

**Investigation into the circumstances surrounding the
death of a man, a prisoner at HMP Manchester, at North
Manchester General Hospital on 16 July 2007**

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

February 2009

This is a report into the circumstances surrounding the death of a man. He died at North Manchester General Hospital on 16 July 2007, having been admitted there following a fall in his cell at HMP Manchester. The cause of his death was a ruptured spleen thought to be due to injuries that he had sustained some days prior to his arrival in prison. The police gathered evidence against two individuals believed to be involved in the assault leading to those injuries and submitted a case to the Crown Prosecution Service (CPS) for charges of murder to be considered. The CPS's consideration of these matters took several months to conclude, and it is for this reason that the issue of my report has been delayed for longer than I would have wished. I apologise for any additional distress caused to the man's family as a consequence.

I extend my condolences to the man's family and friends. I understand his mother and sister were present at his bedside when he passed away.

The investigation was carried out by one of my colleagues. A clinical review, for which I am most grateful, was undertaken by an officer of the Manchester Primary Care Trust (PCT). I included the clinical review as an annex to the draft report and I urge the PCT to consider its findings and recommendations as well as those I have made myself.

In this final version of my report, I have included as a new annex, the comments received from the man's family. I have sent a separate response to many of the questions raised by them, but feel it important to include this as a reflection on how families receive our reports and the importance we attach to their views.

I am indebted to the Governor of HMP Manchester for his and his staff's support throughout this investigation. I would especially like to single out the service and support given by the Principal Officer responsible for the Safer Custody Unit at Manchester. He ensured full and unfettered access was given to my investigator and the clinical reviewer for their enquiries.

I make one recommendation in this report and highlight one example of good practice. The clinical review makes four further recommendations and offers one commendation of good practice.

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SUMMARY

The man died on 16 July 2007 in North Manchester General Hospital having been admitted there from HMP Manchester with what was thought to be at the time a head injury. It was subsequently discovered that the man had actually suffered a ruptured spleen prior to his arrival at Manchester prison on 11 July. This injury had gone undetected during his time in custody and appears to have led to his collapse in his cell on the evening of 15 July, which resulted in him banging his head.

When nursing staff attended his cell they thought the man had suffered a head injury and immediately called for an ambulance. Paramedics arrived and took him to hospital, again believing he had suffered a head injury. It only became apparent after his arrival at hospital that the man's injuries and condition were not the result of his fall and banging his head, but that he actually had internal bleeding. Sadly this was recognised too late to treat the man and he died at 12.15am on 16 July.

The man had been involved in a fight on Wednesday 4 July in the community where he lived. It is believed that he was assaulted by two men, and received blows to his stomach, groin and ribs. He attended hospital with an ambulance crew on this date, but did not stay to receive treatment. These matters have been the subject of an intensive investigation by Greater Manchester Police. The Crown Prosecution Service has brought no charges.

On 9 July, the man was arrested by police on charges of criminal damage (matters that had occurred some time before these other events) and was kept in police custody until appearing at the Magistrates Court on 11 July. He was convicted and sentenced to seven days imprisonment. He was also remanded in custody on further charges of wounding with intent and possession of cannabis. He was sent to HMP Manchester.

He arrived at Manchester and went through the usual initial health screening process, but failed to mention the events of 4 July in any detail. He was concerned and treated mainly for an alcohol related addiction. He was located on the detoxification unit in the prison and received medication for his alcohol withdrawal.

During the afternoon of 15 July, the man began to feel unwell and was therefore seen by two different nurses. Both nurses thought that the man's presentation was typical of someone withdrawing from alcohol whose symptoms were not quite under control. They advised that he should be seen the following day by a doctor with a view to reviewing his medication. Later that evening, the man felt worse and started vomiting. It was at this time that he fell from his top bunk and banged his head, which resulted in him being taken to hospital by ambulance.

The post mortem revealed that the man had a ruptured spleen and fractured ribs from injuries sustained some ten to 20 days before he died.

THE INVESTIGATION PROCESS

1. One of my investigators visited HMP Manchester on 30 July 2007. He was given access to the man's prison records and shown around the prison, including I wing where the man was resident before his death. Notices of my investigation for staff and prisoners were already on display around the prison. My investigator was introduced to members of the local branch of the Prison Officers' Association and the Independent Monitoring Board (IMB). He spent time talking with the chaplain, who had acted as the family liaison officer and had visited the man's family after he had passed away.
2. Manchester Primary Care Trust (PCT) was asked to undertake a clinical review of the care the man received while in custody. An officer of the Manchester Primary Care Trust carried out this review on their behalf. She was asked to look at the entries in the man's clinical record, including those on Egton Medical Information Services (EMIS – an electronic medical record system). The clinical reviewer was also requested to judge whether the care the man received while at Manchester was appropriate and of equal standard to what he might have expected had he been at liberty.
3. One of my Family Liaison Officers contacted the man's mother as his listed next of kin. This gave her the opportunity to discuss the purpose of the investigation and to raise any questions or concerns she would like explored and addressed. The man's mother was concerned there had been a considerable delay in the man receiving medical assistance when he collapsed in his cell. I hope this report helps the man's family better understand the events leading up to his death.
4. This report differs from many I issue in that events prior to the man arriving into custody are included in some detail. The source of much of this information is statements obtained by the police, much of it from the man's family. It is relevant to the circumstances surrounding the man's death and I therefore felt it important to include this material in my report.
5. My investigator interviewed 13 members of staff in the course of his investigation, many of them jointly with the clinical reviewer. One nurse who saw the man on the day he collapsed could not be interviewed because he had resigned before my investigator was able to interview him. I do not believe this was in any way connected to events surrounding the man's death. No prisoners came forward as a result of my notices to staff and prisoners, although I have used the statement taken by police from the man's cell mate on the day he was taken to hospital.

HMP MANCHESTER

6. HMP Manchester is a local prison which accepts people remanded into custody from the courts in the Greater Manchester area. The prison first opened in June 1868. Following a major disturbance in 1990, it has been comprehensively refurbished.
7. Accommodation consists of a mix of single and double cells within two Victorian radial blocks (Wings A, B, C, D, E and G, H, I, K). Treatment for drug and alcohol dependency takes place on H and I Wings.
8. At the time of this investigation, healthcare at HMP Manchester was provided under contract by Manchester Primary Care Trust. The healthcare centre has a capacity for 39 beds. Many of these places were taken by prisoners suffering from mental illness. The prison's Independent Monitoring Board has identified that the prison has difficulty in obtaining suitable secure mental health hospital placements for those who require them.
9. A full unannounced visit by HM Chief Inspector of Prisons in 2004 highlighted a deficiency in the provision of GP cover. At the time, medical cover was supplied by one full-time doctor and a permanent locum who provided two sessions per week. This was deemed insufficient given the size of the establishment and a recommendation was made that the number of GPs should be increased.
10. In a short unannounced follow-up visit (in May 2007), the Chief Inspector noted an improvement in GP staffing levels. There were one full-time and two salaried GPs each undertaking a day's work in the prison, with other sessions covered by locums. However, this was still deemed to be insufficient for the establishment, and the recommendation was repeated.
11. There have been eight deaths from natural causes of prisoners at HMP Manchester since I was given responsibility for investigating all deaths in prison custody in 2004. There are echoes of concern in two earlier issued reports regarding patients not collecting their medication from deaths that occurred in November 2007 and July 2008. However, the man's case is unlike any of the other deaths I have reported on to date at Manchester.

KEY EVENTS

12. The man had been living at his parents' address since March 2007 when the break up of his relationship occurred. He was involved in two incidents prior to his arrest on 11 July 2007.
13. The man received treatment at North Manchester General Hospital on 22 June 2007 for a cut to his toe which occurred while cutting his toenail. It was documented by the triage nurse at the hospital that the toe had been bleeding since the night before, although it was not bleeding when he was seen in the triage room (at 6.42am).
14. The man was seen by a medical doctor, the Senior House Officer on duty, who noted that he was jaundiced and bruised. Blood tests were taken and showed significant abnormalities relating to alcoholic liver disease, but it was felt there was no indication for admission.
15. On Wednesday 4 July, the man was involved in a disturbance outside a public house in North Manchester. It was believed by police that the man had been assaulted by two men. CCTV footage showed one of the men getting out of a car leading to a scuffle during which the man was seen falling backwards.
16. The incident was attended by both the police and the ambulance service. An Ambulance Technician said in her statement to police that this was the third time that she had seen the man since June 2007. On each occasion, the man was taken to hospital to receive additional treatment.
17. On this occasion (4 July), the man's injury was a laceration wound to the back of his left hand near to the knuckle which in the Ambulance Technician's opinion required stitches. The Ambulance Technician said that the man "appeared totally unconcerned about his injury. Again, he was clearly drunk and smelt strongly of intoxicants."
18. The Ambulance Technician provided immediate triage treatment for the wound, applying a fresh wound pad and bandage from the ambulance. The Ambulance Technician said that at this point the man told her he was going to return to the pub, but the police officer at the scene persuaded him to attend hospital.
19. On the way to the hospital, the man told the Ambulance Technician that his assailant had hit him with a police-style extendible baton, and that this had caused his injury. On arrival at North Manchester General Hospital Accident and Emergency Room, the man did not wait to be seen, but instead walked to the nurses bay. The Ambulance Technician found a security guard to accompany her and they arrived at the nurses station to find the first Sister dressing the man's hand.
20. North Manchester General Hospital documents say that subsequently the man was called by the triage nurse at 10.23pm and again at 10.30pm, but there was no response. The note adds that the man was aggressive and rude

to nursing staff and was discharged. Nobody realised the extent of the man's injuries at the time, but the post mortem report suggests the man may well have sustained severe injuries to his ribs and spleen in the fight at the public house. The post mortem reports reads, "His bones showed no features to suggest that they were weakened and so the force required to fracture these bones and displace their ends was considerable. The nature of the injury could be explained on the basis of blow/s or kick/s to the ribs."

21. According to the man's mother, while the man was absent from home the police arrived with a man who alleged that the man had assaulted him. She was not clear when the alleged assault occurred.
22. The man returned home at around 11.00am the following day. He told his mother about the events that had occurred after he left the hospital. The man said he had returned to the public house where he had been assaulted to try and get a drink. He had been refused. He said he remained at the pub and had spoken to a man there. The man's mother told him that the police had been looking for him and asking where he had been. The man replied that she would know where he had been, which she took to mean he had been to the cemetery to speak to his relatives who were buried there.
23. Regarding the alleged assault on the man who the police had brought to his mother's house, the man claimed that the man had followed him home and had been "touching his bum". He had "cracked him one" as a result. The man told his mother he had run from the scene because he thought the police would arrest him for assaulting the man.
24. The man also described details of the assault he had suffered at the public house, saying he had been hit around "his stomach, groin and ribs area". He did not display these injuries to his mother.
25. On Saturday morning (7 July 2007), the man received a visit from police officers about his failure to attend court in relation to alleged damage at his former partner's house. The man's mother said he told the police officers that he could not attend because he had been in hospital receiving treatment for his injured arm. She said that the man was not required to accompany the officers because the psoriasis on his legs was weeping. The man went out all day and returned at some time during the evening. He was home when his mother returned that night.
26. The man again went out during Sunday evening (8 July), returning at around 2.00am on the morning of 9 July. Later that morning, the man's mother saw him on a nearby street. The man said that he was going to Sainsbury's to get a bottle of red wine. Later the same day, the man telephoned his mother to inform her that he had been arrested and was at Pendleton Police Station.
27. The man had been arrested for his failure to attend court on a charge of criminal damage. He remained in custody until he attended Manchester City Magistrates Court on 11 July, when he was convicted of criminal damage and sentenced to seven days imprisonment. He was also remanded in custody to

appear before Manchester Crown Court on charges of wounding with intent and possessing cannabis on 8 June. Following his appearance at the Magistrates Court, the man was moved to HMP Manchester where he was to serve his sentence and remain in custody until he could appear before the Crown Court.

Reception at HMP Manchester

28. On his arrival at HMP Manchester, the man was taken to Reception for an initial Health Screening. This was undertaken by the first nurse, a Registered General Nurse who had 14 years experience in the National Health Service (NHS) and the Prison Service and was employed by the healthcare provider at HMP Manchester.
29. The first nurse described the man as “quite chatty, no communication problems, did not appear unduly low in mood”. In response to her question regarding whether he was under hospital treatment, the man told the first nurse that he was receiving treatment for alcoholism and depression at North Manchester General Hospital (NMGH), and had received prescriptions for Sertraline (an anti-depressant) and Zopiclone (a sleeping pill).
30. The man told the first nurse that he had recently been treated for internal bleeding and cirrhosis of the liver at Bury, and for a blood clotting problem at NMGH. The man also said he had a physiotherapy appointment later in the month at Wythenshawe Hospital. The first nurse recorded that the man had a cut on his right hand as a result of a blow from a baton.
31. According to the first nurse, the man was fit to be located on a normal prison wing. She told my investigator that, if while searching the man the reception staff had seen any injuries which they thought needed treatment, she would have expected to have been notified.
32. On completing the initial assessment, the first nurse referred the man to see the doctor in connection with alcohol use and detoxification. The man was then seen by the first doctor, a locum doctor at HMP Manchester. It was the first doctor’s first day on duty at the prison. He was accompanied by the first nurse. The first doctor said of the man, “He was very pleasant. Other than highlighting his arm problem, he seemed quite comfortable. He did not seem in pain or agony.”
33. The first doctor said that the man had asked when the dressing on his arm was to be changed. On examination of the injury, the first doctor prescribed some antibiotics to treat an infection.
34. The first doctor spoke to the man about his alcohol consumption, which the man admitted was excessive. On assessment, the man scored ‘4’ on the withdrawal assessment, which indicated that he should receive Thiamine, a course of Vitamin B, and Chlordiazepoxide during his detoxification.

35. The first doctor could not recall whether the man was particularly jaundiced, but told my investigator that, since he did not note it, he thought it would not have been particularly pronounced and so did not require immediate action. He described seeing the man as similar to a surgery visit to the doctor, where the doctor deals with the complaint which is presented by the patient (in this case the man's alcohol use and detoxification).
36. The first doctor was clear that the man did not mention pain or injury anywhere other than the existing condition of his hand. He described a wound with cellulitis, caused by an infection, for which he prescribed an antibiotic. The first doctor said that the man did not appear to be in pain on standing up or sitting down.
37. The first doctor expected that the man would receive a secondary examination as part of the normal prisoner induction regime.
38. The man undertook his First Night Assessment and Induction, which indicated no concerns, apart from those relating to his medical conditions. He was considered suitable for cell sharing according to the Cell Sharing Risk Assessment.
39. The man made his first night telephone call, which he used to contact his mother and let her know that he had been sentenced to seven days imprisonment. He said he was okay, doing his detox and had met some friends from his home area. He was assigned to a shared cell (1-10) in I Unit which, along with H Unit, forms the Drug Treatment Unit at HMP Manchester. The cell was shared with the first prisoner, who had been in residence since 29 June.

12 – 14 July

40. The following morning (12 July) the man attended a Secondary Health Screening appointment with the second nurse. The second nurse is a Registered General Nurse who qualified in 1991 and has worked for the Prison Service for a total of 14 years. She helped to develop and run the Detoxification Unit over the last six years and is now a Senior Substance Misuse Worker.
41. The second nurse said that the man had not been identified for any other reason than a routine screening. She had clear recollections of the man, describing his appearance as unkempt, with a dressing on his left hand. Her first impression was that he appeared to be withdrawing from alcohol. The screening took approximately six minutes, during which time the man did not appear to be distressed and did not mention either the fight or having any pain or discomfort.
42. The second nurse weighed the man in his clothes so she did not see his torso or whether there was any bruising. On being questioned about this, she explained that this was standard practice. If required, another room

downstairs was available for examinations as the one they were using was not considered sufficiently private to provide for prisoners' dignity.

43. The man's pulse was measured (a standard check for someone undergoing alcohol detoxification), but his blood pressure was not measured. The second nurse noted on the computerised medical record system (EMIS) that the man had a history of depression and was under the care of the third doctor at North Manchester General Hospital. On completion of the screening process, the man left the room.
44. The second nurse did not know where the man went immediately afterwards. She next saw the man at lunchtime when he collected his medication, which he took under supervision before returning to his cell. He had not taken his morning medication. Prisoners in the Detox Unit are expected to participate in their own care. They are required to make decisions regarding their condition, how they are feeling while undertaking the detoxification, and whether they need their medication. Therefore, the man's failure to take his morning medication was not remarked upon.
45. The man also saw the first officer at the Counselling, Assessment, Referral, Advice, Throughcare (CARATs) team, who carried out an initial assessment and completed the Drugs Intervention Record. The first officer recorded the relevant information on the appropriate paperwork and told the man that he would be referred to Addaction (an alcohol and drugs treatment service in the community) for further help with his alcohol problem after his release. The first officer understood at the time that the man's release date was to be 13 July.
46. On the afternoon of 12 July, the man was escorted to the Health Centre to receive a Hepatitis B vaccination as part of the Secondary Screening process. This was to be carried out by the third nurse.
47. When the third nurse was interviewed she had only a limited recollection of the man. She recalled administering the vaccination and asking whether the man was leaving the prison the following day, because she saw the information on EMIS. From this point, she felt the man was not listening as he was preoccupied with his thoughts. The third nurse explained to him that he would require booster injections in a week and two weeks, and a final booster in 12 months.
48. The third nurse then spoke to the man about the dressing on his hand. He told her someone had hit him with a machete. On examination, she judged the injury to be old. The injured hand was puffy and both hands were dirty. The third nurse dressed the injury on the man's finger as well as a cut on his head, and recorded this on EMIS. The two injuries appeared to be of the same age, and she believed that they might have occurred at the same time. The third nurse planned to have the finger injury reviewed in four days time, in accordance with the type of dressing used.

49. Much of the man's time at Manchester between 12 and 15 July went unremarked by staff. He was variously described as being "compliant with staff," "alert and co-operative," and "responsive and giving appropriate answers," but otherwise his behaviour did not bring him to the attention of staff.
50. Other than the one occasion when he did not take his morning medication on 12 July, the man attended the wing treatment room to receive the Chlordiazepoxide prescribed for his detox regime on each occasion up to and including the evening dose on 15 July.
51. Only one occasion stood out for a member of staff. The first senior officer was part of the supervision team assisting at the treatment hatch on the morning of Saturday 14 July. In interview, the first senior officer remembered the man on this occasion, as she "had a bit of a laugh with him because he tried to walk forward without having his checks, having his security checks that they have, so we were all having a laugh and a joke about him being a bit eager."
52. The first senior officer described the man as "quite an amiable chap", although "quite disoriented and quite unsteady, as you would expect a heavy alcohol detox to be".

15 July

53. The second officer was working as the cleaning officer on early shift for I wing. In interview, he recalled speaking with the man when he unlocked him to get his morning medication from the treatment room. The second officer described the man as appearing well in himself.
54. While waiting to collect his medication, the man asked the second officer if he could take the sandwich pack that had been left on a table outside his cell. The second officer told the man that it was a diabetic pack left over from the previous night. The man said that was fine as he only wanted the oranges in the pack. The second officer agreed that the man could take the pack, which he did. The man then went to get his medication from the nurse and returned to his cell.
55. The second officer saw the man again at lunchtime when he came to the servery to collect his meal. He then left the servery and returned to his cell. According to a third officer, who was also on duty in the servery area, the man seemed okay and had no complaints.
56. During the afternoon, the wing had a security lockdown, so that the dedicated search team could undertake its work. According to his cell mate, the man had been fine during the morning. After lunch, while the man was writing a letter, he began to feel unwell. The cell mate said that the man, "complained about pains in his stomach and his heart, he said he was having a cardiac arrest".

57. The cell mate rang the cell bell to alert officers to the man's condition. The cell mate said that he had to ring the bell three times before it was answered by the second senior officer. On the day, the second senior officer was working on I wing, although his normal duties were on H1 wing as the officer with responsibility to facilitate reintegration of prisoners from H wing into the main population.
58. When the second senior officer opened the cell door, the cell mate told him that the man was suffering pains. The second senior officer entered the cell and asked the man what was wrong. The man replied that he had pains in his abdomen and somewhere else. The second senior officer said that the man looked uncomfortable so he radioed for assistance. He was told that the duty nurse, known by the codename Hotel 1, was dealing with another incident on A wing.
59. The second senior officer therefore left the cell and went to the treatment room at the end of the wing, looking for a member of the nursing staff. The fourth nurse was in the treatment room, preparing to distribute the evening treatments. The fourth nurse had qualified as a Registered General Nurse in 2000, with subsequent training as a Registered Mental Health Nurse, so was dual qualified. The fourth nurse started at HMP Manchester on 8 May 2007.
60. In interview, the fourth nurse said that the time she was called by the second senior officer was around 3.30pm, as the treatments needed to be ready for 4.00pm. The second senior officer told the fourth nurse that the man was complaining of abdominal pain. She believes that he also said the man was complaining of blurred vision. The fourth nurse secured the medication she was preparing and accompanied the second senior officer to the man's cell.
61. On arrival, the fourth nurse saw the man sitting on a chair in the cell. The second senior officer remained outside the cell. She introduced herself to the man who told her that he had got stomach cramps. She noted that the man was "very, very jaundiced" but did not consider this to be unusual as he was an alcoholic on the detox wing.
62. The man told the fourth nurse that he had central stomach cramps which had started around half an hour before and were not letting up. He was unsure whether the pain was also in his chest. The fourth nurse said that if the man had chest pains, she would need to get a blood pressure machine to take his blood pressure and determine whether he had a cardiac problem.
63. The fourth nurse went back to the treatment room to fetch the equipment to take the man's blood pressure. The man's cell mate was removed from the cell by the second senior officer so that the fourth nurse could examine the man.
64. On her return, the fourth nurse took the man's blood pressure. This was recorded as being 110 over 80, with a pulse of 88. The fourth nurse confirmed that this would be considered within the normal range and was not

indicative that something serious was going on. She told the man that the readings meant the problem was not related to his heart.

65. The man then lay on the bottom bunk and the fourth nurse asked to look at his abdomen. The man pulled up his t-shirt and she noted that there was a large diffuse bruise, approximately 2½ inches by 2½ inches round, on the left side of the man's abdomen. She asked how the man had been bruised but his response was dismissive. He told her it was nothing, that he had knocked himself and that the pain was not coming from there.
66. Because the man was dismissive of the bruise, the fourth nurse did not think it was serious. The fourth nurse considered the bruise to be relatively recent, in line with the man's assertion that he had knocked himself. The man also told the fourth nurse that his stomach pains had eased since he had moved to a new position, lying on the bed. The fourth nurse conducted a physical examination of the man's abdomen by touch, but could not identify any particular location for the pain he had experienced. In her experience, a person in pain would not have been expected to lie flat with his legs stretched out as the man was.
67. The fourth nurse was satisfied that the pain did not indicate a cardiac problem and happy that it was eased by the man's move to a new position. She told him that if the pain started to increase, or if he felt worse, he should let one of the wing officers know so that they could contact her or phone Hotel 1.
68. When she left, the man was still lying flat on the bed. He had not mentioned feeling nauseous or sick. In interview, the fourth nurse thought that overall her examination of the man had taken around ten minutes to carry out. The fourth nurse then returned to the treatment room to continue preparing for distribution of the evening medications.
69. The person carrying Hotel 1 was Registered General Nurse, the fifth nurse. He telephoned the fourth nurse to discuss what had happened in response to the emergency call he had received earlier. She told him that the man had complained of difficulty breathing, generalised pains and poor vision. She reported that the man's observations were within normal limits and his symptoms were most likely a result of detoxifying from alcohol.
70. Around 3.40pm, the man vomited and again the cell mate rang the cell bell. The third officer responded and decided to "call healthcare to get a nurse, or see if our nurse was still there. But then a nurse actually walked on." The fifth nurse had received a call from I wing to see the man, and had gone down to the wing. The fifth nurse and the third officer unlocked the cell and went in. The third officer took the man's cell mate out of the cell to give the man and the fifth nurse some privacy.
71. The man complained to the fifth nurse that he felt generally unwell and had vomited on the floor. The fifth nurse inspected the vomit and found it consisted solely of undigested food. The man further complained that his

Chlordiazepoxide detox was reducing, and he felt that he was suffering from the effects of his alcohol withdrawal.

72. The fifth nurse remarked on the man's jaundiced appearance, noting that his eyes were also yellow. The man told him that he had chronic cirrhosis of the liver, which the fifth nurse confirmed later by seeing entries on EMIS.
73. As there was no doctor in the prison at the time, the fifth nurse suggested that the man should see the detox doctor in the morning to discuss his medication needs. The fifth nurse advised the man that he should drink only clear fluids until the nausea had passed, and that he should attend treatments (at the treatment room) to obtain his detox dose and something to settle his stomach. This advice was heard by the third officer.
74. The fifth nurse judged that the man was unwell, but not excessively so. He discussed his findings with the fourth nurse and then returned to Healthcare where he made an entry on EMIS that included both his and the fourth nurses' assessments.
75. The fourth nurse began to distribute detox medication at 4.15pm. The fourth officer was present at the treatment hatch to ensure that the prisoners took their medication correctly. The second senior officer and the third officer unlocked prisoners on the list and sent them for their treatments.
76. The man was the only man who did not go for his treatment. The fourth officer went to the man's cell (I1-10) and asked why he was not going for his medication. The man told him that he did not want it. The fourth officer went to the treatment room and relayed this to the fourth nurse.
77. The fourth nurse said that she would give the man an anti-sickness tablet. The fourth officer returned to the man's cell and told him this, to which the man said "Ok Boss". The man went to the treatment hatch, where he received the anti-sickness tablet and his medication. As he walked back to his cell, the man said to the fourth officer, "It's the fucking food in here, I've got food poisoning." The fourth officer replied that no-one else had complained. The man then returned to his cell.
78. The man's cell mate helped the man into his bunk, then went for tea. The fourth officer remembered that the man's cell mate collected a meal for the man who had not attended. When he returned to the cell the man's cell mate saw that the man was still in bed. The man asked him to get his tablets. The man's cell mate also gave the man some milk to take the tablets with. All the cells were then locked for the night. The man's cell mate said the man tried to sleep, but kept waking up with pains in his heart and stomach.
79. At around 8.00pm, the man got out of his upper bunk bed. As he lowered himself to the floor, he collapsed and hit his head either on the floor or door. The man's cell mate rang the cell bell to call for an officer. At approximately 8.10pm, the fifth officer, the night patrol officer on I wing, arrived in response to the call. He had been in the wing office preparing paperwork for the

following day. The man's cell mate told the fifth officer that the man had fallen from the top bunk and "smashed his head on the cell floor". The fifth officer told the man's cell mate to turn the man onto his side so that he did not swallow his tongue. The fifth officer then called on his radio for Hotel 1 (the duty nurse) to attend.

80. Night staff from H wing, G wing and K wing attended, as well as the Orderly Officer, Assistant Orderly Officer and the sixth nurse (Hotel 1) who all arrived together. The man's cell mate was moved to Cell I2-8.
81. An officer told the sixth nurse that the man had fallen out of bed. The sixth nurse said that he was "mumbling rather than anything, not particularly saying anything coherent". The sixth nurse saw that there was a bump on the back of the man's head.
82. The sixth nurse noted that the man was holding his right side and complaining of pain. On examination, the sixth nurse could find no bruising or distension which she could attribute to the fall. However, given the man's general condition, she asked the officer to call an ambulance straight away. The time was 8.18pm.
83. The sixth nurse recorded the following on EMIS: "On arrival, the man was lying prone on the cell floor in amongst a large amount of vomit. The man checked for any injuries immediately. Large contusion to back of head, small cut apparent, no obstruction to breathing so put into recovery position and airways maintained. Initially the man not responding to external stimulus but after a few minutes although disoriented answered appropriately to questions. The man visibly pale and clammy to touch sweating ++ BP 121/54 Pulse 91 regular Temp 35.6 Respiratory rate 12. Remains slightly disoriented also c/o of pains in lower abdomen, stomach tender when touched. Ambulance requested for Hospital assessment."
84. While waiting for the ambulance to arrive, the sixth judged that the man's condition did not significantly change. She recalled that the ambulance did not take long to arrive. In the meantime, she put the man into the recovery position.
85. The most senior officer on duty, the first Principal Officer (codenamed Oscar 1), had to arrange for escort officers to be notified to accompany the man. A call went out on the radio for sixth officer on B wing to contact Oscar 1. When he telephoned, she told him that he was to escort a prisoner to hospital.
86. On the ambulance's arrival at the wing at 8.31pm, the sixth nurse briefed the ambulance staff on her initial observations of the man. She said that she would be calling North Manchester General Hospital Accident and Emergency room (NMGH A&E) and giving a full history to the sister. The sixth nurse accompanied the man to the ambulance, and then went to Healthcare to get the information from EMIS to pass to the hospital.

87. A second officer, the seventh officer, was selected to accompany the man. She collected some handcuffs and was cuffed to the man. The ambulance left the prison at 9.03pm.
88. The journey from HMP Manchester to NMGH A&E took only five to ten minutes. The sixth officer remembers that during the journey the man said he needed to go to the toilet on a number of occasions. The sixth officer told the man that he would have to wait until they got to the hospital.
89. The sixth officer said that the man was having trouble concentrating and answering questions such as his name and date of birth, and the ambulance crew were having problems understanding him. The sixth officer thought that this was due to the man being in pain, although the only thing that the man was communicating was his need to use the toilet.
90. When they arrived at A&E, they were met at the entrance by a sister who immediately received the handover from the paramedics. The sixth officer heard that this was the man's 37th admission, so he concluded that the man was well known to the hospital staff.
91. The man and the prison officers were allocated to room 8. On arrival at room 8, the sixth officer spoke to the sister, saying that the man really needed the toilet. She apparently replied, "Well, can't he walk?" The sixth officer said he did not think that the man could, but the sister said, "Well, you'll have to wait, we're busy." The sixth officer said, "Fine, fair enough, but sooner rather than later."
92. At this point, the sixth officer sat down to complete some paperwork. The seventh officer was cuffed to the man, who continued to complain that he needed to go to the toilet. Having waited for 20 minutes, the sixth officer went to the nurses station and asked the sister for a bedpan, but she said he would have to wait as the staff were busy. The sixth and seventh officers both received the impression that the sister was unhappy with the situation. The seventh said that when they first went in, "It was like they did not really want us to be there, they were busy and you know ... it was busy. And it was not just the man, we got the same feeling of they don't want us there either." A bedpan was provided ten minutes later.
93. At around 9.55pm, the sister and a nurse came to help the man make use of the bedpan, as he was having difficulty and was in pain. At the same time, the nursing staff took the man's first set of observations (his pulse and blood pressure). There were some difficulties with the cuffs as the nursing staff removed the man's clothing. They then carried out their first set of observations. At that point, the sister realised that there was something wrong with the man's blood pressure.
94. The sister briefly left the room, then came back and moved the man immediately to the Resuscitation Room. No explanation was given to the sixth and seventh officers. On arrival in the Resuscitation Room, a doctor was in attendance.

95. The doctor immediately requested that the cuffs be removed. This was done and an escorting chain was put onto the man instead. (An escorting chain is a long chain with a handcuff at both ends. The officer is attached to the prisoner via this chain to enable the use of a toilet or to allow medical examinations when a prisoner is in hospital.) The seventh officer remained the staff member in charge of the chain. She sat in the corner of the Resuscitation cubicle, in order to give as much space as possible to the medical staff.
96. Medical staff had difficulty inserting intravenous lines into the man (in order to give him blood, medication and other fluids). A call was sent out to get a more senior doctor to attend. On his arrival, the senior doctor asked for a portable X-ray machine. He also requested that the escorting chain be removed, which was done.
97. Having performed two X-rays and looked at the results, a member of the medical staff approached the sixth officer (he does not remember who). They asked whether the prison had contacted the man's relatives. The sixth officer replied that the prison had not. He remembers the medical staff member saying that the man's condition was not looking good.
98. Accordingly, at 10.35pm, the sixth officer telephoned the prison and reported that they needed to contact the man's relatives. He believed that the prison only had the number of the man's girlfriend, who was not answering. The sixth officer was given the number of the man's mother by the hospital, who had already tried it and had left a message. The sixth officer also tried, but got no reply. He did not leave a message, as he thought it inappropriate.
99. During this time, the seventh officer observed that the man's behaviour had changed from being responsive and compliant to uninterested and quiet. The sixth officer noted that the medical interventions did not appear to be successful, although this was not said by any of them. He got the impression that the medical staff did not think there was much more that they could do for the man.
100. In response to the answerphone message, the man's mother and sister arrived at the hospital at approximately 12.10am. The seventh officer remembers a request from the man's mother that no attempt be made to resuscitate him. The man's mother spoke to the man. He opened his eyes, said "Ah, mama" and then closed them. The man died at 12.15am on 16 July 2007.

ISSUES

The man's reception into Manchester

101. From the records and from interviews with staff, it is clear that the man arrived at the prison with little information accompanying him from police custody. However, the man was cooperative and able to give a good account of his medical and personal history to staff at the prison.
102. The first nurse undertook the initial health screening process. She gained information about his previous history relating to his drinking and his earlier depression. The man also volunteered information about his liver disease, blood clotting problems and the recent injury to his hand. He did not disclose at this time that he had been involved in a fight that had resulted in him receiving blows to his abdomen. It is not normal procedure for patients to undress and receive a physical examination unless there is an indication from the patient that this might be necessary.
103. The initial screening process as undertaken by the first nurse was judged by the clinical reviewer as "relevant and as comprehensive as the time and process of reception screening allows". The first nurse also identified from this initial screening that the man should be seen by the doctor on duty that evening. This was primarily in order to start the man on a detoxification process for his alcohol withdrawal.
104. In accordance with policies and procedures in place at Manchester, the man was to be offered detoxification for his alcohol use by the prescription of Chlordiazepoxide on a reducing dose basis. When the first doctor saw the man, he prescribed this course of treatment, and the first nurse (who was present during the man's consultation with the first doctor) administered the first dose. This also was in line with Manchester's policy and procedure for people who suffer from alcohol withdrawal.
105. The first doctor interviewed and assessed the man for both his alcohol detoxification and the injury to his hand. He recognised that the man had cellulitis as a result of his injury. The clinical review describes cellulitis as a "common condition that occurs as a result of an infection of the skin or the underlying tissue. It often begins in an area of broken skin, like a cut, scratch or injury where bacteria invade and spread. The condition causes pain, swelling, warmth and redness." The treatment is by antibiotics, which the first doctor prescribed.
106. The man also enquired about having his dressing changed, and it was during these initial reception health screening processes that the first nurse applied a fresh, dry dressing to the man's wound. This was expected to be a temporary measure until the following day when the man would be seen again for a secondary health screen. The man was then located on I wing (the detox wing).

107. The clinical review notes that the entries in the medical record and on EMIS were undertaken fully and correctly. There is a housekeeping point contained within the clinical review regarding the viability of the written 'Medical in Confidence' documentation which is a matter for the Primary Care Trust to consider.
108. The first doctor was new to prison health work when he first saw the man, although he was an experienced doctor in the community. I note that he was accompanied by an experienced prison nurse during his early consultations with patients. I consider this to be good practice.
109. The man was seen the following day (12 July 2007) in the secondary health screening clinic by the second nurse. This was part of the routine initial reception procedures for Manchester. At this clinic, the man confirmed much of the earlier information gleaned the night before, including that he had received treatment in a mental health unit. The second nurse does not recall gathering much information regarding this matter, although she believes it to have been alcohol related. Nevertheless, the second nurse referred the man to the Dual Diagnosis Nurse specialist for follow up.
110. The man did not volunteer any information about being in a fight recently, nor did he complain or seem in pain or distress, save for what might be expected relating to his alcohol withdrawal. According to the clinical reviewer, entries on EMIS were comprehensive and complete in respect of the secondary health screening process.
111. From prescription records, it appears that the man did not go to the treatment room for his medication on the morning of 12 July. In interview, the second nurse was asked if she was aware of this. She told the clinical reviewer that she was not aware, but that it was not unusual for patients to decide for themselves not to take their medication. It was part of the model of care on H and I wings that patients should be partially responsible for their own care, and they are expected to participate in the medication they receive. Although the clinical reviewer believes that the man must have made an informed choice on this matter, she makes a general recommendation that I would endorse.

The prison healthcare manager should put in place a system that identifies prisoners who do not attend for medication when first located on the detox unit. The system should include a process that satisfies staff on the unit that it is patient choice that has led to them not attending.

112. The dual diagnosis specialist nurse recognises that EMIS contained a referral for her to see the man, but it is clear from her records that she had not seen him before his death. There was a mistaken belief amongst some staff that the man was perhaps to be released from prison on 13 July. The dual diagnosis specialist nurse speculated in interview that she might have had prior patient commitments on 13 July and, because it was a possibility that the man was to be released that day, she might have put off seeing him. The

clinical reviewer is of the opinion that this referral failure is not critical to the man's ongoing care. However, as a housekeeping point, I would suggest the healthcare manager satisfies herself that, had the man remained in prison, the system would have triggered an appointment with the Dual Diagnosis Nurse.

113. On the afternoon of 12 July, the man was seen by the third nurse who gave him a Hepatitis B vaccination and changed the dressing on his hand. Apart from the fact that he became preoccupied when the third nurse asked if he was leaving the prison the following day, she recalls nothing that gave her cause for concern about the man's presentation. She does recall talking to him about the injuries to his hand as the man disclosed they had occurred when someone had hit him with a machete. She judged the injuries to be quite old as the injured hand was quite "puffy". She also remembers giving the man health advice regarding the follow up for his Hepatitis vaccination.
114. The man was kept in the healthcare centre for a period of time (up to perhaps an hour) under supervision, as part of the Patient Group Directive (PGD) for vaccinations. This procedure is to protect patients against adverse reactions from vaccinations, such as anaphylaxis (the man did not suffer any adverse reaction). However, it would also have given him an opportunity to consult with nursing staff, should he have had any medical concerns.

Events of 15 July

115. The clinical review describes in detail the events surrounding the first call for nursing interventions on 15 July. The clinical reviewer concludes that the fourth nurse had no clinical indication of the seriousness of the man's condition when she first saw him at approximately 3.30pm. The clinical reviewer suggests that the fourth nurse's conclusion that the man was suffering the effects of withdrawing from alcohol, and should see the doctor the following day, was reasonable given the man's presentation.
116. The fourth nurse did observe the bruising to the man's abdomen. When she asked him about it, the man brushed aside concern about it by explaining that he had "knocked himself". It does not appear that the fourth nurse was aware that the man had a blood clotting problem, nor is it suggested by the clinical reviewer that the fourth nurse should have responded in any different way.
117. After the fourth nurse's attendance to the man, he was seen by the fifth nurse who was the emergency response nurse on duty at the time. He apparently came to the same conclusion as the fourth nurse (i.e. that the man was suffering the effects of withdrawing from alcohol). Neither my investigator nor the clinical reviewer was able to interview the fifth nurse due to his resignation. However, I am content that the fifth nurse could have added little extra to my enquiries. After the fifth nurse saw the man, the man was seen again by the fourth nurse when he came for his medication. The fourth nurse remembers that the man still looked unwell, but that he did not complain of feeling any worse at this time.

118. At approximately 8.15pm, the sixth nurse was called as Hotel One to a medical emergency on I wing. When she arrived, she was told that the man had fallen backwards from his bed and had hit his head. On examining the man, the sixth nurse found that he was incoherent, sweaty, had a bump to the back of the head, and had vomited – all classic signs of a head injury. The sixth nurse made the assessment that the man needed to go to hospital.
119. There was no delay in summoning an ambulance, and an ambulance arrived at the man's wing at 8.37pm. The sixth nurse gave a handover of facts about the man to the paramedics and the ambulance left the prison at 9.03pm. The sixth nurse followed this up with a telephone call to the hospital to expect the man with his head injury. The clinical reviewer concluded that the sixth nurse acted appropriately in her belief that the man was suffering from a head injury.
120. The clinical reviewer does comment on the fact that, even though the man complained of a pain in his right side, the sixth nurse did not remove the man's clothing to undertake a physical examination. The sixth nurse checked the man by feeling his limbs through his clothing to ensure he had no broken bones. The clinical reviewer reports in her clinical review, "... it should be reaffirmed that she was dealing with an implied fall and consequent head injury with their ... clinical priorities". The clinical reviewer goes on to say that the sixth nurse carried out her duties appropriately.
121. It is clear from their evidence that, when the escorting prison staff arrived at the hospital with the man, they felt they were not welcome there. They also sensed that the man was someone whom the hospital staff knew only too well. They thought that the nursing staff were not very helpful to either the prison staff or to the man, especially over the matter of the man needing to go to the toilet.
122. It seems that the man was not a man who complained readily about feeling unwell. He was someone who 'just got on' with pain and discomfort. This unfortunately contributed to healthcare staff at the prison being unaware he had an underlying injury from before he arrived in prison. Staff were not to know of the significance of this in the man's final collapse and subsequent treatment at North Manchester General Hospital A&E department.
123. Notifying the next of kin proved difficult, but again not because of a lack of effort on the part of those involved. The man's mother was able to get to the hospital before he died, even though that was only a short time before. My investigator has found no evidence to suggest that the family were not treated with respect and dignity after the man's death. It appears that full and proper procedures were also followed by the establishment in respect of staff care.
124. The post mortem report goes into detail regarding the events on 4 July when the man received injuries in a fight. The police asked for a specialist examination of the fractured ribs that the man had received (presumably in the fight on 4 July). A Professor of Osteoarticular Pathology at the University of Manchester School of Medicine was asked for a view on the age of the

fractures. He concluded, "I would age the fracture at about 2 weeks and certainly no less than 10 days and no more than 20 days old."

125. The pathologist comments in his post mortem report that the man suffered from an enlarged spleen because of cirrhosis of his liver. He makes the point that the spleen is in close proximity to the two ribs that were fractured (the man's 9th and 10th ribs), and because of the enlargement of his spleen it was more susceptible to "traumatic rupture" (injury from a blow). He goes on to say that the man would be "more prone to severe bleeding than the general population" because of his abnormal blood clotting condition due to his liver failure.
126. The pathologist explains in his report that, "although death from splenic rupture usually occurs within hours or a day or so of the injury," there can be circumstances where people can suffer a delayed rupture. He would, however, have expected some signs of healing if the damage to the man's spleen had occurred at the same time as the injuries to his ribs. He therefore concludes that it is more likely that the man's spleen was injured more recently than 4 July; "This raises the possibility that though his ribs were fractured in the assault on 4 July, his spleen was ruptured after that date."
127. Although the pathologist would have expected to see some evidence of healing, he is aware of the possibility that the healing process might be altered in people who have a severe illness such as cirrhosis of the liver.
128. Neither my investigator nor the police have found any evidence to suggest that the man was involved in any further trauma once he arrived in prison. The post mortem report indicates that the only external signs of any injuries to the man's body were consistent with the Professor of Osteoarticular Pathology's estimate of between ten and twenty days old and would fit with the fight of 4 July. I am unable to say with certainty when the injury to the man's spleen occurred, but am of the view that it happened prior to the man entering prison. It is likely that the Coroner's inquest will wish to explore these matters further.

RECOMMENDATIONS

The Prison Service have accepted the following recommendation and planned to have a protocol in place for non attendance of detox patients by the end of December 2008:

The prison healthcare manager should put in place a system that identifies prisoners who do not attend for medication when first located on the detox unit. The system should include a process that satisfies staff on the unit that it is patient choice that has led to them not attending.

GOOD PRACTICE

The first doctor was a new member of prison healthcare staff when he saw the man. During his early days of medical practice at the prison, he was accompanied by an experienced nurse in his consultations with patients. This was good practice.