Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Clive Manning, a prisoner at HMP Swaleside, on 31 December 2023

A report by the Prisons and Probation Ombudsman

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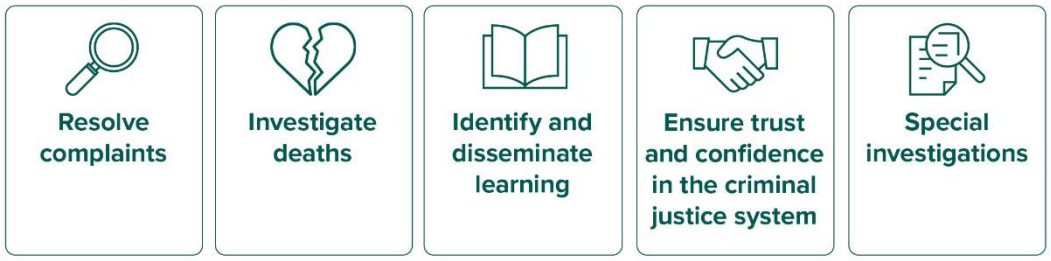
OUR VISION

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

WHAT WE DO



WHAT WE VALUE

1. The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

2. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. On 16 January 2019, Mr Clive Manning was sentenced to 15 years in prison for sexual offences.

4. He died from disseminated cancer (cancer that has spread throughout the body) with pneumonia on 31 December 2023, while a prisoner at HMP Swaleside. He was 59 years old. We offer our condolences to Mr Manning's family and friends.

5. The Ombudsman's office wrote to Mr Manning's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond.

6. NHS England commissioned an independent clinical reviewer to review Mr Manning's clinical care at HMP Swaleside.

7. The clinical reviewer concluded that the clinical care Mr Manning received at HMP Swaleside was of a good standard and at least equivalent to that which he could have expected to receive in the community. She found that Mr Manning's end-of-life care was significantly above the expected standard and an example of good practice. The clinical reviewer made recommendations not related to Mr Manning's death which the Head of Healthcare will want to address.

8. The PPO investigator investigated the non-clinical issues relating to Mr Manning's care.

9. We did not find any non-clinical issues of concern. We make no recommendations.

10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

11. At an inquest held on 12 January 2024, the Coroner concluded that Mr Manning died of natural causes.

Head of Healthcare to note

Delayed certification of death

12. Although Mr Manning died at approximately 7.30am on 31 December 2023, his death was not certified until 5.00pm by paramedics attending another incident. As a result, Mr Manning's body was left in his cell for nearly twelve hours. While it did not make a difference to the outcome, this was not dignified for the deceased, it delayed the police notifying the Coroner and it might have caused distress to prisoners and staff to know that Mr Manning's body remained in his cell for so long.

13. We recognise the resourcing difficulties the prison faced as Mr Manning died on New Year's Eve when there were no suitable healthcare staff on shift to certify his death. We also appreciate that the prison called an ambulance, but this was appropriately given low priority as Mr Manning had already died. However, healthcare staff should have contacted Medway On-Call Care (MedOCC), a local medical service providing on-call care, to request a clinician to certify Mr Manning's death. This would likely have prevented the delay in his body leaving the prison.

Adrian Usher **July 2024**
Prisons and Probation Ombudsman

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