.

Clinical reviewer's findings

65. The psychiatrist assisting the clinical reviewer concludes that the treatment the man received in relation to his mental health was appropriate to meet his needs. Equally, the clinical reviewer indicates that the medical care he received in custody, particularly following his admission to healthcare in July, was appropriate and delivered to a good standard.
66. The psychiatrist makes two recommendations in his report relating to the psychiatric hospital. The first relates to the referral criteria for patients and the second to the timescales for referrals and decisions to be made. These matters are outside my remit, but I support them and commend them to the local mental health trust.

Conclusion

67. The man had clearly struggled for many years with very complex mental health problems, and he was said to have committed offences as a way of highlighting his need for help and support. He had a supportive relationship and, at the time of his most recent offence, appeared to have found some stability in his life.
68. It was apparent to my investigator that he was well known and well liked those who had contact with him at Manchester, and that his death had touched many people. Although his mental health problems are well documented, his physical health was not considered poor. Although the cause of death has been given as a cerebral abscess, there is no indication as to how this might have occurred. However, trauma to the head, such as that which he would inflict on himself, can reportedly be a contributing factor.
69. The investigation has found that the level of medical care the man received in terms of both his mental and physical needs was appropriate. In addition, the way in which staff and prisoners dealt with his condition with understanding and sensitivity should be commended.

GOOD PRACTICE

I commend the prison for its actions in ensuring that a complex mental health problem was dealt with sensitively, and that all staff and prisoners were made aware of how the man's condition could affect his daily life.

After receiving the draft report Manchester responded by saying the Governor would publish notices to staff and prisoners formally acknowledging the efforts made in ensuring that the man's mental health problems were dealt with sensitively.