Investigation into the circumstances surrounding the death of a man in November 2009, at hospital, while in the custody of HMP Manchester

Report by the Prisons and Probation Ombudsman for England and Wales

January 2011

This is the report of an investigation into the circumstances of the death of a man at hospital in November 2009, while a prisoner at HMP Manchester. He was 73 years old. He had been diagnosed with a number of chest and heart conditions for which he was treated in prison and community hospitals. His condition deteriorated during 2009 and he was expected to die. Attempts were made to find a place within a nursing home to enable his release on licence. Unfortunately, he died before these arrangements were completed. I would like to offer my sincere condolences to his family and to the staff at Manchester who were involved in his care and were affected by his death.

My colleague conducted the investigation on my behalf. An independent review of the man's medical care was undertaken by a State Registered Nurse and independent death in custody clinical investigator, on behalf of NHS Manchester. She also considered aspects of the man's care that were outside the remit of this office, but were related to the circumstances in which he died. Her contribution to my investigation is invaluable and I am grateful for her report which I will also share with the Director of Manchester Health and Social Care Department.

I would also like to thank the Governor of Manchester and his staff for their cooperation. I am particularly grateful to the Principle Officer who provided a very high standard of prison liaison and to the officer who gave my investigator a large amount of prison documentation in exceptionally good order.

My investigation has highlighted good probation practice by the man's prison offender supervisor. His community offender manager was also instrumental in the efforts to find suitable accommodation for him. I was particularly impressed with their commitment to try to ensure that he did not die in prison. The fact that their hard work did not bear fruit does not in any way diminish the efforts they made on his behalf. A copy of my report will be sent to the Chief Executive of Greater Manchester Probation Trust and I suggest that the prison offender supervisor should be formally commended.

I make three recommendations relating to the need to develop a falls assessment tool and the coordination of the release of prisoners with specialist health needs. My recommendations aside, I judge that the care the man received at Manchester was of a high standard.

I apologise for the delay in issuing this report, and any additional distress this may have caused.

The National Offender Management Service has accepted one recommendation and partially accepted the remaining two recommendations. Their response, together with the family's response is documented on pages 21 to 23 of my report.

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.

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

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SUMMARY

The man was imprisoned in July 2004 and released on licence in 2005. He was recalled to prison following a breach of his licence conditions in December 2006. He was 73 years old when he died from chronic obstructive pulmonary disease (COPD) in November 2009.

He had an extensive clinical record as he had been diagnosed with a variety of chronic conditions. He initially lived on a wing when he first went into prison. However, he was given a permanent place in the inpatient unit of the healthcare department after a series of injuries following falls in his cell and to manage his COPD. He was admitted to hospital in the community on a number of occasions, although he sometimes refused to go to hospital, preferring to remain in the healthcare unit.

As the man's condition worsened, his offender supervisor at Manchester recommended to the Parole Board that he should be released. His offender manager[1], spoke with the Licence Recall Section of the Ministry of Justice regarding his re-release and was told that this would only be considered when suitable accommodation was found. Although finding accommodation for prisoners released into the community is the responsibility of the offender manager, given the complexity of his needs it would have been more appropriate for the healthcare department to take the lead in this instance and I have made a recommendation in this regard. Nevertheless, his offender manager contacted Manchester Health and Social Care Department to ask for their assistance.

The man's condition further deteriorated in November and he was admitted to hospital where he died the following day. Owing to delays in completing medical assessments to secure specialist residential accommodation and finding an appropriate nursing home, he died before he could be released on licence.

I am unable to comment on the actions of Manchester Health and Social Care as this is beyond the Terms of Reference of my investigation. However, the clinical reviewer has found significant shortcomings in the assessment process and selection of the nursing home. I make recommendations to address the prison's input to the assessment process, as well as highlighting the need for a falls assessment tool.

The clinical reviewer has judged that the man received good care while at Manchester and that his death could not have been prevented. However, it is disappointing that his release was not secured before his death. The efforts made by his offender supervisor in acting as liaison between the healthcare unit, Health and Social Care Department and the offender manager are to be commended.

[1] An offender manager works in the community and is responsible for managing offenders made subject to Court Orders and on prison and on prison licence in the community. An offender manager was formally known as a probation officer.

THE INVESTIGATION PROCESS

1. The man died in November 2009. My office was notified of his death at 2.20am on the same day. Terms of reference and notices were issued to staff and prisoners at Manchester telling them that an investigation would be taking place, and inviting those who wished to make themselves known to the investigator. The investigator requested copies of his core, clinical and probation records, and other records relevant to his time in custody and his death.

2. My investigator also contacted HM Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. The Coroner's Officer told the investigator that the man died of :

    1a Infective exacerbation of Chronic obstructive pulmonary disease
    11 Acute renal failure/congestive cardiac failure

3. My investigator visited Manchester in December 2009. She met the Principal Officer, (PO), who acted as the prison's liaison officer, a Senior Officer (SO) of the Prison Officers' Association and a governor. She toured the prison and visited the healthcare inpatient unit where the man lived prior to his death. She spoke with staff who had known and cared for him, his Offender Supervisor and Head of Healthcare.

4. The investigator and the clinical reviewer also visited Manchester Probation Service and spoke with the senior probation officer. She spoke with the man's Offender Manager by telephone during the investigation.

5. A clinical review of the man's clinical care was commissioned from NHS Manchester and undertaken by a clinical reviewer. She focussed on two aspects, the clinical care he received at Manchester and the assessment and decision making processes surrounding the selection of a care home suitable for his complex medical needs. The clinical review was delayed for a considerable period pending discussions between the Coroner and the clinical reviewer. This, in turn, severely delayed publication of this report although I acknowledge that the lateness of the clinical review was beyond her control. Her review appears as an annex to this report.

6. My investigator and one of my family liaison officers visited one of the man's sons who is a serving prisoner. They explained the purpose of the investigation and gave him an opportunity to ask any questions or raise any concerns regarding his father's care in prison. The son remained in contact with his father and was able to visit him in Manchester when his health deteriorated and wrote to the Governor of Manchester about his concerns about the care his father was receiving. He also raised the following issues with the investigator:

    - Was Manchester appropriately equipped to care for his father?

- Why was his father not transferred to outside hospital?
- Why, during his visits, was his father made to walk from healthcare to the visits centre even though his health was failing and his mobility was poor?
- Had his father suffered from dementia towards the end of his life?

I hope the findings of the investigation help the man's family better understand the events leading to his death.

The man's son has made comments in respect of the draft report. His response is documented on pages 22 and 23 of the report.

HMP MANCHESTER

7. HMP Manchester is part of the National Offender Management Service (NOMS) high security estate. It is a complex local prison holding those remanded by the courts, prisoners convicted of serious offences and those serving a life sentence. The maximum prison capacity is 1,269 men. The prison was rebuilt in 1990 following a major disturbance.

8. B1 complex needs unit was due to be opened in February 2010. The purpose of the unit is to help and support prisoners from the segregation unit and healthcare centre to reintegrate onto the main wings.

9. Healthcare at Manchester is provided by the local Primary Care Trust. The inpatient unit provides 24 hour nursing care for up to 20 patients.

10. The Independent Monitoring Board[2] (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. The IMB have noted that there are high number prisoners with severe mental health needs permanently accommodated on the inpatient healthcare unit during the lengthy process of transferring them to mental health units in the community. The role of a specialist nurse for older prisoners was put in place last year and has been welcomed by the IMB. Concerns have also been raised regarding difficulties accessing healthcare for older prisoners and those with poor mobility.

11. 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.

12. The man's death is one of 30 to have occurred at Manchester since April 2004, when this office began investigating all deaths in prison custody in England and Wales. Eleven of the previous deaths were due to natural causes. There are no similarities between the findings of the various investigations.

[2] 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.

KEY FINDINGS

13. The man was convicted of offences at Crown Court on 27 July 2004. He was released on licence to live at an approved premises in October 2005. (Approved premises [formerly known as bail hostels] provide controlled accommodation for offenders under the supervision of the National Offender Management Service. They do not provide care for people with nursing needs.) He breached the conditions of his licence and, following his recall to prison, arrived at HMP Manchester on 22 December 2006.

14. A First Night Assessment and Induction document shows that he did not have any telephone numbers in his possession to contact his family and tell them he was in prison. He went through the induction process and was assessed as not having any immediate medical problems. He was judged to be a "poor coper" with limited literacy skills and resided on the vulnerable prisoner unit.

15. The clinical record shows that the man reported having undergone a heart valve replacement some years before coming into prison. As a result, warfarin (to thin his blood) had been prescribed. His blood was frequently tested to monitor his International Normalised Ratio [3] (INR) to ensure that the warfarin was effective. In interview with the investigator, Prison Doctor A said that the man's warfarin was very difficult to control because of his particular body chemistry. He said that the INR results could be very low for no apparent reason. In an effort to manage this, he said that the man was prescribed a low dose of steroids.

16. The man used a salbutamol inhaler to help with his breathing but, because he had COPD, was also vulnerable to chest infections. Efforts by healthcare staff to encourage him to stop smoking proved fruitless and he continued to smoke against medical advice.

17. The man had a series of falls in his cell. On 19 August 2007, following another fall the day before, he was examined by a prison doctor (unnamed) and referred to a physiotherapist for a mobility assessment. The following day, the physiotherapist assessed him and judged that he needed a walking frame. In the afternoon of the same day, the prison doctor diagnosed him as suffering from spinal sclerosis[4]. This was thought to be the underlying cause of his falls as he had complained of pain and weakness in his right leg. Healthcare staff thought that he would need help with everyday tasks such as making his bed, showering and dressing.

18. The man's community offender manager spoke with the Licence Recall Section of the Ministry of Justice regarding his re-release into the community in May 2008. Release would only be considered when suitable accommodation was found.

[3] The INR is used for monitoring the effects of warfarin.
[4] Spinal sclerosis is considered by many to be a subgroup of motor neurone disease, a slowly progressive degenerative disorder of the motor neurones resulting in widespread weakness.

19. In March 2008, the man complained of increased pain in his legs and in May, he had severe pain in his right side. The clinical record shows that, on a number of occasions, he refused to go to hospital for his chest condition and staff managed his symptoms with medication. An entry in the clinical record on 1 September by Prison Doctor B, says that she diagnosed that he was suffering from cellulitis.[5] She commented that he should keep his legs raised and might need antibiotics.

20. A letter dated 17 December, from a consultant gastroenterologist said that the man was ready for discharge from hospital following an admission, when the hospital noticed that he was anaemic. The consultant said he would arrange for a colonoscopy[6]. The man refused to attend the appointment arranged for 3 February 2009.

21. A probation officer based at Manchester prison, and the man's offender supervisor, had recommended to the Parole Board that he should be released. Owing to the deterioration in his condition, it became clear that he would need to be accommodated in a residential care home rather than an approved premises. The Parole Board directed that the Manchester Health and Social Care Department should be involved, so a referral was made. Funding for the place had been agreed by the Primary Care Trust.

22. In January 2009, the man's offender supervisor asked his offender manager for an update on his release plan. She told the offender supervisor that she had "submitted numerous referrals" to housing associations, housing providers and had made contact with the social services department of the local authority. However, no one was willing to offer him accommodation because of his offending and the level of nursing care that he needed.

23. The offender manager told the investigator that she contacted Manchester Health and Social Care on a number of occasions and again on 15 April. She described them as very unco-operative and she felt she was being "passed from pillar to post". The following day, she spoke with a senior social worker for Adult Health and Social Care.

24. The clinical reviewer said that the man's Health and Social Care referral for assessment for accommodation on his release was not treated as urgent. She has noted that it took the social worker seven weeks to assess him. I refer to this matter in the Issues section of this report.

25. The man's offender supervisor arranged for Nurse A, specialist nurse for older prisoners, to assess his condition and health needs. This was required as evidence of his high health needs and would be submitted to the Health and Social Care Department to ask them to take responsibility for his care.

[5] Cellulitis is an inflammation due to infection in the skin and the soft tissues underneath.
[6] A colonoscopy is an examination of the colon using a camera.

26. The Healthcare Unit Manager and Deputy Healthcare Manager spoke with the offender supervisor on 21 April. He asked if she could speed up the release process as it was very likely that the man would die in prison. He, in turn, agreed to ensure that the assessment she had asked for was carried out. The investigator noted that the offender supervisor attended the healthcare centre the following day to ask for an update on the man's health and collect the report. This was not ready and she received a short email detailing his medical needs the following day.

27. The offender manager and the senior social worker arranged to go to the prison to meet the man on 12 May. Although it was initially thought that he had refused to attend the meeting, it was later established that he had not been well enough to go to the visits room, and so it was postponed until 2 June when he was seen in healthcare.

28. Prison staff allowed the man's cell door to be unlocked during the night after a risk assessment called "predicted unlocking of prisoners in State A" was completed on 13 May. This decision about risk appears to have been reviewed fortnightly and was taken because he suffered from congestive heart failure[7], peripheral vascular disease[8], heart attacks and deep vein thrombosis. He was using oxygen to help his breathing. He suffered chest infections which led to mental confusion and loss of co-ordination. Therefore the cell door was to remain open during the day and overnight with officers on constant supervision outside, to ensure prompt assistance for any medical emergencies or if he fell. Constant supervision was thought unnecessary during the day as staff were passing all the time.

29. The clinical reviewer raised the matter of the number of times that the man fell. She noted that, while he was referred and assessed by a physiotherapist in a timely manner, there is no evidence of a falls assessment by healthcare staff. I address this matter later in this report.

30. A contact log entry dated 4 June shows that following the senior social worker's visit on 2 June, he told the offender supervisor that, in his opinion, the man needed residential care. He completed a community care assessment and asked the nursing staff to complete a nursing needs assessment. The following day, he emailed the offender supervisor and told her that the nursing assessment was incomplete. He emailed again 11 days later to say that he could not proceed until it was completed. Her contact log suggests that she went to the healthcare unit and asked a member of staff to ask Nurse A to complete the nursing assessment. Another email to the offender supervisor on 16 June from the social worker says that he still did not have a contact in the healthcare department who would complete the nursing assessment. She replied that she was trying to contact Nurse A. It was still not completed on 20 June when he again contacted her and said he could not

[7] Congestive heart failure is a condition in which the heart can no longer pump enough blood to the rest of the body

[8] Peripheral vascular disease is a narrowing of blood vessels that restricts blood flow. It mostly occurs in the legs, but is sometimes seen in the arms.

process the application for a home. She agreed to contact healthcare again to try to resolve the issue. In the man's case, she acted as liaison between the healthcare and Health and Social Care departments. It is not clear why healthcare staff did not liaise directly with the Health and Social Care department or why it took so long to complete the assessment.

31. In interview with the investigator, the offender supervisor said that the senior social worker gave the prison details of a nurse at the local hospital who would undertake a further nursing assessment. The assessment was made available to all who needed to see it, including the nursing home.

32. Prison Doctor A wrote to the hospital in August to say that the man had developed ascites[9] and was increasingly short of breath. His stomach was swollen and he had excessive fluid extending from his feet to lower back. The doctor was worried about the fast pace at which the oedema[10] had progressed and how this should be managed.

33. On 10 August, the senior social worker contacted the offender supervisor to say that the man had been offered a place at a nursing home in Cheetham Hill that had agreed to take him on the basis of the nursing assessment. However, he added that the place could be lost if the Parole Board did not grant his release soon. The investigator was told that this was because the nursing home was privately owned and his place would not be reserved if someone else needed it.

34. The offender manager and offender supervisor both contacted the Parole Board to check the progress on the decision regarding the man's release. The Parole Board agreed that they would review his case the following week. The offender supervisor sent an email to the Parole Board which included the opinion of healthcare staff that the man had approximately two months to live. The Parole Board agreed that he could be released on 19 August.

35. The Healthcare Unit Manager told the investigator that, as a courtesy and because there had not been any other contact, he rang the nursing home at 9.00am on the morning that the man was due to be released. The nursing home owner told him that he did not meet their criteria and refused to accept him. He said the owner told him that they did not have oxygen equipment and so the prison offered to loan this to him. The owner still refused saying that he had not completed his own assessment on him. At the prison's insistence, he went to the prison to undertake an assessment the same day.

36. Meanwhile, the Healthcare Unit Manager used the internet to look for information on the nursing home. He saw that the home was inappropriate for the man because it was for individuals with mental health needs. He also noted on the website that the home would undertake an assessment and this had not been done. When he

[9] Ascites is an abnormal accumulation of fluid in the stomach
[10] Oedema is swelling from excessive fluid.

arrived, the owner confirmed to the man that the nursing home was for residents with mental health needs. The offender supervisor's contact log shows that the owner described the behaviour of the residents to the man. Understandably, he decided that he did not wish to go.

37. In interview, the offender supervisor told the investigator that the man was disappointed and that staff who were close to him were saddened for him and found the situation very difficult. A new home had to be found and the process started again.

38. After speaking with the offender supervisor, the offender manager contacted the Parole Board and asked them to revoke the decision to release the man as the accommodation was no longer available. Otherwise, he would have been released, homeless, into the community. The Parole Board agreed to revoke the licence and review the case in one month.

39. The senior social worker told the offender supervisor that he was struggling to find a home that would accept the man. The offender manager and offender supervisor appeared to have explored every avenue, without success, to find suitable accommodation for him. This included contacting Manchester City Council medical team who were unable to help with the level of care he needed. On 1 October, a home was found and another nursing assessment had to be completed. The manager of the home said that she would like to visit the man to undertake her own assessment.

40. His health continued to deteriorate. He continued to suffer from shortness of breath, frequent coughing fits and severe pain in his legs and stomach. He spent most of his time in a chair by his bed which was more comfortable than trying to sleep in his bed. Healthcare staff managed his condition with medication and looked after his personal care needs. An entry in the clinical record by Nurse B on 9 September evidences the man's determination not to go to hospital as he thought that they would be able to do little for him.

41. An entry in the clinical record made by Prison Doctor C on 25 October says that the man refused to go to hospital despite the doctor's explanation that his shortness of breath might get worse. The doctor advised staff to call for an emergency ambulance if the condition deteriorated further.

42. The next day, Prison Doctor A recorded the man's "point blank" refusal to go to hospital. The doctor increased his lisinopril[11] medication for congestive heart failure. He noted that he was also taking supramaximal dose diuretic [12]and spironolactone[13]

[11] Lisinopril is for high blood pressure and congenital heart failure.
[12] Supramaximal means being higher or greater than the usual dose.
[13] Spironolactone is a diuretic used for patients with heart failure.

43. The clinical record shows that Nurse A spoke with the matron of the new home to ask when she would come to the prison to assess the man. The matron told Nurse A that this would not be until 4 November because of staff sickness.

44. The man had difficulty breathing on 1 November. Staff went into his cell as an emergency and gave him oxygen via a face mask. During the following two days, he complained of pain.

45. On 4 November, healthcare staff asked Prison Doctor D, to review the man because they were concerned that his health had deteriorated further. Following a discussion between the doctor and the Healthcare Unit Manager, they decided to transfer him urgently to hospital. The clinical record shows that he initially refused to go to hospital but later withdrew his objection. Later that day, the prison received information on his condition and treatment from the hospital.

46. The security assessment in the bedwatch log shows that restraints, such as handcuffs, were not used because of the man's poor health. (The bedwatch log is a history, recorded by escort officers, of time and events which take place while a prisoner is out of the prison as an inpatient at hospital.) Healthcare and discipline staff discussed contacting next of kin. An entry in the wing observation book at 5.00pm on 4 November says that the governor asked for information about next of kin.

47. Shortly afterwards, the prison contacted the governor of the prison where the man's son was located and told him of the deterioration in his condition. It was agreed that they would try to arrange for him to visit his father in hospital as soon as possible.

48. Senior Officer (SO) A and Officer A were carrying out the escort duty[14] at the hospital. In his statement, the SO said that at 9.45pm, a hospital doctor examined the man. He said that he was gravely ill and would not be resuscitated if he stopped breathing or his heart stopped beating as there would be no chance of survival. However, treatment would continue in the hope that he would improve.

49. SO A said that the man's daughter telephoned from Dublin at 11.00pm, saying that she hoped to visit as soon as possible. At 1.00am, the officers became very concerned as his face was blue. The SO called a nurse, who said that she did not think he was breathing. She left the room and returned with a colleague. At 1.04am, both nurses left the room and confirmed that he had died. The nurse told the officers that she would need a few minutes to verify his death. The SO rang at 1.20am to tell the prison that the man had died.

50. In his statement dated 5 November, the duty governor on 4 November said he came into the prison and assumed responsibility for the contingency plans regarding a death in custody. He spoke with the chaplain at 2.30am. The chaplain agreed to go

[14] a prison escort officer is a an officer designated to accompany a prisoner to hospital. Their role is to ensure the safety and security of the prisoner and the public.

to the prison at 6.30am and said he would contact the prison where the man's son lived. The escort staff went home due to the lateness of the hour. The duty governor identified a problem with contacting the duty care team representative as the control room had no lists and control room staff were not aware of the names of the care team. He said that, despite the fact that the escort staff had gone home, he held an informal hot debrief[15] with control room staff and the night orderly officer.

51. The man's son spoke positively to the investigator and the Family Liaison Officer about the help and support he had received in prison. He was particularly grateful to the lifer manager at his own prison and confirmed that he had received a letter of condolence and payment of the funeral costs from Manchester.

[15] A hot debrief is a meeting for prison staff chaired by a senior member of prison staff. It must be held as soon as possible after every serious incident or death in custody. It is for staff to receive support and to have an opportunity to raise any learning points or good practice that may have occurred during the incident.

ISSUES

Clinical care

55. The clinical reviewer undertook a review of the man's clinical care on behalf of the local Primary Care Trust. Her review is based on prison medical records, interviews with staff, liaison and joint interviewing of staff with my investigator. She concluded that the nursing and clinical care the man received at Manchester was appropriate and timely. Healthcare staff made him as comfortable as possible within the restrictions of a prison. They had an "open door" policy which allowed them to provide immediate care and, when necessary, he was admitted to hospital. She was confident that there was "nothing that healthcare staff could have done to prevent his death". She was, however, critical of Manchester Health and Social Care Department and the events surrounding the man's failure to be released on licence into the community and makes a number of recommendations. She made the point that, had he been in an acute hospital setting, social services would have seen him within two days of receiving the referral in line with the Delayed Discharge Act. I endorse those recommendations which fall within the remit of my Terms of Reference.

56. The man had poor mobility and fell a number of times in his cells on the wing and in healthcare. The clinical reviewer identified that, although he was appropriately referred to a physiotherapist, there was no evidence of a falls assessment tool. The tool is used to assess the reason for the falls and plan ways to reduce the likelihood of them happening again. She makes the following recommendation, which I endorse.

    The Head of Healthcare should liaise with the local Primary Care Trust to develop and introduce a falls assessment tool.

The role of healthcare in the man's release arrangements

57. The man's clinical and physical health needs were very complex. In view of this, I suggest that the responsibility for finding suitable accommodation should have been placed on the prison's healthcare department, with support and advice from the National Offender Management Service. Offender supervisors and offender managers are rarely clinically trained and the role of the prison-based offender supervisor in his case became pivotal. The offender supervisor's liaison between healthcare, Health and Social Care and the offender manager in the community was crucial to driving forward the search for a nursing home for him and achieving the hoped for release from prison.

58. Once it was decided that the man would require residential care on release, a nursing assessment was required to secure a place in a nursing home. The initial assessment was incomplete and, for a period of over two weeks the social worker attempted to arrange for prison nursing staff to complete it. Unfortunately, the

nurses at Manchester had not been trained to undertake such assessments and the clinical reviewer points out that the guidance clearly indicates that training is required to complete this documentation. There is no evidence of how healthcare staff should take the lead in such circumstances in the future.

The Governor and the Head of Healthcare should develop a protocol to enable healthcare staff to work with offender supervisors and offender managers and plan for the release of prisoners with complex health needs.

59. The man's release into the community would have been faster and more effective if the Head of Healthcare had designated a member of the nursing staff as lead with direct responsibility for the clinical aspects of his release into the community from the outset. The clinical lead could have liaised directly with Manchester Health and Social Care in the community regarding the required nursing assessment and kept the offender supervisor informed of events and progress. I believe there was an over reliance by the healthcare department upon the National Offender Management Service to deal with his accommodation issue when the matter, on this occasion, was entirely a clinical concern. The offender supervisor and social worker were not helped by having to remind the healthcare unit on more than one occasion of the importance of completing the nursing assessment which meant that valuable time may well have been lost.

The Head of Healthcare should designate a member of the nursing staff to be responsible for the clinical aspects of the release of a prisoner with specialist health needs requiring residential accommodation. The person identified should be trained to complete a nursing needs assessment and continuing healthcare screening document.

60. The liaison work undertaken by the offender supervisor was extensive and I believe that it exceeded what is normally expected of an offender supervisor. It is regrettable that, in spite of her considerable efforts, his release was not secured before his death.

The Chief Executive of the Greater Manchester Probation Trust should write to the offender supervisor to commend her concerted efforts in attempting to secure the man's release into an appropriate nursing home.

Liaison with Manchester Health and Social Care

61. The clinical reviewer extensively described and commented on the actions and decisions of the Manchester Health and Social Care Department. These matters fall outside of my Terms of Reference and I therefore make no comment on them other than to outline the key issues to provide context for my investigation. I will also arrange for my report to be brought to the attention of the Director of Manchester Health and Social Care Department.

62. In interviews with the investigator, the offender manager and offender supervisor outlined the difficulties persuading Manchester Health and Social Care to take responsibility for the man's care. The social worker diligently reminded the prison nurses of the need for their nursing assessment. However, there was a time lapse of seven weeks between the man's referral on 16 April and the social worker's visit on 3 June. The referral was not treated as urgent and I do not believe that this was equivalent to what the man would have received in the community where the department would have been required to respond within two days. (The clinical reviewer was of the opinion that this could have been extended to five days to allow for the necessary prison security arrangements to be put in place.) The selection of an inappropriate nursing home was also raised by her. The consequence was that this contributed to the man dying in hospital as a prisoner before he could be released.

Contact with the prison care team

63. After the man's death, the duty governor had difficulty contacting a representative of the duty care team. The control room had no lists and control room staff were therefore unaware of the names of the care team. From my other investigations at Manchester, I know that this was unusual and I am sure that the Governor will wish to ensure that there is no repetition. Control room staff should have up to date contact information for members of the duty care team which will ensure that staff involved in serious incidents are given every opportunity to obtain care and support.

CONCLUSION

64. The man had a chronic and progressive illness that was well managed by prison, probation and healthcare staff at HMP Manchester, including an open door policy to enable immediate treatment when it was needed. Greater Manchester Probation Trust made considerable efforts to secure his release to a nursing home. Unfortunately, his release was delayed as the first nursing home was unsuitable and he died before another place was arranged.

65. I make recommendations relating to actions during the final weeks of the man's life. The search for accommodation for a prisoner with extensive health needs who is due for release must be a joint enterprise between the prison healthcare department, who should lead manage the clinical aspects of care and the National Offender Management Service whose role and responsibility should be directed to managing risk.

66. It is outside the remit of my investigation to examine the handling of Manchester Health and Social Care Department's involvement in the procedures for the man's release. However, the clinical reviewer has found that their response was disappointing. It seems that this was a deciding factor in him dying in prison and not in the community where he was entitled to be.

67. My recommendations aside, I judge that the care the man received at Manchester was comparable to, and possibly exceeded, that which he would have received in the community.

RECOMMENDATIONS AND COMMENDATION

1. The Head of Healthcare should liaise with the local Primary Care Trust to develop and introduce a falls assessment tool.

   Accepted. A falls too assessment is currently being developed and it will be introduced once agreed with the local Primary Care Trust.

2. The Governor and the Head of Healthcare must develop a protocol enabling healthcare staff to work with offender supervisors and offender managers and take the clinical lead in planning for the release of determinate sentence prisoners with complex health needs.

   Partially accepted. The Healthcare Centre will take the clinical lead within the establishment and this will be incorporated into the reducing re-offending pathways.

3. The Head of Healthcare should designate a member of the nursing staff to be responsible for the clinical aspects of the release of a prisoner with specialist health needs requiring residential accommodation. The person identified should be trained to complete a nursing needs assessment and continuing healthcare screening document.

   Partially accepted. The Head of Healthcare appreciates that there is a need for their involvement however discussions need to be undertaken as to whether this practice would be acceptable to both social care and health services.

Commendation

5. The Chief Executive of the Greater Manchester Probation Trust should write to the offender supervisor to commend her concerted efforts in attempting to secure the man's release into an appropriate nursing home before his death.

   A copy of the report was sent to the Chief Executive of Greater Manchester Probation Trust.

Paragraph 29

The prison have commented on paragraph 29 of the report that the governor was unaware of a report request at the time because the referral went to Manchester Social Services on 16 April and nursing assessment documentation was not brought into the prison by the social worker until 3 June.

It is fair to say that the governor would be unaware of a report request and there was no expectation on his part that he would have been aware of such a request because this

was a matter that was dealt with by healthcare, social services and with liaison assistance from the seconded probation officer.

Paragraph 33

The prison has commented on the clinical review in respect of the nursing assessment. They are unclear as to why the offender supervisor was involved when the social worker 'had control of the situation'. It is asserted that the nursing assessment brought into the prison by the social worker on 3 June was completed and faxed on 4 June and the clinical record confirms this. However, the assessment was incomplete and there was a gap of 11 days before he contacted the prison to say he could not proceed until it was completed. An email to the offender supervisor on 16 June from the social worker says that he did not have a contact in the healthcare department who would complete the nursing assessment and she contacted healthcare in order to progress the matter. He contacted her again on 20 June to assist as the contact in the prison, because the assessment was still not completed.

The offender supervisor's involvement in the man's release arrangements was because, as his offender supervisor, it was the responsibility of Manchester Probation Trust to find suitable accommodation for him and to keep the Parole Board informed of progress. He was a determinate prisoner who was gravely ill and eligible for release by the Parole Board subject to suitable accommodation being found to suit his needs. It was also because healthcare had made it clear to her that they were concerned that time was extremely short and he was likely to die in prison unless a place was found. Although a clinical matter, healthcare firmly placed the onus upon her, as offender supervisor, to communicate this to the offender supervisor in the community for her information and action. Further, he would be subject to probation supervision while released on conditional licence in the community with an expectation that the offender manager would set the conditions of his licence which would include a condition of residence. Therefore, a sense of urgency (because of his frail state of health and an involvement with healthcare and social services) was essential for the offender supervisor to inform the offender manager so that the appropriate licence conditions were set.

The family's response

One of the man's sons, a serving prisoner, has responded to the draft report. He said he would like to thank his father's prison offender supervisor and also the community offender manager for their hard work and the compassion they showed to his father. He also wished to thank the healthcare staff who looked after his father before he died and he realised that 'they all became very close to him'.

The man's son has commented on the number of falls his father had, counting 11 with approximately 8 in his cell on A wing. He has said that he finds it difficult to understand why his father remained on the wing when he could not cope and he should have been in healthcare. He has found the breakdown in the release arrangements to be a

distressing experience for himself and his father. He has commented at length on the issue and has expressed a negative view on the actions of the care home owner.

The man's son has praised the prison healthcare department and feels that they 'did above and beyond the duty of care for my dad' including thanking the department for offering to supply oxygen equipment to the care home as this is beyond his experience of prisons. He also accepts that his father could be difficult and went against medical advice on occasion.

Concerns about the state of his father's mental health were not made clear as he believed that his father was suffering from dementia and he was told by staff that there were clear signs of this. (The investigation learned that the confusion was caused by chest infections). He agrees with the recommendation that a falls assessment tool should be created.

He has made observations regarding the severe delay in finding his father a suitable placement and has commented negatively upon Manchester Social Services whom he feels did not treat his father with any urgency.

Finally, he expressed his concern that when visiting his father, his father was expected to walk to the visits block despite obvious walking difficulties and shortness of breath. He said it had been upsetting to see his father suffer such unnecessary distress and asked whether more can be done to assist prisoners with health and mobility problems when they need to go to the visits area of the prison.