Investigation into the death of a man at Hope Hospital in October 2010 whilst in the custody of HMP Manchester

Report by the Prisons and Probation Ombudsman for England and Wales

March 2011

The man died at Hope Hospital, Salford, in October 2010, whilst in the custody of HMP Manchester. He was diagnosed with cancer before coming back into prison in 2008 but his death is suspected to have been caused by a stroke. He was 71 years old. My investigation concentrates on the months since January 2010 which is when the symptoms of secondary cancer first appeared.

He was estranged from his family. I offer them my sympathies and trust that my report answers any questions they may have.

I have conducted this investigation myself and my colleagues have provided invaluable practical assistance.

The Governor and his staff have helped my investigation proceed smoothly and I have been impressed by their compassion for the prisoners they are responsible for.

North Manchester Primary Care Trust appointed the clinical reviewer to review the man's clinical care whilst he was in prison. We have worked closely together and I am grateful for her assistance and her timely review.

There is much about the man's treatment which was thoughtful and individualised. I agree with the clinical reviewer that his care equalled what he could have expected to receive in the community. However, I consider two issues further. Most importantly I regret that the restraints were only removed ten minutes before the man died. He was only in hospital for a few hours but, in that short time, I believe that at least two opportunities were missed to take the escort chain away and give the man greater dignity in his last moments. I also consider the important role of the staff who escort prisoners to hospital appointments, especially when prisoners are told that they are terminally ill, and make a recommendation regarding their training and support.

The 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.

Jane Webb
Acting Prisons and Probation Ombudsman **March 2011**

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SUMMARY

The man was already diagnosed with skin cancer when he was recalled to HMP Manchester in August 2008. He was convicted of sex offences and was estranged from his family. The prison is part of the High Security estate and holds Category A prisoners as well as others. He was not in the highest security category.

Regular hospital appointments took place and eventually the man was diagnosed with secondary cancer of the lungs. Chemotherapy treatment proved ineffective and the man knew that his condition was terminal. Nevertheless he remained fit and active, continuing to live on the wing and work in the laundry until about a month before he died.

His health deteriorated in September 2010 and he was admitted to hospital as well as having palliative radiotherapy treatment. (Palliative treatment ensures that the patient is comfortable and without pain but does not remove the underlying cause of the symptoms.) He moved reluctantly to healthcare and, as late as 4 October, still hoped to go back to the wing when a place became available.

His death was sudden and largely unexpected. The man had what I believe was a catastrophic stroke in the early hours of 15 October. He was taken to a specialist stroke unit at 1.25am and died five hours later. Restraints were in place when the man left the prison and he was accompanied by two escort officers. Hospital staff telephoned the prison nurse twice to ask for information about the man and his next of kin. They did not ask for the restraints to be removed and they remained in place until ten minutes before his death. I suggest that the initiative to remove the restraints should have been taken, which could have given him more dignity at the end of his life.

THE INVESTIGATION PROCESS

1. I opened the investigation on Monday 18 October, three days after the man died. I met the Governor and toured E wing (where the man served most of his sentence) and the healthcare centre where he spent the last two weeks of his life until he was taken to hospital. In the course of my visit I spoke informally to prisoners on the wing, including a Listener who is trained by the Samaritans to give confidential support. I also spoke to wing staff who knew the man and the nurse who was on duty on 13 October.

2. I sent Notices announcing the investigation to the Governor. They invited any prisoners and staff to contact the investigator if they had information about the man. The Notices were published in the prison but no one responded to the invitation to contact the investigator.

3. The safer prisons deputy coordinator and her colleague efficiently provided copies of the man's records including a copy of his medical records for the clinical reviewer.

4. NHS Manchester (National Health Service Manchester) commissioned the clinical reviewer and we returned to the prison on 9 and 19 November to interview staff. Together we spoke to:

    - The offender supervisor
    - Officer Support Grade escort and bedwatch officer
    - The man's personal officer
    - The lead older prisoners nurse
    - The workshop instructor
    - The chaplain and prison family liaison officer
    - Hotel I (emergency cover on 14/15 October)

5. The night duty manager on 14/15 October, was interviewed on the telephone. The notes and transcripts of the interviews are annexed to my report.

6. One of my family liaison officers wrote to the man's daughter to tell her about my investigation and invite her to ask any questions for me to consider. The family were estranged and have not replied to the letter.

7. Her Majesty's Coroner knows about my investigation and a copy of this report will be sent to assist his enquiries. The coroner has been asked to provide a copy of the post mortem report. The report is not yet available and so the cause of the man's death remains unconfirmed.

HMP MANCHESTER

7. HMP Manchester is part of the National Offender Management Service (NOMS) high security estate as well as being a local prison. It is a complex prison for those remanded by the courts, prisoners convicted of serious offences and those serving a life sentence. The maximum prison capacity is 1,269 men.

8. One wing, E wing, accommodates prisoners who are identified as vulnerable, often because of the nature of their offences. This is the wing where the man served most of his sentence. The vulnerable prisoners make up the workforce in the prison laundry, where the man worked until a month before his death.

Healthcare

9. Healthcare at Manchester is provided by Manchester Primary Care Trust. The inpatient unit, where the man spent most of the last weeks of his life, provides 24 hour nursing care for up to 20 patients. A cell for prisoners with disabilities is being developed and it was anticipated that the man would move there if his illness had run its course.

10. Following a recommendation arising in a previous death in custody, the Primary Care Trust appointed a lead nurse for prisoners who are over 55 years of age. This is a part time role which enables the lead nurse to assess each prisoner as they reach that age and refer them to specialist services as required. The lead nurse explained that she is well known on the wings and prisoners and staff alike refer people to her. The healthcare unit runs a clinic for older prisoners which monitors and advises on their health problems.

11. One of the nurses is responsible for responding to healthcare emergencies at night. The nurse is referred to by their radio call sign of Hotel 1.

Use of restraints

12. Each time that a prisoner is escorted outside the prison to hospital, a risk assessment considers the risk to the public, potential for escape and likelihood of outside assistance. The assessment informs the decision about the number of escorting officers and the type of restraint to be used (single cuffs or two metre long escort chain with a cuff at either end). It also determines the circumstances and the authority required for the restraints to be removed. The risk assessment should be reviewed each day that a prisoner is in hospital and amended where necessary.

13. The policy for removing restraints from prisoners in hospital is set out in the prison's local policy. The policy says that:

"When a healthcare professional seeks the unplanned removal of restraints for health reasons, the escorting staff are directed to:

- "Tell the healthcare staff that restraints will remain in place

- Immediately contact the Duty Governor."

The policy does not suggest that anyone other than hospital staff might seek the removal of restraints. It continues by saying that the duty governor will decide on one of the following courses of action:

- "Removal of restraints
- Retention of restraints
- Delay treatment until alternative security measures can be put in place."

The safeguards for high security prisoners, which did not include the man, are more stringent.

14. The prison's security manager explained that a governor is on duty each night as the night duty manager. The manager, who is referred to by their radio call sign of Victor 2, is responsible for sending prisoners to hospital when they require treatment. The night duty manager can authorise the lowest level of restraint, that is the escort chain and a two officer escort, but anything less can only be approved by the duty governor (Victor 1) who is on call and contactable by telephone.

15. Each risk assessment includes a healthcare contribution. Hotel 1, who contributed to the assessment when the man went to hospital for the last time, told the investigators that she often carries out this task. She described it as a "paper exercise" and said that she would not normally see the prisoner in the course of her assessment.

16. One of the prison managers is required to visit during each day that a prisoner is in hospital. The purpose of the management check is to establish that the risk assessment is up to date and the appropriate restraints are in place, as well as seeing the prisoner and the bedwatch staff. The man was only in hospital for a few hours and so no management checks had taken place.

17. Manchester has appointed a group of staff to carry out escort and bedwatch duties. They are known as the Externals group. Although support is available after a prisoner dies, and staff can approach their care team regarding any of their work, no particular preparation or support is offered regarding other duties such as escorting prisoners when they are told that they are terminally ill.

The prison's performance

18. The Independent Monitoring Board[1] (IMB) Annual Report for the period 1 March 2008 to 28 February 2010 raises a variety of concerns. They include a number of healthcare appointments that were cancelled because of a lack of prison escort staff. I am pleased to say that this did not apply to the man.

[1] The Independent Monitoring Board comprises volunteers from the community. They monitor daily life in prison to ensure that decency is maintained, deal with prisoners' complaints and submit an annual report to the Secretary of State for Justice.

The role of a specialist nurse for older prisoners was put in place last year and has been welcomed by the IMB. Concerns were also raised regarding difficulties accessing healthcare for older prisoners and those with poor mobility. Again, neither seems to apply to the man.

19. The most recent report published by HM Inspectorate of Prisons noted that there was evidence of strong support from the Primary Care Trust. This was seen through an improvement to services and greater access to a range of prison and specialist clinics. Pharmacy and dental services were judged to have improved and there was efficient management of external appointments to clinical services.

Previous deaths in custody

20. The man's death is one of 30 to have occurred at Manchester since April 2004, when my office began investigating all deaths in prison custody in England and Wales. Eleven of the previous deaths were due to natural causes. Where there are similarities with earlier findings, I am pleased to note that the recommendations have been addressed.

KEY EVENTS

21. The man was born on in April 1939. He lived in Merseyside, where his family remained. He was convicted of serious offences including sexual offences, use of firearms, property, theft and against the police. The victims of his offences were relatives and the man had been estranged from his family for many years. His sentence began in 2002 and was served at HMP Manchester. He named his daughter as his next of kin when he came into prison on that occasion. The man's medical history at this point included asthma, varicose ulcers, abnormal heart rhythm (atrial fibrillation) and hypertension.

22. The man was released on licence on 16 June 2006 to live at a Greater Manchester probation approved premises. The conditions of his licence included being supervised by a probation officer, living in the approved premises and complying with its rules. Whilst he was on licence, he was referred to Wythenshawe Hospital for investigation of a skin lesion. The treatment resulted in his right thumb being amputated and lymph glands (left axillary glands) removed. He was diagnosed with malignant melanoma, which is the most serious type of skin cancer. It was a grade four cancer, meaning that the cancer cells tend to be fast growing and spread quickly.

23. In August 2008, the man was arrested for breach of licence and returned to Manchester prison the following day, 16 August. His records indicate that he did not name a next of kin this time.

24. The man's personal officer first met him when he was recalled to prison. She was the personal officer for six prisoners, including the man, on E wing and described her role as being "responsible for their wellbeing and dealing with any concerns". The man's personal officer described the man as a cooperative prisoner, who worked hard and had no adjudications on his record. He was assessed as standard, rather than enhanced, level on the Incentives and Earned Privileges (IEP) scheme because he continued to refuse to undertake sex offenders' treatment programmes (designed to reduce their offending behaviour). The IEP scheme aims to encourage good behaviour from prisoners by giving additional privileges to those on the enhanced level. The man's personal officer said that he "kept himself to himself", was not a problem and rarely came to the attention of staff.

25. The routine secondary healthscreen took place on 20 August when it was noted that the man had skin cancer and secondary cancer of the lungs.

26. The lead nurse for older prisoners knew the man from the start of this period in custody. She saw him regularly and he was also monitored at the asthma clinic. His medication included anti coagulants to prevent blood clots forming. Blood tests were carried out regularly to check that his blood was clotting properly. The lead nurse knew about the malignancy to his hand, which had led to the removal of his thumb before he was recalled.

27. The lead nurse for older prisoners described the man as a “big” personality who was popular with prisoners and staff. He worked throughout his sentence and, for most people, she said that his frequent nosebleeds were the only visible sign of poor health.

28. The workshop instructor in the prison laundry, met the man when he was first in prison. He was respectful and a hard worker who got on well with the other prisoners (also VPs). The instructor said that the man returned to work as before and seemed exactly the same as when he was last in the prison.

29. An extra 280 days was added to the man’s sentence on 9 September and he would have been due for release on 16 June 2012.

30. The man was referred to Christie’s Hospital, a specialist cancer hospital, and went to his first outpatient appointment in October 2008. The officer who escorted the man to hospital was one of a group of staff, known as the “Externals”, who regularly undertake escort and bedwatch duties. The escort officer described the man as a jovial man who liked to involve himself in other people’s conversations.

31. Another wing officer said that the man was a “larger than life” character. She said that he was a big man, although he lost a lot of weight in the last months of his life. He “kept his pain to himself” and did not talk about it. The wing officer also said that he was “cantankerous” and so he had several cellmates over the years.

32. The older prisoners’ nurse continued to monitor the man’s treatment and he attended hospital outpatient’s appointments. On 25 January 2010, the man was referred to Wythenshawe Hospital under the National Health Service two week rule for people suspected of having cancer because of a lump in his right armpit. The appointment took place on 19 February, which is more than two weeks later. As far as I can tell, the delay was not caused by the prison. A scan and removal of the lump were arranged for 9 March.

33. The man used the prison’s complaint procedure on 24 February as he did not want to share a cell with a smoker. Prisoners are not permitted to smoke in communal areas of the prison. However, for the purposes of the smoking legislation, cells are regarded as the prisoner’s home and smoking is allowed within. He was told that:

> “… due to operational reasons you are in with this prisoner however you will be moved as soon as possible with a non smoker.”

34. I understand that smokers and non smokers are placed together as a “last resort” when population pressures are high. I am told that the prisoners are moved immediately a space becomes available “as was the case with the man”. Although I make no recommendations about the man’s complaint, it seems reasonable to me that a prisoner with his diagnosis should not have been expected to share a cell with a smoker. I trust that the Governor will

consider my remarks and assess whether they have implications for other prisoners.

35. The man went to the University Hospital of South Manchester where the doctors found a significant tumour on the right side of his chest which was consistent with melanoma. He also had an abnormality in his left lung suspected to be a secondary cancer. The man was admitted to hospital so that the axillary nodes could be removed. On 11 March, the prison doctor received confirmation that the lump was a secondary cancer arising from the malignant melanoma. The doctor informed the Externals group that the man was a high priority for going to outpatients appointments.

36. Later in the month, on 26 March, the lead older prisoners nurse assessed the man together with a prison doctor. They wanted to find out how much the man knew about his diagnosis and prognosis, and whether he needed more care. The lead nurse said that he knew that he had cancer and spoke about disposing of his belongings. For example he had a motability scooter at his home, and considered whether to donate the proceeds to charity. She described him as being reconciled to having no contact with his family. The man had another appointment with the prison doctor three days later when the diagnosis was explained to him again.

37. The man was referred to Christie's Hospital for treatment and went to the first appointment on 29 April. He was to have six cycles of Dacarbazine chemotherapy to treat his cancer, beginning on 10 May. The prison doctor spoke to the doctor at Christies on 4 May. They arranged for healthcare to carry out routine blood tests before each treatment and this could be done without him being admitted to healthcare. His temperature was to be monitored after each chemotherapy session.

38. An officer took over as the man's offender supervisor in April 2010. As the man was assessed as high risk of re-offending, the officer had regular one to one meetings with him. He also saw the man regularly each working day when he was en route to the laundry. The purpose of their meetings was to motivate the man to take part in offending behaviour programmes and address the requirements of his sentence plan. In the main the man refused to enrol on the programmes and, when he eventually agreed, the offender supervisor decided that it was not compatible with his forthcoming chemotherapy sessions.

39. The lead reviewed the man's condition on 13 April although she said that he grumbled about staying off work to keep the appointment. He knew that he was going to have palliative radiotherapy and that it would not cure his condition. The lead nurse said that the man did not complain of pain and "never made a fuss about anything".

40. On 28 April, the man went back to Christie's Hospital where he was assessed by a specialist oncologist (who treats people with cancer). The doctor commented that the man knew that his cancer was not curable. The

response to the chemotherapy was between ten and 20 percent with an estimated survival rate of nine months.

41. The first cycle of chemotherapy took place on 10 May at Christie's Hospital and two more were planned. He was monitored by the prison nurses for any signs of infection and any adverse reactions to the treatment. The only side effect noted was that he experienced fatigue.

42. The man continued to work in the laundry even though he was of pensionable age and was not obliged to work. The offender supervisor explained that the man felt that he was "better kept occupied" and healthcare noted that "he wishes to carry on working as long as he is able to".

43. On 4 June, the man fell in the laundry. A nurse went to see him on the wing and dressed a wound on his shin. He went to the clinic the next day for the wound to be checked. The lead nurse saw him and also asked how he was coping with the chemotherapy. The man said that he was tired and became short of breath on exertion but still wanted to continue working. His leg was dressed again on 6 June and a doctor's appointment made for the next day as his legs were becoming swollen.

44. The second outpatient chemotherapy appointment took place on 9 June. It had originally been booked for 7 June but the wrong appointment was given by the hospital (the only time that the man's appointments seem to have been missed). He was described as "coping well with treatment".

45. The man's wound became infected and so antibiotics were prescribed on 11 June.

46. Although the man coped well with the chemotherapy, the man's personal officer said that healthcare recommended that he should be allocated a cell to himself. The cell sharing risk assessment tool was used as a mechanism for arranging this cell. He had been in the same, double, cell for a long time and so staff arranged for his cellmate to move out so that the man could have it to himself. The officer said that healthcare staff had advised that this was the best course of action at the time as the treatment could effect his immune system.

47. On 20 July, the chemotherapy session was cancelled due to the "aggressive nature of the disease". The hospital consultant wrote that no more cancer treatments would be given as the man "has not benefited from the three cycles of chemotherapy" and the tumour had increased in size. The consultant was considering palliative radiotherapy and referred the man for an assessment. His prognosis was less than a year, which he was aware of. The consultant recommended a liquid diet because the man had difficulty swallowing.

48. The escort officer told the investigator that the man seemed to take the news in his stride and appeared unconcerned about his prognosis. He did not

mention any pain and the only sign which the officer noticed that something was wrong was that he lost a lot of weight.

49. The man's personal officer said that the man "never used his illness to gain anything" but "just got on with it". He told the wing staff that the treatment had not been successful and the officer said that she admired his ability to cope. He continued to go to work, which was down two flights of stairs and across the prison, and his mobility was fine. She said that he never complained or asked for help from staff or prisoners. For example he continued to collect his own meals even though they could have been brought to him. The officer noticed that the man had lost weight but she thought that he ate the regular meals and had no difficulty with the menus.

50. The man saw a locum prison doctor the next day, 21 July, because of his difficulty swallowing. He was advised to eat a soft diet and arrangements were made for him to be weighed once a fortnight. The records show that the man was weighed as planned and slowly lost weight. He talked to the lead nurse on 23 July about his health problems and she said that he was in good spirits. However, he was surprised that the chemotherapy had not been effective as he felt well.

51. The workshop instructor said that the man had shown no signs of poor health but he started going for treatment in the summer and told him that it was not successful. He described the man as a conscientious worker who liked to work overtime at the weekends. Prisoners were required to put in a full week's work in order to be entitled to overtime, which is why the workshop instructor thought that the man spoke about his illness. He had missed work in order to go to appointments but wanted to work at the weekends.

52. The instructor said that he could see that the man was tired but said that he "didn't seem bothered" about his prognosis. He showed no other symptoms, other than nose bleeds, and did not complain of pain. The instructor would recommend that he should take the afternoon off to rest and provided a chair in the laundry for him to sit on.

53. The offender supervisor had his last offender supervisor meeting with the man in August, which was before the radiotherapy began. He described the man's health as "okay". They discussed his prognosis and the man knew that he had less than a year to live. He hoped to be released on compassionate grounds to a hospice. The officer said that the man was a chatty and amenable prisoner who never referred to being in pain. He was philosophical about his prognosis and told the offender supervisor that he "had had a good innings".

54. The hospital decided that the man should have four palliative radiotherapy treatments and the appointments took place as planned at Christie's Hospital. He saw the prison doctor on 26 August as he was suffering from constant nose bleeds. The same day he went to the older prisoner's support group. As usual he interacted well and was described as in good spirits. The man

openly discussed his health problems and was said to have a very positive attitude.

55. The lead nurse saw the man again on 27 August. He told her that he felt reasonably well and wanted to continue working. He agreed that the lead nurse should refer him to the Macmillan nurses. The lead nurse described the man as "up beat" and "hoping for early release" from prison. As he did not have any contact with his family, the lead nurse established that he had friends on the wing and was also in touch with the chaplain.

56. A second prison doctor saw the man the same day and advised him how to deal with his nose bleeds instead of blocking it with paper. He was weighed again and had lost more weight.

57. Another prisoner, trained by the Samaritans as a Listener, told the investigator that the man was comfortable and well supported by wing and healthcare staff.

58. In response to the difficulty swallowing, the lead nurse referred the man to two community Macmillan nurses speech and language therapist. A visit was arranged because the man had told the lead nurse that his throat was sore and he had lost weight.

59. The speech Macmillan nurse visited on 17 September and commented that the man appeared to be "coping with his diagnosis". His only concern was getting parole which the nurse "could do nothing about". He had some pain which was to be alleviated by a low dose of paracetamol. He told the nurse that he had been having heavy nose bleeds for the last week and had unexplained bruising in his left rib area. The nurse assessed that he had "no specialist palliative care needs" at this point and she would see him again if his needs changed.

60. The speech therapist, visited at the same time. She noted that the man reported that "difficult food textures stick in his throat and make him choke". He told her that his appetite was good but that he missed meals because he was unable to swallow them. The speech therapist recommended that his drinks should be thickened to make it easier to swallow and he should have a soft, moist diet. No follow up was planned unless the man needed more advice.

61. The man's personal officer explained that the man was offered a place in healthcare but he preferred to remain in the wing, saying that he would only move when he felt it was necessary. Although a soft diet was suggested, she said that the man preferred to order food which he could eat from the normal menu, rather than having any special food.

62. The radiotherapy treatments took place as planned and, afterwards on 23 September, the man had an appointment with the first prison doctor as his skin was painful. The doctor prescribed an antibiotic cream to treat the condition.

63. At 2.17pm during the afternoon on 27 September, E wing staff called healthcare to the man as he had pain in his lower back. He was permitted to keep paracetamol in his possession and taking a dose had eased the pain.

64. The nurses were called back at 4.48pm as the man had chest and back pain. An electrocardiogram (to measure the heart activity) was taken which indicated an abnormal heart rhythm. Healthcare staff consulted the local accident and emergency department who checked the ECG results. The hospital doctor advised that admission was not necessary and that the man should see the prison doctor in the morning. The prison doctor increased the man's pain relief medication.

65. The man experienced blurred vision and fell again on 28 September. The second prison doctor first admitted him to healthcare and later decided that he was too poorly to stay there. The doctor sent him to accident and emergency at North Manchester Hospital. The man had had one or two blackouts during the day and the doctor described him as pale, with a thready pulse (which can indicate a blood or heart problem) and wondered if he was anaemic. Double handcuffs were in place but they could be removed whilst he was being treated. Two officers escorted him to the hospital and he was admitted as an inpatient.

66. After four days in hospital, the man returned to the prison on 1 October. He was diagnosed with hypertension, a rapid heart beat (tachycardia) and anaemia. He was given a blood transfusion and his nose was cauterised to stop the bleeding. The prescription for warfarin was stopped and fragmin (which stops the blood from clotting) was prescribed unless his nose bleeds recurred. In fact the bleeds did recur and so the fragmin was stopped.

67. Instead of returning to E wing, the man was admitted as an inpatient in healthcare so that his pain control could be stabilised. He was said to prefer his own company and expected to return to E wing when a place became available. The lead nurse confirmed that he was independently mobile and able to look after himself. The nursing care plan described him as lucid with all his faculties. His medication was administered by one of the nurses and he was prescribed:

- omeprazole to prevent acid building up in the stomach
- co-codamol to relieve mild to moderate pain
- lactulose which is a laxative
- digoxin to treat atrial fibrillation
- ferrous sulphate for iron deficiency anaemia
- dalteparin sodium injection, which is also known as fragmin and is an anti coagulant
- cetirizine hydrochloride tablets, an anti histamine used to treat skin conditions.

The comment about the man's pain levels was that, if needed, they would be controlled by medication. He was described as "not unduly concerned or

afraid" about his prognosis. The lead nurse said that he did not want to stay in healthcare and was keen to return to the wing.

68. The man's condition improved and, on 4 October, he was described as feeling well. He still wanted to return to E wing but the doctor decided that this should be postponed whilst he was still having nose bleeds. The bleeds had stopped by 6 October but no places were available on the wing. The prescription for fragmin was restarted on 12 October.

69. During the early hours of the morning on 13 October, the nurse who was Hotel 1, which meant that she was responsible for responding to any medical emergencies. Hotel 1 was called to see the man who had complained of back pain and breathlessness. She had not met him before although she knew that he had skin cancer and had completed the risk assessments so that he could go to out patient appointments. She said that he was breathless, with chest and back pain, and she thought that he had an abnormal heart rhythm. The Hotel 1 administered oxygen and gave an electrocardiogram which confirmed her suspicions. She telephoned the accident and emergency department to ask for advice and was told to monitor any change in his condition.

70. Hotel 1 returned to assess the man at 6.00am and found that he had deteriorated. His blood pressure had fallen, his pulse was very slow and he was grey and clammy. The nurse suspected that he had had a heart attack and called for an emergency ambulance straightaway.

71. The ambulance arrived 35 minutes after the Hotel 1's request, which she described as unusually slow. In her experience an emergency ambulance usually arrives, including going through the security gates, ten or 15 minutes after it is called.

72. The man was admitted to North Manchester General Hospital. He was examined, an ECG and blood tests were taken. The cause of his collapse was unclear but it was not thought to be due to a heart condition.

73. The man improved and returned to the prison later on 13 October where he was admitted back into healthcare. The only change to his prescription was co-codamol and healthcare were asked to carry out an ECG over a 24 hour period. The nurse who was on duty said that she was satisfied that he was fit to return to the prison. She said that the man was matter of fact about his diagnosis and they discussed possible pain relief. Extra pillows were provided and he was allocated a single room near to the nurses' office.

74. Also on 13 October, the offender supervisor was in contact with the Parole Board regarding plans for an oral hearing for the man's parole application. Previous Board hearings had not recommended that he should be released because he had not completed any offending behaviour programmes. The offender supervisor told the investigator that he expected that the next hearing would have considered whether moving to a hospice was appropriate.

75. The nurse who was on duty again on 14 October went to see the man to find out how he was. She was surprised that he had returned to the prison but he told her that he was “feeling okay”.

The night of 14 and 15 October

76. The man was described as very tired and complaining of pain and a headache. At 11.41am, he got out of bed to turn the television off and fell to the floor. The nurse who was Hotel 1 and she was contacted by another nurse at 11.45am who asked her to assess him. The nurse who was Hotel 1 asked the night duty manager, to attend so that she could go into the cell and examine the man. (Cells are locked during the night and may only be unlocked with the permission of the night duty manager. Usually additional security is provided by the presence of a prison dog and handler.) The night duty manager asked for a prison dog to attend, which is the routine practice when going into cells at night time at Manchester. The dog handler arrived with the dog five minutes later, and they went into the cell.

77. The nurse who was Hotel 1 said that the man was sitting with his back against the wall. He had become dizzy and slid down the wall to the floor. She said that he was a large man with a long standing knee problem which meant that it took three staff to help him to his feet. He walked independently to the bed and all four of his limbs were working normally. He complained of a headache and the nurse who was Hotel 1 knew that he had taken co-codamol, which she said can cause headaches. She saw no visible injuries and he did not complain of any other problems. The staff helped the man back into bed and the cell was locked. The nurse who was Hotel 1 went to the office to complete the necessary paperwork.

78. At 12.30am, after completing the record of injury forms, the nurse who was Hotel 1 left the office to go downstairs, passing the man’s cell on the way. She looked through the observation flap and noticed that he was sitting on the bed. She said that he was clammy and she could not understand what he was saying. She asked the night duty officer to return, which he did quickly, and they did not wait for a dog before going back into the cell.

79. The man’s mouth was drooping and his speech was slurred. The nurse said that he could not move his left arm or leg and his sight went on the left side, but he could follow a simple instruction such as to smile. The nurse carried out clinical observations and his oxygen levels were low, but other results were “not unusual for him”. She asked for an ambulance which arrived at 12.55am, which she described as a quick response.

80. The paramedics thought that the man had had a cerebrovascular accident, meaning a stroke, and decided to take him to Salford Royal Hospital which has specialist facilities for stroke patients. The nurse said that the man could not walk and the staff lifted him on to the trolley. She did not complete an assessment for the level of restraints and told the investigator that “personally she wouldn’t have put restraints on” as he was very poorly. She prepared a

list of his medication and printed the basic record for the paramedics to take with them.

81. The night duty manager was responsible for signing the risk assessment before the man went to hospital. The risk assessment advised that an escort chain and two officers should be used because of "risk to public and insecure location". The night duty manager told the investigator that he became aware that the man was being sent to outside hospital and he went to see him in the ambulance. He was unwell and his prognosis was unclear. The man had been moved on a trolley in the lift from the healthcare centre and the night duty manager was unsure whether he would otherwise have been independently mobile. The PO confirmed the risk assessment on the grounds that the man was a MAPPA (Multi Agency Public Protection Arrangements) high risk offender which meant that the prison, police and probation services monitored his risk of re-offending. The night duty manager said that the restraints were necessary as the man "was alive", had a limited awareness of his surroundings and "could follow a simple command such as to lift his arm".

82. One of the bedwatch officers and he came to the healthcare centre to accompany the man. He said that the man was on a stretcher and had no mobility. His speech had deteriorated and he could only mumble. The officer thought that the man was not conscious. According to the centre office observation log, the ambulance left the prison at 1.25am.

83. The bedwatch officer accompanied the man into the hospital and the escort chain remained in place. He was checked in the accident and emergency department at 1.40am and the paramedics handed over to the nurses 35 minutes later at 2.15am.

84. The centre office observation log records an update at 2.00am, signed by the night duty manager (although he said that he could not recall it). The times differ and the man's medical record notes the time as 2.14am whilst the nurse who was Hotel 1 who took the call from the hospital, said that it was at 2.35am. The nurse said that she was telephoned by a stroke nurse at the hospital asking for more information and saying that the man's condition had deteriorated. The hospital nurse asked for details of his next of kin, which The nurse took to mean that he was unlikely to survive. She told the night duty manager about the telephone call and he recorded that:

> "Hospital staff asking for details of next of kin – unclear as to whether this is a formality or due to condition of prisoner."

85. In correspondence with the investigator, the night duty manager said that he knew how poorly the man was but he did not amend the level of restraints as he thought that the bedwatch officers were sufficiently experienced to alert him if this was necessary. He said that he was:

> "… also confident that should we reach that point [when death was imminent] then the bedwatch officers would immediately phone the prison to make us aware of the gravity of the situation and I was also

confident that in those conditions permission to remove the restraints would be given."

86. The PO did not think that, by asking for details of the next of kin, the hospital thought that the man's death was imminent which he thought might have been requested for several reasons such as to complete their paperwork. The night duty manager said that:

> "Asking for this information does not automatically suggest that death is imminent. At the same time, I was not, to the best of my knowledge, aware of any significant deterioration in the man's health and so I did not feel that the requesting of this information warranted a new consideration of whether or not to remove restraints."

87. The nurse who was Hotel 1 said that the hospital nurse did not refer to the presence of the restraints and she herself did not know what was in place. She said that hospital staff often ask for restraints to be removed and, had they done so, she would refer the request to the night duty manager.

88. According to the escort log, a hospital doctor examined the man at 2.30am and decided that he should have a scan. He was sent to the x ray department at 3.05am so that the scan could take place. The escorting officer said that, even though he did not seek the permission of his managers, he removed the escort chain whilst the scan was carried out and then replaced it.

89. The scan was completed by 3.25am and the man was taken back to accident and emergency. He was admitted to the acute stroke unit at 4.00am and the escorting officer said that, although not recorded in the bedwatch log, he would have notified the prison as the man was now in another part of the hospital. The officer described the man as comfortable, asleep and snoring. The escorting officer said that he did not think that any treatment was being given to the man and he did not realise how poorly he was.

90. Blood samples were taken at 4.00am and a drip was put in place half an hour later to administer intravenous medication.

91. The nurse who was Hotel 1 took a second call from the hospital at 4.35am, which was noted in the medical record as at 4.40am and recorded in the observation log but without a time. The nurse said that a hospital doctor telephoned on this occasion and asked her for more information. Again no mention was made of the restraints, which remained in place. The nurse reported the telephone call to the night duty manager and, although he said that he has no recollection of it, he wrote in the observation log:

> "… confirming the man is staying at Salford Royal for the foreseeable as he is too poorly to be [taken] to NMGH."

92. The escorting officer said that the man's condition worsened and more blood samples were taken at 5.30am.

93. At 6.10am, the officer said that the doctor told the bedwatch officers that the man was very poorly. The bedwatch log records that the doctor anticipated that he would die within half an hour. The officer telephoned the prison and the officer who had taken over from night duty manager gave permission to remove the restraints.

94. The officer who had escorted the man to hospital told the nurse at 6.30am that he thought that the man had died as the machine monitoring his heart registered zero. A full briefing was given by the night staff who then awaited the doctor. The curtains around his bed were drawn by a nurse ten minutes later.

95. At 7.10am, the man’s death was pronounced by a doctor from the hospital.

96. The man’s daughter was told of his death by the chaplain and family liaison officer, the safer custody deputy coordinator. The chaplain is a Roman Catholic deacon and member of the chaplaincy team. He knew the man in passing from the wing, describing him as polite and ready to talk although he did not raise any pastoral issues. The chaplain was the only family liaison officer on duty that day and so he was asked to visit the family. He said that it was difficult to find any contact details but eventually the daughter was traced and he visited with the family liaison officer. Until they sat down with the man’s daughter, neither member of staff had realised that the nature of her father’s offences. (I make no recommendation in this regard as the chaplain assures me that the lapse is unusual.)

97. Although the family liaison officer contacted the man’s daughter during the following few days, she and her siblings did not want to become involved. The prison arranged the funeral which was led by the Anglican chaplain and attended by the chaplain and the family liaison officer.

ISSUES

98. In many respects my investigation finds that the man received a good level of care which was equivalent, or better, than what he would have expected to receive in the community. As the clinical reviewer says:

> "For the majority of the course of the man's illness, he was self caring and received appropriate, comprehensive and timely care from the prison's healthcare team. He was referred to the appropriate community services for advice on the management of his condition.
>
> "The care the man received from the prison healthcare team was equal to that he would have received in the community. There was nothing more that the prison health team could have done to prevent the man's death. "

99. The man was already diagnosed with a terminal illness when he was recalled to prison and the prison made sure that hospital treatment was properly arranged. I have found that his appointments and treatment were generally conducted to an appropriate standard. He was provided with appropriate pain relief and medication. Healthcare staff, especially the older prisoner's nurse, monitored his health and referred him appropriately to outside agencies for assessment and advice. He was given full information about his condition and treatment and seems to have accepted philosophically when the treatment was deemed to have been unsuccessful. Despite being terminally ill, he managed well during his treatment, remaining independent and avoiding reliance on healthcare staff.

100. As far as his location was concerned, offers of moves to healthcare were made but the man only accepted them in what were to be the last few weeks of his life. He expressed the wish that, in due course, he would be granted compassionate release and move to a hospice. This would eventually have been considered by the Parole Board. However, given that he was in relatively good health until shortly before he died, given the nature of his offences and that he had been recalled after breaching his licence conditions, I am satisfied that it was entirely appropriate for him to stay in prison.

101. From talking to the staff who looked after the man, it is clear that they take their responsibilities seriously and gave high quality, individualised, care. Throughout my contacts with all the staff interviewed for this investigation I was struck by their knowledge of the man and their compassion for his needs. Prison staff have a duty to protect the public and reduce re-offending. I am pleased to see that these responsibilities did not stop them showing insight and compassion. For example, the wing and workshop staff were aware of his diagnosis and were flexible about his attendance at the laundry and, as the clinical reviewer says, "showed compassion when he did not feel a hundred percent".

102. However, there are two aspects of the circumstances of the man's death which do warrant further consideration. The first concerns the use of restraints and the second considers support for escort staff.

Use of restraints

103. As I have explained, the man was taken to hospital in the early hours accompanied by two escort officers and with an escort chain in place. He was already immobile and only able to follow the simplest of instructions such as to smile and to lift his arm. The staff involved give different accounts of the man's condition. Victor 2, the most senior person in the prison that night, said that the simple fact that the man was alive meant that the escort chain was necessary. Hotel 1, as the lead nurse that night, says that she did not contribute to the risk assessment but, with hindsight, does not believe that restraints were necessary. The escort officer thought that the man was already unconscious.

104. I am careful not to use hindsight in my reports. Although Hotel 1 realised how poorly the man was, no one else seems to have done so. Nonetheless he was clearly immobile, barely conscious and, in my view, can hardly have presented a risk to the public even when taken to a public place like a hospital. It is difficult to see why he needed the safeguard of an escort chain as well as two bedwatch officers. This seems to me to be a very cautious view of whether restraints were necessary. The man may well have been in the custody of a high security prison but he was not a Category A prisoner.

105. The chain was removed briefly whilst the man had a scan and then replaced until ten minutes before he died. Although he was very poorly, it seems that his death came as a surprise to every member of staff other than the nurse who was Hotel 1 and dealing with emergencies that night.

106. I know that the National Offender Management Service, like my office, does not think that generally prisoners should die with restraints in place or that they should be removed so close to death. Whilst being in custody and accompanied by bedwatch officers, the added restraint of an escort chain removes the prisoner's dignity as well as being demanding of staff. In the clinical reviewer's words:

> "The man's last hours would have been more dignified if the restraints had been removed when hospital staff identified his very poorly condition."

107. I appreciate that the man was not in hospital for very long and so the daily management check had not been made. I also recognise that, although terminally ill, the man's health had generally been very good until the sudden illness on 14 and 15 October.

108. Nevertheless, I believe that four groups of people or individuals could all have taken the initiative to remove the restraints earlier. The officer carrying out the Victor 2 duties could have questioned why the next of kin details were

required and considered whether restraints were still needed. He could then have contacted the duty governor to ask for permission to remove the chain. The nurse carrying out the Hotel 1 duties could have found out what restraints were in place and, having realised that he was likely to die, could have suggested that Victor 2 arrange for the restraints to be removed. The hospital staff could have asked for the restraints to be removed in the course of either of their telephone conversations with Hotel 1. Finally, had they realised how poorly the man was, I am sure that the bedwatch officers would have asked for permission to remove the restraints.

109. Manchester's policy for using restraints suggests that permission to remove them begins with a request from hospital staff. This is what frequently happens and it is unfortunate that hospital staff did not ask for the restraints to be removed on this occasion. In correspondence with the Governor regarding this matter, the Governor confirms that:

> "In practice it is common that as a person's condition deteriorates for the responsible manager to amend the risk assessment and therefore cuffing arrangements accordingly."

Whilst stating that "It would be very difficult to expect [prison] staff to make judgements based on an assessment of risk arising from a medical condition", the Governor concludes by writing that "… it remains very much a managerial task to assess the risk presented by individuals".

110. I suggest that prison staff and especially those carrying out the duties of Victor 2 and Hotel 1, should ensure that the lowest level of security is used. On this occasion I believe that the opportunity was missed to consider whether the escort chain was necessary. Had Hotel 1 questioned the restraints which were in place and suggested that they were unnecessary, they may well have been removed earlier in the night giving the man more time without the indignity of being chained to the bedwatch officer. I recommend that the prison's policy is amended to clearly state that the lowest level of restraints should always be used and that any member of staff can take the initiative to ensure that this happens. Relying on the hospital staff to take the initiative is not, in my mind, consistent with the prison's duty of care.

The Governor should review the policy to ensure that healthcare and discipline staff take the initiative to reduce the level of restraint to the lowest level and do not rely on hospital staff to ask for restraints to be removed.

Advice and support for escort staff

111. It is not often that my office's investigations include interviews with the prison staff who escort prisoners to their hospital appointments and are present when they are told that they are terminally ill. Indeed my investigation into the man's death did not list the escort officer amongst those to be interviewed. It was a coincidence that the bedwatch officer present when the man died was

the same member of staff who was there when he was told that his treatment had been unsuccessful.

112. My investigations routinely ask bedwatch staff about the support they were offered afterwards and I am pleased that the arrangements are generally satisfactory. In this case the staff interviewed all felt that they were supported by their colleagues and managers.

113. However, unexpectedly meeting the officer with the man when he was told that he was terminally ill, prompts consideration of whether the same support is offered to those staff. The officer concerned had not only been with the man when he was told that he was dying, but had been present when other prisoners were given the same upsetting news. I am confident that the officer conducted himself professionally and offered support to the prisoners concerned.

114. I suggest that escorting a prisoner in these circumstances may well be as demanding as being there when a prisoner dies. In correspondence with the Governor assured me that occupational health, counselling and care team support are available for any member of staff regarding any of their duties. However, I suggest that this is not enough. The staff working in the Externals team (who conduct these duties) have a difficult role and may well witness events which change the course of prisoners' lives. I think that they should be advised of the demanding nature of the role when they are appointed and reminded of the support that is available.

The Governor should ensure that escort staff understand the demanding nature of the role, when prisoners go to out patient appointments and are admitted as inpatients, and remind them of the support that is available.

CONCLUSION

115. Although already diagnosed with malignant skin cancer when he was recalled to prison, the man remained in good health until the last few weeks of his life. He continued to work and to live on the wing until the end of September 2010. Other than one occasion, his hospital appointments and treatments took place as required. Unfortunately the chemotherapy proved unsuccessful and the man was told that his condition was terminal.

116. The man's health deteriorated significantly and unexpectedly during the night of 14 and 15 October. He was taken promptly to hospital and died five hours later. Although the cause of his death is unconfirmed, I understand that it is likely to have been due to a stroke. He was restrained by an escort chain when he went into prison and it was only removed ten minutes before he died.

117. I appreciate that prison discipline and healthcare staff especially in a high security prison like Manchester, have to balance public protection with the needs of an individual. I also recognise that their decisions about the man were made over a short period of time. Nevertheless I criticise their apparent reliance on the hospital to ask for the restraints to be removed. I suggest that the healthcare nurse should have recognised the man's deterioration and, with the officer responsible for the prison, used their initiative to remove the restraints earlier. Removing the restraints would have given the man greater dignity at the end of his life.

RECOMMENDATIONS

1. The Governor should review the policy to ensure that staff take the initiative to reduce the level of restraint to the lowest level and do not rely on hospital staff to ask for restraints to be removed.

   Accepted – Restraints are reduced to the lowest level when the escort is confirmed as a bedwatch, this is already included in the escort risk assessment.
   The removal of restraints for emergency life threatening medical treatment is currently in place.
   Each escort remains very much a managerial task to assess the risk presented by individuals.

2. The Governor should ensure that escort staff understand the demanding nature of the role, when prisoners go to out patient appointments and are admitted as inpatients, and remind them of the support that is available.

   Accepted – All staff undertaking escort duties will be reminded of all the support networks available to them both during and following their duty.