

**Investigation into the circumstances surrounding the
death of a man at HMP Manchester
in November 2008**

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

January 2010

This is the report of an investigation into the death of a 55 year old prisoner at HMP Manchester who died from natural causes in November 2008. He was serving a sentence of nine months imprisonment imposed in August 2008, and had been diagnosed with terminal lung cancer.

I would like to add my personal condolences to those already expressed to the man's family on behalf of this office by my Senior Family Liaison Officer.

The investigation was conducted by an investigator. In addition a clinical reviewer was asked by the local Primary Care Trust to undertake a review of the man's clinical care. I am grateful for the assistance they both received from staff at HMP Manchester and would like to thank the Governor and his staff for their co-operation. I must apologise for the delay in issuing this report which was caused by the late receipt of the clinical review.

The man's family has expressed concerns about his care and treatment which I have carefully considered. The clinical reviewer has concluded that his care was not equivalent to that he would have received in the wider community. She has also judged that his palliative care, while of an acceptable standard, was not in line with the best practice advised by the Macmillan Cancer Support. Her review raises a number of learning points that the prison health partnership will need to consider seriously. She has made six recommendations which I endorse.

I have made no separate recommendations of my own.

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

Stephen Shaw CBE
Prisons and Probation Ombudsman

January 2010

CONTENTS

Summary

The investigation process

HMP Manchester

Key events

Issues considered

Conclusion

Recommendations

SUMMARY

The man was born in 1953. He was 55 years old when he died at HMP Manchester in November 2008. His death was from natural causes as a consequence of lung cancer (bronchial carcinoma).

The man had been sentenced to nine months imprisonment in August 2008 at Crown Court. He was received into custody at HMP Manchester on the same day. At his first health screening interview it was recorded that he had received burns on his hands and face in an accident in 2007, and previously had suffered a collapsed lung. He was a smoker but he chose not to accept assistance to help him to stop smoking.

The man was admitted to local hospital in October 2008. Following tests, he was diagnosed with lung cancer. The prognosis was that his condition was terminal. He transferred to hospital in November.

Whilst the man was in hospital, a bedwatch was carried out by prison staff. The initial security risk assessment concluded that handcuffs were to be used and two officers needed to be at his bedside. The assessment was later revised by the duty governor in October and handcuffs were no longer used. His family were allowed to visit him whilst he was in hospital. He was discharged from hospital in November and returned to HMP Manchester where he was admitted to the healthcare centre.

During November, the man returned to hospital for palliative chemotherapy. He returned to Manchester at 9.55pm and was again admitted to the healthcare centre. At around 6.40am, a nurse commenced her duty on the healthcare centre and checked on him around five minutes later. As she was unable to rouse the man, the nurse informed her colleagues of her concerns. They then all entered his cell. They could not find any signs of life and an ambulance was called. On arrival at his cell, the paramedics took over responsibility for his care. They carried out an electro-cardiogram (a graphical recording of the electrical activity of the heart) which confirmed that there were no signs of life. The paramedics pronounced that he was dead at 7.24am.

After it was confirmed that the man had died, HMP Manchester activated its death in custody contingency plan. The police were informed and visited the prison. They found no suspicious circumstances. His body was released to the undertakers who removed him to the mortuary for post mortem examination.

The review carried out by the clinical reviewer has identified a number of issues relating to the care provided for the man. The review highlights areas of practice that could be improved, and makes six recommendations.

I make no recommendations of my own.

THE INVESTIGATION PROCESS

1. The investigation was opened in November 2008 by my investigator. He issued notices announcing the investigation to staff and prisoners. These notices included an invitation to anyone who wished to submit information relating to the man's death to make themselves known. In the event no one came forward. My investigator also studied all relevant prison records, which included the man's main prison record and his medical records.
2. My investigator visited HMP Manchester in November 2008 and February 2009 and discussed aspects of the man's treatment with staff. He met a representative from the Independent Monitoring Board and interviewed the Director of Healthcare.
3. The local Primary Care Trust commissioned a clinical reviewer, a trained nurse, to carry out an independent review of the man's clinical care. I am grateful to her for undertaking such a thorough review.
4. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. Upon completion, this report will be sent to the Coroner to assist in his enquiries into the man's death.
5. My Senior Family Liaison Officer contacted the man's family. This gave them the opportunity to discuss the purpose of the investigation and to raise any concerns or questions that they wanted to be addressed. My Senior Family Liaison Officer and investigator later met the family to discuss the following matters:
 - The poor level of healthcare and medication the man received whilst he was in the custody of HMP Manchester.
 - Why he had been located on the lifers (C) wing when he only had to serve a short sentence.
 - His complaint against a prison officer who had acted unprofessionally.
 - Why early release had not been considered in view of his medical condition.
 - Why they had not been informed that he was dying and the delay in informing them of his death.
 - The delay in making arrangements for the family to identify his body.
 - The family also said that some of his property was missing. This included clothing, letters and a notebook.
6. The family praised the two prison officers who were with the man at the hospital. The family also confirmed that Manchester had arranged and paid for the funeral and service.
7. My investigator has attempted to address the issues raised by the family within this report. I hope that it provides them with a better understanding of the events leading up to the man's death.

HMP MANCHESTER

8. HMP Manchester is a large prison, Victorian in external appearance but greatly refurbished internally. Cells have televisions, electric sockets and sanitary facilities. Manchester holds both unconvicted and sentenced prisoners, as well as a small number of high security (category A) prisoners. For this latter reason, it is part of the high security estate and physical and other security within the prison reflects this.
9. At the time of the investigation, the prison served Magistrates' and Crown Courts in the Greater Manchester area holding up to 1,269 male adult prisoners. The prison is divided into two main blocks. The upper prison contains four wings (G-K) which include the First Night Centre and the induction wing. The lower prison has five wings (A-E).
10. After the evening roll call to confirm prisoners are all accounted for, the prison enters what is called patrol state. This is defined as follows: 'Prisoners are locked up and staff numbers are reduced to the minimum needed to patrol. The main role of staff at this time is to maintain the security of the prison and the safety of all prisoners.'
11. When the night patrol officer arrives on the wing, a hand-over is given by the officer on evening duty and a sealed packet containing keys is passed from one to the other. The keys in the sealed packet are only to be opened in an emergency. When the officer on duty the next day arrives, he or she receives a hand-over from the night patrol officer and another roll check is carried out before the night patrol officer leaves the wing. When staff were unable to rouse the man on a morning in November 2008 and had to enter his cell, the prison was in patrol state.
12. Healthcare at Manchester is commissioned by the local Primary Care Trust. The healthcare centre provides 24 hour nursing care and medical cover, and has beds for up to 38 prisoners.
13. During 2008, there were two other previous deaths from natural causes at Manchester. The investigator has reviewed my reports into those deaths but has found no common factor between them and the circumstances surrounding this investigation.

Independent Monitoring Board

14. Each prison has an Independent Monitoring Board (IMB). IMB members are independent and unpaid. They monitor day-to-day life in their prison and ensure that proper standards of care and decency are maintained. Each IMB produces an annual report. In their report on Manchester for the period 1 March 2007 to 29 February 2008, the IMB expressed their concern that elderly prisoners with complex mental health and physical needs were being held in the healthcare centre which had neither the appropriate facilities nor equipment to respond to their needs. The IMB referred in their report to an inquest into the death of a 75 year old prisoner when HM Coroner commented that the healthcare centre of a

category A prison was not a suitable environment for the care of the elderly and infirm. The report also said:

“Manchester is a well-run prison which is meeting most of its Key Performance Targets ... The Board has witnessed many occasions when staff have demonstrated sensitivity to prisoners’ needs, e.g. in Reception on arrival at prison, officers giving information on what was happening and answering any questions ... “

Her Majesty’s Chief Inspector of Prisons

15. The most recent inspection by Her Majesty’s Chief Inspector of Prisons was an unannounced, short inspection in May 2007 as a follow-up to her 2004 full inspection. Her report of this latter inspection, published in October 2007, said in relation to safety at Manchester that “the application of category A procedures to the small number of category A prisoners had implications for the quality of life for all prisoners, 630 of whom were merely category C prisoners. Better and more equitable risk management was required.” Her report spoke about the improvement in staff-prisoner relationships, and in particular the impact of the group officer scheme which meant that prisoners would be allocated a named officer who would be responsible for engaging proactively with them.

KEY EVENTS

16. In August 2008, the man was sentenced by Crown Court to nine months imprisonment. He arrived at HMP Manchester the same day. This was not his first experience of prison although he had not been in custody since August 2000.
17. During the man's first reception health screening interview, it was recorded that he had been diagnosed with asthma, had previously had a collapsed lung, and had received burns on his hands and face. (In January 2007, he was injured in a fire at an electrical substation and subsequently spent six weeks in the Burns Unit at a local hospital.) He was allowed to keep his Salbutamol (asthma) inhaler and Diprobace cream (for his burns) in his possession. He was a smoker but he chose not to accept help to stop smoking. He was located on the healthcare centre for his first two days at Manchester before he moved to G wing.
18. In August, the man was assessed for Home Detention Curfew (HDC) by a Probation Service Officer. (HDC is also known as "electronic tagging". A small electronic "tag" is fitted to the ankle. The tag sends a regular signal to a monitoring centre that confirms the presence of the person in their place of curfew. If they are absent or try to tamper with the equipment the monitoring centre is alerted and the breach investigated.) She recorded that the man had previously breached curfew orders and failed to surrender on many occasions. HDC was therefore not authorised. On the following day he moved to K wing.
19. The man was seen in September by a locum doctor. He had been feeling light-headed and experiencing palpitations whenever he stood up. An electrocardiogram (ECG, a graphical recording of the electrical activity of the heart) was carried out. It indicated that there was no sign of a heart attack. A referral was made to local hospital for a 24 hour ECG to be carried out. An appointment was also made for him to attend the Blood Clinic two days later.
20. The man was seen by a prison doctor in September. In his letter to the Cardiology Department at the local hospital following his consultation with him, the prison doctor wrote:

"I would be grateful for your opinion of this man who has been complaining of feelings of dizziness whenever he stands up, for approximately 2 weeks. On occasions he has actually passed out. ... He is difficult to auscultate [listening to the sounds made by the internal organs of the body for diagnostic purposes], but I think I heard a systolic murmur. ... I am sure he would benefit from an Echocardiogram or 24 hour ECG."
21. On the following day a second locum doctor carried out a routine review of all the new blood test results that had been returned to the healthcare centre. During her review, she noted that the man's blood test results were not within normal limits. The results suggested he had developed anaemia due to blood

loss. She arranged for him to attend an emergency appointment with the doctor for the following day.

22. A second prison doctor saw the man in September. After she examined him, the doctor noted that he was not losing blood but he did have a chest infection. She prescribed Flucloxacillin (an antibiotic capsule) and iron tablets. A further appointment was arranged for the blood test to be repeated the next day but this appointment was cancelled by the man.
23. In September, the Deputy Director of Reducing Re-offending reviewed the man's application for HDC. He noted that there was a pattern which indicated a likelihood of re-offending during the HDC period. He also noted that there was a likelihood of failure by the man to comply with the conditions of the HDC curfew. He therefore considered that the man would find it difficult to comply with the conditions of HDC and he could not grant it. He suggested that if the man was not satisfied with his response he could take forward this matter with the Governor and by appeal to my office as Prisons and Probation Ombudsman. The man made a formal request for a hearing to appeal against being refused permission for HDC in November. One of the Governor's secretaries acknowledged his request three days later and said that arrangements would be made for him to meet with the Deputy Governor. There is no record of the man pursuing this issue further with my office.
24. The man moved to C wing in September.
25. In September, the man was seen for a routine patient review by the second locum doctor. After her review with him, she wrote to the Gastroenterology Department at the local hospital. In her letter she asked if the hospital could:

“Organise an endoscopy for the man [An endoscopy is a test that looks inside the body. The endoscope is a long flexible tube that can be swallowed. It has a camera and light inside it.] ... [he] has had a persistent burning sensation in the epigastium and cough at night with burning feeling in the gullet. He has had this for several months. He has now been found to be anaemic. I now enclose copies of his recent full blood count. He thinks he has lost a stone over the past few months. His past medical history includes heavy drinking, and he tells me he had an endoscopy done 15 years ago, but cannot remember the results. I am concerned about a possible gastric malignancy. I would be grateful for your input.”
26. In October, the man was taken to hospital for a chest x-ray and an endoscopy. He returned to the prison on same day. The result of the x-ray was reviewed by the prison doctor which indicted possible lung tumour. The prison doctor faxed the x-ray results to the Rapid Access Clinic and the Day Case Clinic at the local hospital. The x-ray results recorded:

“There is a soft tissue mass in the medial aspect of the right upper lobe which might extend beyond the horizontal fissure with moderate pneumonitis reaction around this mass is as well seen in the base of

the right upper lobe on the lateral view and is highly suspicious of malignant lung tumour. A CT [Computerised Tomography] scan to be organised as soon as possible.”

27. In his letter to the prison doctor dated October, the man wrote that his breathing:

“ ... had deteriorated further I find I need to rest to catch my breath at least there is time to make my bed the same thing with the simple task of sweeping the cell floor. The dizzy spells are more often and a great deal more intense. Palpitations feel like my heart is going to burst. ... The only time I leave the cell is to collect my meals and hot water for a cup of tea, I feel vulnerable, useless, dirty, smelly and a complete waste of space. No I’m not being bullied or threatened but I do realise how weak and incapable I’ve become.”
28. At around 4.13pm three days later in October, the man was admitted to the healthcare centre at Manchester as he was experiencing problems with his breathing. Two hours later he was taken by ambulance to hospital where he was admitted to a ward. A CT scan was carried out after he was admitted. Eight days later he moved to another ward.
29. A bedwatch was carried out whilst the man was in hospital. The initial security risk assessment concluded that an escort chain should be used and two officers should be in attendance at his bedside. A log of activities was maintained by the officers on bedwatch duty which was checked on a regular basis by a visiting duty governor. The man’s family was able to visit him whilst he was in hospital.
30. In her letter received at Manchester in October a Senior House Officer at the local hospital wrote:

“The CT scan showed a large mass in his right lung with superior vena cava [the large vein which returns blood to the heart from the head, neck and both upper limbs] obstruction consistent with carcinoma [cancer] ... He had a biopsy and will be liaising with another hospital regarding management however the prognosis is poor with a life expectation on three to twelve months.”
31. The risk assessment for the man was revised in October: restraints were no longer to be used although two officers would continue to remain at his bedside. On the same day, a nurse was informed that he was going to be transferred to another hospital in November. He was being transferred for a procedure to insert a stent. (A stent is a tube which is inserted into a vessel to keep the channel open and prevent closure.)

32. In his letter dated 31 October, the Consultant Chest Physician at the local hospital, wrote that the man had:

“incurable lung cancer, which is currently causing breathlessness and obstruction of the main blood vessel draining from his head and upper limbs. This is causing considerable swelling of his head and symptoms of dizziness. On occasions to his admission [to hospital] he had collapse secondary to this. He has been referred to another hospital for further management of his problems, but unfortunately his life expectancy is very poor. There has been deterioration in his physical state since he has been admitted and I would estimate that he has no more than four to six weeks to live. In view of this I would be grateful if you would consider relaxing the security restrictions around the man. In particular the need for him to be chained to a prison officer, restrictions on telephone calls, and visiting. The telephone calls are a particular concern to him as his sister is agoraphobic and he is unable to see or contact her in any other way at this moment in time ... The treatments to be provided at the other hospital may well require regular attendance every two weeks for burst of chemotherapy.”

33. During the morning in November, the man made a complaint that the snoring of one of the bedwatch staff had kept him awake all night. A Senior Officer made arrangements with Manchester for the duty governor to visit him. The duty governor wrote the following entry in the bedwatch log:

“Enquiries made with the man regarding his allegation ... He was very complimentary regarding the way he had been treated by prison staff, and was clearly upset about the previous 10-6 shift. He was encouraged not to dwell on the incident but allow us to investigate the matter. He was content to do this and appeared in much better spirits by the time we left.”

34. In November, the man moved to another hospital. On the following day he was granted release on temporary licence (ROTL). The licence was only applicable for the periods he was in the local hospital and the other hospital. The condition of the licence was that he was not allowed to leave the hospital without prior permission from the prison. During the afternoon of 4 November, he had a stent inserted. He was discharged from the hospital and returned to Manchester two days later (on 6 November).
35. On his return to Manchester, the man was admitted to the healthcare centre. The discharge information from the other hospital stated that he had a prognosis of between three and nine months to live. The man told healthcare staff that he thought that he had a prognosis of two weeks. He informed staff that he wished to be kept pain free and was hoping that he would be released early on compassionate grounds.
36. The prison doctor advised that for his pain relief the man should be given 20mg of MST (Morphine Sulphate Tablets, an opioid painkiller which mimics the

action of naturally occurring pain-reducing chemicals called endorphins) at 12 hourly intervals and 10mg/5ml of Oramorph (an oral form of morphine sulphate) at four hourly intervals. A second nurse wrote in his medical record:

“On asking him how he feels about his prognosis he states okay as long as he is pain free. He also informs me that he hopes to be released on compassionate grounds as his family will look after him. I have informed him that at present he will be looked after within healthcare and his needs will be reviewed accordingly. He appears content with this at present.”

37. The prison doctor saw the man in November and they discussed his prognosis. They also discussed the issue of resuscitation and the man told him “to let me go and not mess”.
38. A staff nurse came on duty at 8.00pm in November; she was informed half an hour later that the man was to due to have his dose of MST. When she checked the MST blister pack the expiry date was recorded as “20.11.05”. She discussed this with a colleague and as the medication appeared to have expired they decided not to administer it. In medical record, the staff nurse wrote:

“Informed by nursing staff on the late shift that no MST tablets in pharmacy. I contacted the hospital and spoke to the Night Sister informed her of this and asked if there was any way a dose of MST could be obtained from them tonight to prevent the man from missing his dose and potentially being in pain due to this. I was informed by her that this was not possible, against hospital policy and advised I speak to their on call pharmacist. I spoke to on call pharmacist, informed him of the situation. He again stated that this was not possible even though I informed him that a member of nursing staff from healthcare who had been on the late shift was prepared to go to the hospital to obtain this as this way it could still be checked by two nurses, one at the hospital and on arrival back at the prison.”

39. As the staff nurse was unable to resolve the situation she contacted the prison doctor at home. He advised the staff nurse to increase the man’s dose of Oramorph of 10mg/5ml from four hourly to two hourly intervals. He recorded in the man’s medical record that this would make up for the missing dose of MST. It was later discovered that the date on MST blister pack had been read incorrectly and was in fact not out of date.
40. At around 9.57pm in November, the staff nurse entered the man’s cell as he was short of breath and appeared quite panicked. In his medical record, the staff nurse wrote:

“The man stated he had not been using his oxygen for the last two hours as felt he hadn’t needed it. Has been up having a wash, trying to arrange his pillows. He is now using his oxygen via mask. Deep breathing exercises encouraged and reassurance given. No specific

concerns raised by him. Denies any pain at present. Advised to use his oxygen as needed and inform staff if he feels breathless or has any concerns. I made his bed for him and arranged his pillows in the way he informed me would be comfortable for him and aid his breathing. After a short while he appeared more settled.”

41. When my investigator met with the representative from the Independent Monitoring Board (IMB) at Manchester, she said that healthcare staff have a good relationship with prisoners and that the staff resources in this area seemed to have increased. She confirmed that she had not known the man but she produced an entry log completed by her colleague who saw him during the morning of 10 November. Her colleague had visited the healthcare centre and had been accompanied by a new member of the board. Her colleague wrote:

“... in H.C.C [healthcare centre] do not appear to be any problems. New member of the board and I met the man, a terminally ill patient, at own suggestion he sent in a Confid/Access App [confidential access application] to Gov 1. Seeking early release on compassionate grounds. We understand this may be considered favourably. We are to remain in contact with the man.”

42. After his visit from the IMB, the man was taken to hospital for palliative chemotherapy. He returned to the prison at around 9.55pm and was again located on the healthcare wing (cell MX-07). As he was struggling with his breathing, he was advised to use the oxygen in his room and to press his cell bell if he needed assistance.
43. At around 00.15am in November, the man rang his cell bell and asked for pain relief. The night nurse checked with the hospital to confirm the dose of the man’s pain relief medication. The nurse at the hospital confirmed that the man had received 20mg of MST tablets whilst he was at the hospital. The night nurse took the medication to him. However, as he was unable to get up from his bed and as the prison was in patrol state permission was given for the cell door to be unlocked. The man was given the MST at 01.00am. At around 01.48am, the night nurse recorded that he was “awake, lying in his bed, using O2 [oxygen] intermittently says he is still feeling the pain but not as much as before. Advised to be on his buzzer if he needs any more help. Continue to be observed.”
44. The first nurse commenced her duty on the healthcare centre at around 6.40am, and she checked on the man around five minutes later. She noted that he was propped up in his bed by the backrest and cushions. As she was unable to rouse him, she immediately informed the Healthcare Senior Officer (HCSO) and a third nurse of her concerns. The HCSO contacted the Principal Officer (radio call sign Oscar One) and, as the prison was still in patrol state, asked for permission to enter the man’s cell. The HCSO then entered the cell. He was accompanied by three nurses. They laid the man flat and checked for signs of life. His pupils were fixed, no heart beat could be detected using a stethoscope, and no breathing sounds or movements could be heard.

45. At 7.02am, the HCSO informed the prison control room that the man did not have a pulse and asked for an ambulance to be called. The ambulance arrived at 7.15am and the paramedics were immediately escorted to the healthcare centre. They then took over responsibility for his care and carried out an ECG. The ECG confirmed that there were no signs of life, and the paramedics pronounced that he was dead at 7.24am. Staff then brushed his hair, put a sheet over his body and locked his cell. The ambulance left the prison at 7.46am.
46. The Director of Healthcare and a Principal Officer were appointed by Manchester as the prison's Family Liaison Officers. They contacted the man's family to inform them of his death and to offer their condolences. A chaplain from the prison chaplaincy accompanied his family when they went to view his body. The Director of Healthcare maintained contact with the family and assisted with the funeral arrangements. Manchester also offered financial assistance with the costs of the funeral. The man's funeral took place on 27 November and the Director of Healthcare attended at the express wish of the family.
47. The prisoners in the healthcare centre were told about the man's death on the day he died. Staff also asked prisoners whether they required anything or wanted to speak to a Listener. (Listeners are trained by Samaritans to provide confidential emotional support to fellow prisoners in distress.) The staff who discovered that the man had passed away when they opened his cell were offered support from the prison's care team.
48. The post mortem report records the man's death as due to natural causes, as a consequence of disseminated bronchial carcinoma (lung cancer).

ISSUES CONSIDERED

49. When visited by my investigator and family liaison officer, the man's family told them that they had concerns about the care he had received whilst in custody. I set these out in the paragraphs that follow.

Clinical care

50. The man's family felt very strongly that the level of healthcare and medication he received whilst in custody at Manchester was poor. They said that he had written notes and letters detailing his level of care whilst at Manchester and in outside hospital. The content of the letters has caused the family additional distress. As already mentioned above, he wrote a letter to the prison doctor asking for additional medication to relieve his pain and treat his condition. In other letters to his family he wrote that he was only receiving iron tablets and Salbutamol (asthma medication).
51. As noted above, a review of the man's medical care was undertaken by the clinical reviewer on behalf of the local Primary Care Trust. My investigator informed the clinical reviewer of the concerns raised by the man's family and she reviewed his medical notes and the interventions of healthcare staff. She also interviewed a number of staff. In order to evaluate the action of clinicians involved in the man's care, the clinical reviewer also consulted with members of the local Primary Care Trust death in custody panel.
52. From the medical records, it was clear that the man was seen regularly by healthcare staff and referred to secondary care when appropriate. However, the clinical reviewer notes that there was no evidence that a secondary health screening took place for him. (The secondary health screening is a general health assessment and should be offered to every prisoner in the week following arrival in custody. This assessment is equivalent to a primary care assessment when registering with a General Practitioner in the community. It provides an opportunity for gathering further health information, health education and promotion, and importantly checking how a prisoner is settling in.) An appointment was made for him to have a secondary health screening but it was cancelled and no further appointment was made. The clinical reviewer makes a recommendation that this process is reviewed by the Director of Healthcare at Manchester.

The Director of Healthcare should review the Secondary Screening Process. The process should occur wherever the prisoner is located and whatever pathway he is following.

53. When interviewed by the clinical reviewer, the staff nurse recalled that the man was annoyed when he had to wait for his pain relief medication. The clinical reviewer notes that the normal practice in the healthcare centre was for medication to be issued at timed intervals (for example two or four hourly). The hospital and Macmillan Cancer Support advocate that the patient self manages their pain relief. This means that the medication is taken when and how often the patients feels it is necessary. The clinical reviewer also notes that

healthcare staff did not have contact with the Community Macmillan Nursing Team. They could have advised healthcare staff on the current best practice in the care of terminally ill patients.

54. The clinical reviewer makes a number of recommendations relating to the terminal care for prisoners at Manchester. These include identifying a suitable member of staff to take a lead role for palliative and end of life care and providing additional training for staff.

The Director of Healthcare should identify a member of the nursing staff to take a lead role for end of life and palliative care and to establish and maintain a wider engagement with local palliative care networks.

The Director of Healthcare should ensure that members of the nursing staff attend pain management workshops, as well as training to address holistic assessment and communication skills in palliative care.

The Primary Care Trust should develop a 24 hour help line for palliative care issues as described in the NICE Guidance: Improving Supportive and Palliative Care for Adults with Cancer which includes the Prison Service.

55. The clinical reviewer also recommends that the Director of Healthcare ensures that nursing staff are aware of reflective practice. Reflective practice is part of the requirement for nurses constantly to update professional skills. The nurse can focus on their knowledge, skills and behaviour to ensure that they are able to meet their responsibility for providing care to a patient to the best of their ability.

The Director of Healthcare should ensure that the nursing staff are aware of reflective practice.

56. The clinical reviewer further recommends that the Director of Healthcare should ensure that Manchester's palliative care policy takes into account the principles outlined in the End of Life Strategy (issued by the Department of Health, July 2008). The aims are to provide high quality care for prisoners approaching the end of their lives thereby ensuring that prisoners are treated as individuals and that there is recognition of their changing needs and detention requirements.

The Director of Healthcare should review and ensure that HMP Manchester's palliative care policy takes into account the principles outlined in the End of Life Strategy (DOH, July 2008).

57. The clinical reviewer concludes that the man was not a well man when he arrived at Manchester. His medical problems were identified and acted upon in a timely manner. He was treated in the local hospital and another hospital where he had steroid medication and a stent inserted to relieve his symptoms. The consultant at the other hospital decided that he would then receive palliative chemotherapy treatment. However, the clinical reviewer has found no

evidence of any discussion at the other hospital or at the prison as to where the man should receive palliative care.

58. Healthcare staff cared for the man once he was discharged from hospital. They carried out a nursing assessment and developed a care plan on his return to Manchester. However, this did not include pain management tools which would be expected when managing a person in the terminal stages of life. The clinical reviewer has also found no evidence of the management of the man's psychological and emotional needs. There does not appear to have been any contact with Macmillan Cancer Support who could have offered advice in pain management and palliative care. However, the clinical reviewer notes that the man was only in the healthcare centre for a short period before his death. She also acknowledges that the prison doctor did spend time speaking to him regarding his prognosis and pain management. He also discussed whether the man wanted to be resuscitated. This was good practice. Overall, the clinical reviewer judges that the practices in healthcare were acceptable but not up to date with pain management as advised by Macmillan Cancer Support and the other hospital.
59. Unfortunately, the misunderstanding by the nursing staff as to whether the man's pain relief medication was out of date did lead to an initial delay in the administration of this medication during his first night in the healthcare centre. The clinical reviewer says that the paramount principle in terminal care is the management of a person's pain. Self management of breakthrough pain is encouraged by the other hospital but was not the practice in HMP Manchester. She suggests this probably had an adverse effect psychologically for the man. He expressed frustration about the management of his pain relief, due to moving from self management at the hospital to a timed managed administration when he returned to prison.
60. The clinical reviewer believes that palliative care patients should receive individualised care with ongoing assessments. She has found no evidence of anticipatory end of life planning. She notes that the Director of Healthcare at Manchester was involved in discussions to expedite the man's early release, although unfortunately he died before this could be agreed.
61. The clinical reviewer judges that, although staff at Manchester did their best to give effective care in the circumstances, terminal care patients should be transferred to a more appropriate setting to receive end of life care.

Location in prison

62. The man's family wanted to know why he had been located on the lifer wing (C wing) when he was only sentenced to nine months. According to the family, prisoners sentenced to five years or more are located on the lifer wing.
63. The man was located in several different wings throughout his time at Manchester. The Deputy Safer Prisons Co-ordinator has confirmed that although C wing predominantly houses prisoners serving life and indeterminate sentences for public protection (IPP), it was also home to other prisoners, like

the man, who had shorter sentences. My investigator noted that he was only located on C wing from late September until he taken to hospital in October. When he returned to the prison in November, he was located on the healthcare wing where he remained until his death.

64. In his written response to my investigator a Senior Officer wrote:

“Whilst the man was on C wing he never really came to staff's or my attention. Even his cell mates never raised any issues. I have asked staff if they can remember anything about him and all seem to have the same opinion. He was a quiet man but didn't have any problem in approaching or talking to staff. He appeared to get on with numerous other prisoners and never raised any concerns. I'm sure he attended treatments daily and I remember on one occasion getting his inhaler replaced. I can't remember any other issues, medical or anything else during his stay on C wing.”

Behaviour of prison staff

65. The man's family said that he had made a complaint against a prison officer. In one of his letters to the family, he referred to the officer making noises in his ear every time he tried to sleep and making him kneel down in his restraints and pretending that the man's son was driving a car at great speed. This has caused his family additional distress. The family also expressed their concern about a comment made by an officer on reception at Manchester. As the man was being taken to hospital, they believed an officer had said to him 'Dead man on arrival'.

66. Before he met the man's family, my investigator had noted that he had made a complaint about the behaviour of a member of staff who was on bedwatch duty. The man had complained that a Principal Officer's (PO) snoring had kept him awake all night and that he blocked his route to the en suite toilet. In his bedwatch log entry for 1 November at 3.30am, the PO wrote: "Prisoner complaining that the vibes from the staff were keeping him awake ... checked with nursing staff and this can be attributed to the medication."

67. The man's complaints were investigated by the Director of Operations at Manchester. He found no evidence to substantiate the man's claim of inappropriate behaviour. An officer who was on the bedwatch duty with the PO told the Director of Operations that the PO was quietly reading notes for most of the night. The officer confirmed that the man had used the toilet just outside his room on each occasion and had not asked to use the en suite toilet. The officer also said that he believed that at no time did the PO act in an unprofessional manner. When interviewed by staff at Manchester in November, the man apologised for what had happened and said that the officer had not done anything wrong. The man believed that his medication had made him act in an irrational manner. The Director of Operations found no evidence to substantiate the man's complaint or evidence of inappropriate behaviour by the PO. He did recommend that the PO should not carry out bedwatch duties for the man to avoid any further misunderstandings.

68. My investigator was unable to find any supporting evidence to substantiate the complaint made by the man. No officers or prisoner approached my investigator to raise any concerns about the care provided to him.
69. In her written response on this matter, the Deputy Safer Prisons Co-ordinator wrote that she could not find any reference in the copies of the man's letters to "Dead man on arrival". She wrote that the man was complimentary in his documented comments that he made about staff, stating that officers had been:
- "... absolutely magnificent with me, and I can feel proud in the fact that such a fine body of your officers who showed exceptional kindness, courtesy, understanding, respect and manners that were impeccable."
70. My investigator was unable to find any evidence to substantiate the alleged comments made by staff when the man left the prison.

Early Release

71. The family said that they were aware that release papers had been submitted two weeks before the man's death, and were concerned this had not been considered earlier in view of his medical condition.
72. As mentioned previously, release on temporary licence was agreed for the man in October 2008 whilst he was in hospital. The licence was only applicable for the periods he was in hospital. The condition of the licence was that he was not allowed to leave the hospital without prior permission from the prison. In her family liaison log, the Director of Healthcare wrote:
- "It had been highlighted to myself that the man was terminally ill. ROTL [release on temporary licence] had been discussed the week previous, so I brought it to the attention of the Governor first thing on Monday morning and that I felt ROTL was necessary for him, to give him dignity in life, prior to his death, as he had only been given what I felt at that time was 3 – 6 months to live. On returning to the Health Care Centre I was informed that we had had a further letter, and the man had now been given a shorter life expectancy. I informed the Governor, and myself, the Governor and a Nurse had a meeting to discuss this."
73. I believe that Manchester took action at the earliest juncture to investigate the possibility of releasing the man from custody. Home Detention Curfew had already been considered but not agreed due to his previous history of non-compliance. Once it became clear that his prognosis was very poor a meeting was arranged to investigate the options available to the prison. Unfortunately, the meeting was arranged but did not convene as he had already passed away.

Use of restraints

74. The initial security risk assessment when the man was taken to hospital identified that an escort chain should be used and that two officers needed to be in attendance. This was in line with normal practice and enabled the nursing staff to have easy access when they carried out their duties. The use of handcuffs for prisoners on escort to hospital has been the subject of recent case law in relation to the issue of decent and humane treatment. (Judgment by Mr Justice Mitting on 23 November 2007 in case of (1) Graham (2) Allen v Secretary of State for Justice.) I know that the Prison Service is currently drawing up new guidance in relation to this matter. Manchester's decision that the man should be handcuffed in the first instance was in line with its standard procedures.
75. I am pleased to report that the risk assessment for the man was regularly reviewed and revised during his time in hospital. As a result, the level of restraints was reduced and the escort chain removed. In my judgement, this was well managed. My investigator also found that the bedwatch notes were concise with legible and appropriate entries.

Notification of the man's death

76. The man's family wanted to know why they had not been informed that he was dying and why it took six hours for them to be informed of his death. They were concerned that the notification of the death had not happened as soon as possible. The family explained that the Director of Healthcare and a Police Officer had informed the family of his death at 1.30 pm.
77. My investigator was able to confirm that staff were not aware that the man's death was imminent. He was ill and his prognosis was very poor but his sudden death was not expected by staff at Manchester.
78. With regard to how the news of the death was delivered, the Deputy Safer Prisons Co-ordinator wrote that:
- “... a full risk assessment and collation of facts is essential when delivering the news and making the first visit to the family. The Director of Healthcare and the PO completed this and attended Stalybridge Police Station (at police request) and then arrived at the address at approximately 11.00am.”
79. In the Director of Healthcare's note about the visit in November, she wrote:
- “At approximately 06.55am in November 2008 I was informed that the man had died of natural causes in his bed during the night. At approximately 09.30am I was given the task of designated Family Liaison Officer. Myself and a PO, who is also a Family Liaison Officer, collated all the necessary information about the next of kin, and the circumstances surrounding the man's death. We had informed the Police Liaison about the address of his daughter ... we were instructed

to attend Stalybridge Police Station before we attended the family. We arrived at the man's daughter's address at approximately 11.00am."

The Director of Healthcare subsequently accompanied the man's daughter to inform other members of the family of his death before she returned to Manchester.

80. The man had been quite poorly but there was no indication that his death was imminent. He appears to have passed away peacefully in his sleep and was discovered by staff around 6.40am in November. His death was confirmed by paramedics at 7.24am and the prison then implemented its death in custody procedures. The prison's family liaison officers ensured that they collated all necessary information for their visit. They were then told by the police that as there had been "incidents" at the family's address they had to attend the local police station before they informed the family.
81. I believe that staff at Manchester informed the man's family of his death in as timely a manner as was possible. The delay was unfortunate but necessary as the family liaison officers had to act on the information they had been given by the police. After the Director of Healthcare informed the family about the man's death they asked her to attend another address to tell other family members. She was also later asked by his family to attend his funeral.

Delay in identification

82. The family were informed on the day of the man's death they would need to identify his body and someone would ring that afternoon to arrange. However, there was no contact for another five days and this had caused additional stress for the family.
83. In her family liaison officer log, the Director of Healthcare wrote:

"In November 2008 I received a telephone call from the man's family. I rang them back and they both stated that they had not had any contact with the police. I attempted, on numerous occasions to contact the DI on the number given, to no avail. I then contacted the Police Liaison Officer within HMP Manchester, who also tried to contact Grey Mare Lane Police Station, but was unsuccessful, so she e-mailed the DI ... At approximately 5.30pm in November 2008 I also contacted the man's family, to advise them that I was unable to contact the police, but the Police Liaison had attempted on my behalf. Unfortunately one member was unavailable to speak, but I did speak to another member. At 12 o'clock in November 2008 I had still had no contact with the DI, but I have been in contact with the Coroner's Liaison and arrangements have been made for the family to attend hospital at 10 o'clock tomorrow morning."
84. In November 2008, the prison chaplain attended the mortuary with member of the man's family for the identification of his body. I appreciate that the man's family were upset by the delay. My investigator found no evidence that the

prison did not attempt to assist with this process. The Director of Healthcare followed up the concerns raised by his family and attempted to get the police to contact them. When this did not work, she contacted the Coroner's office and arrangements were made for his family to identify his body with the prison chaplain attending to give them support.

Return of the man's property

85. The man's family said that some of his property was missing. This included clothing, letters and a notebook. The notebook detailed his wishes and thoughts. His family had written their telephone numbers on the front cover of the notebook. They had received a photocopy of the front cover of the notebook from the Director of Healthcare but not the rest of notebook. They had asked for the rest of the notebook but were told it has been misplaced. The family were concerned that, if the prison could provide a photocopy of the notebook cover, then they must have the rest of the notebook. They had also requested the letters the family wrote to the man but were told that he must have thrown them away. They did not believe this was the case as he kept everything. The family were also concerned that they only received a small amount of his clothing and would like to know what has happened to the rest.
86. My investigator discussed the concern about property in his interview with the Director of Healthcare. She confirmed that she had spoken to the man's son in November about returning the property. This was taken to the man's daughter's house the following day. During her visit to his family in November, the Director Healthcare contacted both the local hospital and the other hospital. This was to check that the hospitals had not retained any of the man's property.
87. When the Director of Healthcare returned to the prison she spoke to two officers who had been on bedwatch duty in November, about the man's notebook. The first officer recalled an A4 size book but did not recall a notebook. The second officer confirmed that the man packed all of his own belongings at the hospital. The Director of Healthcare confirmed that she checked Healthcare, Security and Reception at Manchester but was unable to locate any further property. This information was relayed to the family by her.
88. In November, the prison chaplain spoke to the man's daughter about her father's property. The Director of Healthcare contacted the man's daughter after checking her father's property card. On the following day, the Director of Healthcare spoke to the nurse on Ward 4 at the other hospital who had discharged him. The nurse confirmed that no property was left there. She again checked all areas within the prison and spoke with the Dedicated Search Team who had completed the clearance of his cell. She also contacted the Detective Inspector to check if the police had retained any of his property.

89. In her written response to the concerns raised by the family the Deputy Safer Prisons Co-ordinator wrote that in March 2009:

“Safer Custody Team have contacted HM Coroners Office to establish if they have a notebook or any property belonging to the man. They have confirmed they have only what we copied and provided them. They confirm they do not have a notebook.”

90. My investigator tried to find a resolution to these concerns. The property noted in the man’s records has been returned but the family do not accept that this was all of his belongings. Unfortunately, I do not know how to resolve this situation with regard to his alleged missing property. I am frankly puzzled that a front page of notebook was located and copied to the family but that the rest of the notebook cannot be located. This is a regrettable situation as the contents of the notebook allegedly contained his personal thoughts which are now lost. I commend staff for allowing the man to pack his own bag when he left hospital for the last time, but unfortunately we will never know if the rest of the notebook was lost at this point or at an earlier or later juncture. I regret that my investigator was unable to resolve this issue satisfactorily.

Aftercare

91. The family has praised the two prison officers who were on bedwatch duty with the man at the hospital. They described them as ‘brilliant’. The family confirmed that Manchester had arranged and paid for the funeral and service.

CONCLUSION

92. The man arrived in HMP Manchester in August 2008 with a history of health problems. He died of natural causes three months later.
93. From the bedwatch log, it was clear to my investigator that the staff involved with the man's care behaved with compassion and sensitivity. The security arrangements at the hospital were in line with current policy and expectations.
94. In light of the clinical review, I judge that the man's care was not equivalent to what he would have received in the wider community. The findings of the clinical review and my own investigation highlight that there is a need for some improvements to healthcare practices at HMP Manchester.

RECOMMENDATIONS

1. The Director of Healthcare should review the Secondary Screening Process. The process should occur wherever the prisoner is located and whatever pathway he is following.

Recommendation accepted: An audit calendar will be initiated to ensure that the secondary screen process is adhered to.

2. The Director of Healthcare should identify a member of the nursing staff to take a lead role for end of life and palliative care and to establish and maintain a wider engagement with local palliative care networks.

Recommendation accepted: A lead nurse will be appointed to palliative care and networks will be established

3. The Director of Healthcare should ensure that members of the nursing staff attend pain management workshops, as well as training to address holistic assessment and communication skills in palliative care.

Recommendation partially accepted: A lead nurse will be appointed to undertake necessary qualifications in pain management and will be the lead on this for the other staff.

4. The Primary Care Trust should develop a 24 hour help line for palliative care issues as described in the NICE Guidance; Improving Supportive and Palliative Care for Adults with Cancer which includes the Prison Service.

This is for the Primary Care Trust to comment on.

5. The Director of Healthcare should ensure that the nursing staff are aware of reflective practice.

Recommendation accepted: Staff will be reminded of the benefits of reflective practice.

6. The Director of Healthcare should review and ensure that HMP Manchester's palliative care policy takes into account the principles outlined in the End of Life Strategy (DOH, July 2008).

Recommendation accepted: The Palliative Care policy will be reviewed to ensure the principles are recognised.