Circumstances surrounding the death of a man in hospital in January 2006 while a prisoner at HMP Manchester

Report by the Prisons and Probation Ombudsman for England and Wales

June 2007

This is the report of an investigation into the circumstances of the death of a man who died in hospital on 30 January 2006. At the time of his death, the man was on remand at HMP Manchester. He was 84 and died from apparently natural causes.

My colleagues and I would like to extend our sincere condolences to the man's family and friends for their loss.

One of my investigators conducted the investigation. I would like to thank the clinical reviewer for her assistance and for carrying out the clinical review on behalf of North Manchester Primary Care Trust.

I am also grateful to the Governor of Manchester, and his staff for their co-operation with my investigator. The liaison officer ensured that all necessary documentation was made available.

I endorse the recommendations made by the clinical reviewer. The man spent nearly five months as an inpatient in the prison's Healthcare Centre. Although his needs must have been apparent at reception, they were not fully identified and during the rest of his imprisonment nursing care plans were not always complete or appropriate. As a result, his deteriorating health and increased dependency did not receive the necessary attention. This was aggravated more than once when he was discharged from hospital without proper planning by the hospital authorities. However, I acknowledge that the man was located in the healthcare centre for increased supervision and care.

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Prisons and Probation Ombudsman **June 2007**

CONTENTS

Summary

Investigation Methodology

HMP Manchester

Key Findings

Issues

Recommendations

SUMMARY

The man died on 30 January 2006, while in hospital. He was aged 84 and in the custody of HMP Manchester at the time. The man had been remanded into custody on 1 September 2005, charged with sexual offences against a woman.

The man was a frail and elderly with mobility problems. On reception into prison, he was admitted straight to the Healthcare Centre where he remained other than when he went into hospital. He became increasingly dependent on staff to assist him with day to day needs. He used crutches, had breathing difficulties and required medication as well as help with his personal care.

The man had a number of falls while at the prison which resulted in minor injuries. He then had a fall which required hospital treatment and two operations for a fractured collarbone. He died having developed pneumonia after an operation.

INVESTIGATION METHODOLOGY

1. My investigator was given access to all the man's prison records including his medical records, and was given copies of everything that was required. My investigator did not interview any staff or prisoners.

2. Notices to staff and prisoners were sent to the liaison officer appointed by HMP Manchester, to be displayed around the prison. These announced the investigation and invited staff and prisoners to submit to my investigator any concerns or views they wished to express.

3. North Manchester Primary Care Trust (PCT) was invited to undertake a review of the clinical care the man received while in custody and in North Manchester Hospital. Her review can be found in full as an annex to this report. The clinical reviewer interviewed many of the healthcare staff involved with the man's care.

4. One of my family liaison officers contacted the man's son and she and my investigator met him at his home. The man raised a number of concerns:

- how did his father fall?
- was there any indication that he might have been pushed or shoved?
- how quickly and appropriately did the prison respond following the fall?
- whether his father should have been provided with more support, such as a zimmer frame.

5. This final version of my report reflects extensive comments received from the Prison Service on earlier drafts. This has revealed discrepancies in some accounts of events that the Coroner may wish to explore at inquest.

HMP MANCHESTER

6. HMP Manchester first opened in 1868. It is a core local prison (that is, it can take category A prisoners), which accepts people remanded into custody from the courts in the Greater Manchester area. The accommodation is on two Victorian radial blocks, with a mix of single and double cells all of which have power points and integral sanitation.

7. The Healthcare Centre's inpatient unit is a 38 bed purpose built facility for prisoners with either physical or mental health needs. The Centre contains a gated cell which is located directly opposite the office. It has a normal cell door with an observation panel and a full-length gate covered with perspex. Either the door or the gate can be locked in place.

8. The inpatient unit is staffed by a combination of healthcare and discipline staff, all of whom are employed by the prison under the commissioning arrangements with the local Primary Care Trust (PCT). (At the time of the man's death, this was North Manchester PCT.) There is a joint handover meeting at the beginning of each shift, followed by a discussion by healthcare staff of confidential medical matters. Each patient should have a nursing care plan which identifies their needs, identifies the objectives of the nursing care, and details how it will be provided.

9. During the night, the prison is in patrol state with fewer staff on duty. One officer and two nurses are on duty during the night and are located in the Healthcare Centre. The nurses are also responsible for a range of routine administrative tasks for the following day's clinics. These are undertaken in the ground floor offices of the Healthcare Centre and may result in them being away from the cell area. (The cell area remains supervised by the officer at all times.) The nurses remain available for emergencies and nursing duties and patient care are not compromised. In the event of any clinical emergencies in other parts of the prison, the nurses will attend to support their colleagues in administering emergency aid.

10. Should access be required to cells during the night, the healthcare staff contact the prison control room to contact the Night Orderly Officer. The Night Orderly Officer will then attend the Healthcare Centre and unlock the cell door so that treatment can be given. (The Night Orderly Officer is the senior member of discipline staff on duty and is in charge of the prison throughout the night period.) However, in the event of a life threatening situation, staff should not wait for other staff to attend and should gain immediate access to begin the necessary treatment.

KEY FINDINGS

11. The man was remanded into custody on 1 September 2005. He attended court on a regular basis until 13 December 2005.

12. When the man arrived at HMP Manchester, he was the subject of the standard health screening process conducted by a reception nurse. The nurse was working in reception as part of her induction programme, having been at the prison for the previous three weeks. The clinical reviewer interviewed her, and she remembered the man because of his physical frailty. She described him as a doddery man who needed assistance from staff. The man told her that he had medication for a heart and breathing condition, but she said that he was not breathless during her interview with him. In accordance with the usual procedure, the reception nurse referred the man to the doctor on duty in reception. However, the clinical reviewer could find no evidence of this actually happening.

13. The reception nurse discussed the man's condition with her colleague, a second nurse. The second nurse had gone to the transport to see the man, but did not conduct the screening himself. Although he normally checks a screening document himself, he had no recollection of doing so on this occasion. A decision was made to admit the man to the prison's Healthcare Centre. There he was assessed by a healthcare nurse and she completed a care plan for the first 24 hours of his imprisonment.

14. The next day (2 September) at approximately 2.30pm, the man was found sitting on the floor of his cell by a third nurse who said his breathing was rapid and that he felt dizzy. The third nurse told the full time doctor at the prison. The prison doctor found that the man had no visible injuries, and he was not concerned about his condition at that time. The prison doctor told the clinical reviewer that he recalled assessing the man but thought that this was because he was a new prisoner, rather than because he had fallen.

15. On 6 September, the man was reported to have collapsed during a court appearance at Manchester Crown Court. He was taken to hospital where he remained until 10 September when he returned to the prison. Whilst he was in hospital, the healthcare staff made efforts to obtain information about the man's clinical needs from his community GP. However, his discharge back to prison took place without any warning or planning by the local hospital.

16. The prison doctor saw the man again on 13 September. He was mobile and the doctor confirmed the continued prescription of oral iron for the next three months.

17. Between 11 and 15 September, the man appears to have settled well with no new concerns. The clinical reviewer commented that there was no proper assessment of his needs, and a new care plan was not prepared at that time.

18. On 15 September, the man was seen by the lead nurse for general nursing. She prepared a care plan the following day. This identified the need for

nurses to assist the man to bathe and dress, to supervise him whilst he took his medication, and to remain with him at meal times to ensure that he ate his food. The lead nurse recalled that the man had changed cell and landing more than once, and the gated cell had been used at times. (However, this was to improve the levels of support they could provide him and enable staff to better observe the man.) The lead nurse described the man as cantankerous and said that his mobility had noticeably deteriorated after his admission to hospital.

19. On 30 September, the man was removed from the gated cell because there was no plug socket for his nebuliser. A fourth nurse said she was concerned that the man would become disorientated if his location were to change too many times. The fourth nurse attempted to assess whether the man was at risk of developing pressure sores, and eventually located the correct documentation for carrying out the assessment.

20. The man was seen by the prison doctor on 27 September. He was seen again on 4 October as he had been coughing for 24 hours. He was prescribed antibiotics and steroids (Prednisolone).

21. An agency nurse who had worked at the prison for more than a year. She reassessed the man on 9 October. She said that he was frail and she thought that his cell was unsuitable. She discussed her concerns with other nursing staff.

22. The man saw a GP on 12 October. The GP is employed by the prison as a part time GP. He followed up the prison doctor's consultation, judging that the man was not confused and that he was mobile but doddery. The GP said that he was not concerned about the man at that time. His medication was changed and the alterations recorded on the prescription chart.

23. The man had a court appearance on 14 October. When he returned, he said that he had not had his medication in court and was feeling the effects. He had a bath and a shave, then was settled back into his cell. It was at that point he complained of having a pain in his groin. After a triage assessment by the nurse on duty, the man was told he would see the doctor during his routine weekly round on Tuesday. The presenting symptoms were not considered to be life threatening.

24. The prison doctor saw the man on 18 October regarding the pain in his groin, the man was still coughing and the doctor reassured him that no further action was required.

25. On 25 October, the man slid to the floor while getting out of his bed. No injuries were seen and he raised himself unaided. The next day he was assessed by a physiotherapist who adjusted his walking sticks and referred him to the optician as he said he could not see.

26. There are a number of entries in the nursing records between 28 October and 10 November indicating the man's continuing frailty, incontinence, slow

mobility and need for continued assistance. No attempt was made formally to assess his needs in a care plan which could be followed by all staff. Throughout November, the man became increasingly difficult. He was incontinent of faeces, did not manage his nebuliser and refused his medication. On one occasion, he was reported as angry and aggressive and threw his food at the prisoners who work as cleaners.

27. The man was seen by the prison doctor on 15 November because he had developed a rash. He was prescribed Oilatum for his bath and liquid soft white paraffin. The man was more settled and communicative in the latter weeks of the month. His mood was stable although he occasionally said he was unwell. His mobility at this time was considered poor, and three members of staff were required to bathe him.

28. A locum doctor saw the man on 26 November as he had complained of feeling rough. He recalled that the man walked slowly and was co-operative. The man told him that he felt tired all the time, and was not eating or sleeping. The locum doctor arranged blood tests and conducted an examination but could see no signs of injury or any particular illness. The man was weighed.

29. During November, the nursing notes indicate that the man's health continued to deteriorate, although it was a relatively settled period for him. He was reported as interacting with others and his mood appeared stable.

30. During the night of 27 November, the man was seen on the floor of his cell. The nurses gained access to the cell and placed the man back in bed. They put another mattress on the floor beside the bed to provide some protection should he fall again. He was noted to have a small cut to his arm.

31. The following night, the man was seen again on the cell floor at 8.20pm. Two nurses went into the cell and lifted him back onto his bed. There were no apparent injuries but the man's breathing was deteriorating. The second nurse assessed and observed him. After a short period, a swelling and superficial bruise began to develop on the right side of the man's head. The second nurse also noticed a swelling developing on his collarbone. At interview with the clinical reviewer, the second nurse said that he contacted the GP, apprised him of the situation and requested further advice. The GP decided that the man could reasonably be left overnight and seen the next morning. (In a letter of 27 April 2007, the Prison Service said: "The second nurse did not contact him but appraised the situation and stated that the man could be left for further advice and reviewed the following morning by the prison doctor.")

32. The next morning (28 November), the prison doctor saw the man as soon as he came on duty and confirmed that he had apparently fractured his right collarbone. The prison doctor arranged for a priority (999) ambulance to take the man to the Accident and Emergency Department of the local hospital. The man was sent back to prison the same day without any discharge notes or instructions for how he should be cared for.

33. Between 28 and 30 November, the man's condition continued to deteriorate, his mood was low and three nurses reported him saying that he wanted to die. They observed him closely, but did not consider placing him on the prison's suicide and self harm monitoring arrangements. The man was closely monitored as he was disorientated and unable to stand unaided. He also required full assistance with his personal care, including dealing with his incontinence.

34. On 1 December, one of the nurses telephoned the hospital and was told that the man was scheduled for surgery the following day. There is nothing in the prison records to indicate when the man was admitted, but he was discharged on 3 December again without a discharge letter or instructions for his post operative care. A fifth nurse telephoned the ward and was told that the man's operation had been for a plate and fixation of the right clavicle. There were no specific instructions other than routine observations. The fifth nurse was also told that he would need physiotherapy but she did not know when.

35. The man was located back in the gated cell so that better observations could be carried out. The fifth nurse arranged access with the night orderly officer. The fifth nurse told the clinical reviewer that, in her view, the cell and bed were unsuitable for the man and that staff removed as many obstacles as possible. There is no care plan for the man's nursing care, but the nursing notes for 3 and 4 December record that he was confused and disorientated. He was cared for by staff and needed encouragement to eat and drink. He was unsteady on his feet, but slowly mobilising. The pressure points on his body were at risk of breaking down and pressure sores were developing.

36. The Head of Healthcare was aware of the deteriorating situation and tried to arrange open access to his cell to enable the nurses to attend to the man's needs whenever it was required. She completed the relevant application, known as the Authority to unlock a Prisoner Out of Hours, which she passed to the Security Department. She also made the Governor aware of the position.

37. The lead nurse also attempted to improve the man's situation by arranging a Community Care Assessment by the Social Services Department with a view to a nursing home placement being arranged. In her interview with the clinical reviewer, the lead nurse said: "The man had been visited and the feedback at the time of the visit was he was not suitable." The Prison Service subsequently told me that: "the lead nurse obtained a verbal report from the Care Assistant which said that he [the man] was not suitable for a nursing home."

38. The prison doctor saw the man on 6 December and warned that there was a risk of a chest infection developing. The next day, the man saw the doctor again as he was having difficulty breathing. The prison doctor did not record any particular concern, and recommended that the man should be encouraged to move about and to expectorate.

39. On 8 December, the man reported that he had fallen and had a small cut on his lip. He fell again the next day and was found on his cell floor. He said that the mattress had slid off the bed, and he had no injuries on this occasion. The man fell again on 9 December at 3.30am, and had a further four falls on 10 December during which he sustained a small cut on his left arm. He was seen twice by the duty doctor on 11 and 12 December, and again moved to the gated cell.

40. The prison doctor was asked to see the man on 14 December as he had been complaining of being in pain since his fall four days earlier. When the doctor examined the man, he discovered that he had a dislocated elbow and arranged for him to return to hospital.

41. Between 14 December 2005 and the day of his death, the man remained a patient at hospital. On 16 December, he was taken to the operating theatre for an operation. He returned to the ward at 1.20pm. While in hospital, the man received visits from his solicitor and regular visits from a friend (a community care worker who is believed by the man's son to be his partner). The nursing staff in the prison kept in contact with the hospital so that they were aware of the man's progress and could plan for his discharge.

42. The man underwent a second operation to repair his injured shoulder on 13 January 2006. He remained in hospital and his treatment continued. On 30 January at 4.38am, a prison officer, who was on duty at the hospital, telephoned the night orderly officer to tell him that the man's condition had worsened.

43. At 4.45am, the prison officer again telephoned the night orderly officer to inform him that the man had died. The night orderly officer immediately instigated the prison's arrangements for dealing with a death in custody. At 4.53am, the duty governor was informed and he instructed the officers at the hospital to return to the prison after they were no longer required. They returned at 5.15am, and were given a full de-brief by the duty governor and offered support from the staff care team.

44. The man had had no contact with his family while he was in prison, or when he was taken into hospital. His family was traced by the police some weeks later when they were notified of his death.

45. The post mortem report concluded that the man died as a result of pneumonia following treatment and hospitalisation for a fractured clavicle.

ISSUES

Clinical care

46. A clinical review was carried out of the care the man received whilst he was at Manchester prison. During the course of the review, she interviewed various members of the healthcare team involved in the man's care.

47. The clinical reviewer notes that the staff at Manchester have made considerable progress in the care of prisoners, and there was clear evidence that all disciplines of staff are both caring and eager to learn. However, she acknowledges that, despite the commitment and caring culture, there is work to be done to equip the nurses and associated staff to deliver care to NHS standards.

48. The man was elderly with a range of health needs and a degree of frailty when he was received into custody. He was treated within the guidelines for newly received prisoners. However, the reception screening nurse was inexperienced and working in reception as part of her induction programme. This resulted in an only moderately well completed reception screening document. The reception nurse discussed the man with the senior nurse in reception and correctly decided to refer him to the doctor. However, there is no documentary evidence that this in fact happened.

49. If a clinical task is delegated by a registered nurse to an inexperienced member of the healthcare team or a non-registered practitioner with appropriate competencies to carry out the task, the registered nurse must be satisfied that the task has been carried out adequately.

    The prison should introduce a system which ensures that all reception health screenings are checked and countersigned by an experienced registered nurse.

50. Following the man's admission to healthcare, a Risk Assessment and Risk Management Plan was completed and dated but not signed. Furthermore, the information gathered does not appear to have been transferred to the Nursing Care Plan. The clinical reviewer suggests that the healthcare admission process was not as robust as it could be and that there was no evidence of either a nursing model or process being used. This resulted in no comprehensive assessment of the man's needs being undertaken. As his needs were not fully identified, an effective care plan for his management was not put in place.

51. The clinical review observes that the staff who came into contact with the man continued to care and be concerned for him. Whenever he complained of any medical need, he was quickly seen by a doctor. However, throughout his period at the prison there was no proper assessment of his needs, and care plans were not adequately prepared. It is clear that the man was very dependent on the staff who were caring for him and expressing concerns about his situation. However, they did not all have expertise in the care of frail

elderly patients, and the reviewer considers that the assessment of his needs was incomplete. Even when the man's dependency increased and staff had to provide full care, no efforts were made to assess his needs and prepare a care plan.

All prisoners should have their clinical needs assessed by a competent practitioner and should have an individualised nursing care plan.

One of the senior managers in the Healthcare Centre should take the lead on issues concerning older prisoners and those with physical disability.

52. The clinical reviewer evaluated the care processes and writes: "Individually the entries by most nurses appear insignificant, but in almost all the entries there are further indicators of the man's increasing needs that would have been picked up if the process for assessment had been more robust and the skill of the nurses more appropriate for someone of the man's age and frailty. There is no doubt in my mind that individually the nurses were caring and expressing concern for the man."

53. There are several entries in the medical record indicating that the man had falls, all indicating a continuing deterioration in his condition. The entries also make reference to the unsuitability of the cell for his increasing health and social care needs. However, when the man fell and injured himself he was dealt with appropriately and staff attempted to reassure him.

54. Prison healthcare staff were not assisted by the discharge arrangements from local hospitals. The man was admitted twice to hospital, but on neither occasion were proper discharge arrangements made. He returned to the prison without warning and without any advice as to how he should be cared for.

The Head of Healthcare and PCT should liaise with the local hospitals to improve and formalise the discharge planning process to ensure continuity of care.

55. The staff who had contact with the man were concerned for him and eager to care and support him as his health declined. However, the clinical reviewer concludes that "... healthcare staff have a responsibility to deliver safe and effective care, based on current evidence, best practice and where applicable validated research." I hope that the recommendations the clinical reviewer has made will be considered by the prison health partnership as part of their clinical governance responsibility, and a strategy developed to address these learning opportunities.

The prison health partnership should review the recommendations of the clinical review and develop an action plan to address the identified learning.

The man's location

56. Unusually, the man spent his whole period on remand as an inpatient in the Healthcare Centre. Staff became increasingly aware that his cell environment was unsuitable, and he was moved on several occasions including spending some time in the gated cell. There are no clear records of all the cell moves, and the information has been obtained by interviews carried out by the clinical reviewer. Staff also reported that there were several occasions when the man's cell had to be unlocked during the night.

57. While staff did their best and made what seemed to be sensible decisions to move the man, the environment was less than suitable and may well have contributed to his accident. The cell moves did not assist his disorientation, deteriorating mobility and tendency to fall. The clinical reviewer says that the conditions in which the man was located were unsuitable for his needs, and contributed significantly to his accident. Although the gated cell provided some safeguards, it did not offer privacy or dignity. The clinical reviewer suggests that a multi disciplinary approach, via a case conference, might well have reached a decision about where he should best be located.

    The prison health partnership should develop a locally agreed policy for management of the location of frail, elderly and physically disabled prisoners to ensure safety whilst maintaining dignity.

Family Concerns

58. The man's son expressed several concerns about his father's care. I set out those concerns and my findings here. First, the man's son asked how his father had fallen. This report has shown that the man had become very unsteady on his feet, and that his general disorientation and dizziness almost certainly resulted in his falling. Second, the man's son asked whether there was any evidence that his father could have been pushed over. My investigator could find no evidence to suggest that the man was pushed or treated badly. Third, he asked how quickly and appropriately the prison dealt with the man following a fall. On the basis of this investigation, I am satisfied that this aspect of the man's treatment was appropriate. Finally, he asked if all the necessary equipment was made available to his father. As I have noted, the man was unusual in spending his whole period in custody in the Healthcare Centre. Unfortunately, he had been assessed as unsuitable for a nursing home placement, even if the court would have agreed to the arrangement. Moreover, because the man had regular court appearances and out patients appointments, it was not considered appropriate for him to transfer to a prison with more suitable accommodation. However, a lack of care planning and due consideration of his environmental needs meant that at times the man's care was potentially compromised. (In concluding thus, I fully acknowledge the commitment of staff at HMP Manchester to help meet the man's health and social care needs.)

Care of the elderly and physically frail in prison

59. The number of prisoners with age related problems is increasing. Many of my reports on natural cause deaths in custody indicate the need for the Prison Service to recognise and respond appropriately to this changing profile (and changing health and social care needs) of the prisoners in its care. Although I am aware of a number of initiatives that have been taken, I have judged that a more general recommendation is required:

The Department of Health and Prison Service should ensure that there is an appropriate strategy in place for the care and management of the older prisoner and the physically frail.

RECOMMENDATIONS

- **The prison should introduce a system which ensures that all reception health screenings are checked and countersigned by an experienced registered nurse.**

- **All prisoners should have their clinical needs assessed by a competent practitioner and should have an individualised nursing care plan.**

- **One of the senior managers in the Healthcare Centre should take the lead on issues concerning older prisoners and those with physical disability.**

- **The Head of Healthcare and PCT should liaise with the local hospitals to improve and formalise the discharge planning process to ensure continuity of care.**

- **The prison health partnership should review the recommendations made by the clinical reviewer and develop an action plan to address the identified learning.**

- **The prison health partnership should develop a locally agreed policy for management of the location of frail, elderly and physically disabled prisoners to ensure safety whilst maintaining dignity.**

- **The Department of Health and Prison Service should ensure that there is an appropriate strategy in place for the care and management of the older prisoner and the physically frail.**