

**Investigation into the circumstances surrounding the
death of a man, a prisoner at HMP Manchester,
in August 2011 at outside hospital**

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

July 2012

This is a report into the death of a man, a prisoner at HMP Manchester who died at outside hospital in August 2011. He was 66, and died from Merkel cell carcinoma (a form of skin cancer). I offer my condolences to the man's family and friends.

The investigation was conducted by one of my investigators. A clinical review of the man's healthcare was conducted by a clinical reviewer on behalf of NHS Manchester. I apologise that this report has been delayed.

The man was recalled to prison in 2008 after he breached the conditions of a life licence. He had previously been sentenced to life imprisonment in 1966. Shortly after he was recalled, he suffered a heart attack and was diagnosed with myelodysplasia, a condition in which the bone marrow does not produce enough viable blood cells. He received treatment for this condition, but in 2011 he was diagnosed with a malignant skin tumour. Treatment continued but after a short period back at Manchester, he was taken to outside hospital for a blood transfusion. His condition deteriorated while there, and he died a week later.

The clinical reviewer has found that the standard of care provided to the man was of the same standard as that he might have expected in the community. However, I make two recommendations as a result of this investigation. It was not clear whether a referral for him to see a dermatologist was made appropriately, or whether it was not chased when the hospital failed to make an appointment. The first recommendation is aimed to ensure that all such referrals are made and followed up as necessary. I also note that medical staff at Manchester considered arranging blood transfusions in the prison so that he did not have to go to outside hospital. While I appreciate that this is not easy to achieve in the prison environment, it has been arranged in at least one other prison. It would have benefits in terms of patient care and, potentially, cost and I therefore make a recommendation that this is pursued further at Manchester.

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.

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Prisons and Probation Ombudsman

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SUMMARY

1. The man was born in 1946. In 1966, he was given a life sentence for murder. He was released on life licence in 1978, but recalled in 1982 for possession of an offensive weapon, and again in 1985 for robbery. He was next released in 2004, but recalled again in August 2008 for breaching some of his licence conditions.
2. Following his recall, the man was taken to HMP Manchester. Shortly after his arrival, he was taken to outside hospital after complaining of chest pains. He was diagnosed with a heart attack.
3. The man returned to the prison but, in October 2008 he was again taken to hospital a blood test found his haemoglobin level was low and he required a blood transfusion. While at hospital, he suffered a further heart attack but was successfully resuscitated. He was taken to outside hospital for a coronary bypass operation, and while there was diagnosed with myelodysplasia, a disease in which the bone marrow does not produce blood cells effectively.
4. The man was treated appropriately for myelodysplasia, although he continued to suffer from anaemia (low red blood cell count) and bruising. Treatment included chemotherapy and regular blood transfusions, which were given at outside hospital.
5. In March 2011, the man saw a locum GP at HMP Manchester, who noticed that he had a lesion (an area of abnormal tissue) on his forehead. Although the doctor noted that a referral should be made to a dermatologist, there is no record that this was done. The same doctor saw him five days later but did not follow up whether an appointment had been made.
6. The man saw a different doctor in May 2011 as he had wax in his ears. At the appointment, the doctor noticed the lesion and made an urgent referral for him to see a dermatologist. The lesion was later diagnosed as malignant. In July, he went to outside hospital for a blood transfusion and chemotherapy. While there, a CT scan (which provides a 3D scan of the body) showed that the cancer had spread to his chest and possibly his liver. He remained in hospital for most of July, although he returned to Manchester for two days. He chose to go onto a wing rather than stay in the prison's healthcare centre.
7. After returning to outside hospital, the man's condition deteriorated, with him suffering from a high temperature. Although staff began to prepare for his release on compassionate grounds, he died before these could be completed.
8. We make two recommendations as a result of this investigation – about the referral system for secondary health care appointments and the possibility of establishing a blood transfusion facility within HMP Manchester.

THE INVESTIGATION PROCESS

9. This office was notified of the man's death on 5 August 2011. One of my investigators led the investigation and visited HMP Manchester on 16 August and spoke to various members of staff, as well as collecting documents relating to the man's time in prison.
10. NHS Manchester commissioned a clinical review into the care provided for the man while he was at HMP Manchester. The final version of the review was not received in this office until March 2012 which has led to a regrettable delay in the production of this report.
11. One of the Ombudsman's Family Liaison Officers (FLOs), contacted the man's family to explain the purpose of the investigation and to provide them with an opportunity to raise any issues about the care he received in prison. She spoke to the man's brother, who said that the family did not wish to raise any concerns about his care at HMP Manchester at this stage. His family asked what had happened to his wedding ring that had not been returned with his property. This issue is covered in the section "Other issues" at page 11 of this report.
12. The man's family received a copy of the draft version of this report and raised no new issues or concerns as a result. His brother explained to the FLO that the matter of the missing wedding ring had not been resolved. This has been brought to the attention of the Coroner.
13. The National Offender Management Service (NOMS) also received a copy of the draft report. The response to the recommendations can be found on page 13.
14. The investigation has assessed the main issues involved in the man's care including his diagnosis and treatment, liaison with his family, his location and security arrangements, whether compassionate release was considered and whether appropriate palliative care was provided.

HMP MANCHESTER

15. HMP Manchester forms part of the High Security prison estate, but also acts as a local prison, taking both remand and sentenced prisoners from courts from the North West. As such, it holds prisoners from a variety of security categories, including Category A (for whom escape would be highly dangerous for the public or national security). The man was a Category C prisoner (a prisoner who is unlikely to try and escape, but is not suitable for open conditions).

HM Inspectorate of Prisons' report

16. HM Chief Inspector of Prisons conducted a full, follow up inspection of Manchester in September 2011. Overall, he found that the prison "managed the whole range of prisoners very well". In the health services section of the report, inspectors reported that

"Patients had access to a wide range of clinics run by visiting specialists and consultations with hospital specialists using telemedicine. Patients' external health care appointments were subject to strict security. On average, only one appointment a month was cancelled for security reasons. More appointments were cancelled during major security incidents but these events were rare."

Inspectors also found that the palliative care and end of life policy was compassionate and partnership working with the local NHS and hospital services was good.

Independent Monitoring Board report

17. Each prison has an Independent Monitoring Board, which comprises of members of the local community appointed by the Secretary of State for Justice. Their role is to ensure that proper standards of care and decency are upheld.
18. In their last report, which covers the period March 2010 – February 2011, the IMB noted that a palliative care cell had been provided in healthcare, and that there was a specialist nurse providing care for prisoners over 55.

Previous deaths in custody at Manchester

19. Since 2004, we have investigated 15 previous deaths from natural causes at HMP Manchester. Before this man's death, the most recent death from natural causes at Manchester was in 2010. Our recent investigations did not raise issues similar to those covered in this report.

ISSUES

The diagnosis of the man's terminal illness

20. Shortly after his arrival at Manchester in August 2008, the man was taken to hospital after complaining of chest and gastric pain. He was diagnosed as having suffered a heart attack, and also having helicobacter pylori, which is a bacteria found in the stomach which can cause stomach pain and illness. When he was discharged back to the prison, he initially went to the healthcare unit, before going back on the wing.
21. In October, the man had two more episodes of chest pain. Blood tests were taken, and showed that he had a very low level (4.6) of haemoglobin (a protein which transports oxygen in the blood). He was taken to outside hospital as an emergency. While there, he had another heart attack, but was successfully resuscitated. He remained at the hospital, but was moved to a further hospital in November, where he had a coronary bypass.
22. During this period, the man was diagnosed with myelodysplasia, a disease which causes ineffective production of cells in the bone marrow. Once this was recognised, he was given monthly blood transfusions and was also treated with chemotherapy. These took place at hospital.
23. In March 2011, the man saw a locum GP at Manchester. (This GP works for a locum agency. The agency was asked to contact the GP to invite him to be interviewed. The GP has not responded to this invitation.) During this appointment, the GP noted that the man had a lesion on his forehead, and noted that he should be referred to a dermatologist (a skin specialist) in case the lesion was cancerous. It is not clear if that referral was made.
24. The man saw a different GP on 3 May 2011, as he had wax in his ear. The GP noted the lesion, and made an urgent referral to a dermatologist. In the meantime, the man continued with a course of chemotherapy for his myelodysplasia. He was seen at outside hospital by a doctor who referred him to a specialist cancer hospital. On 16 June, he attended the hospital. He was diagnosed as either having a Merkel cell carcinoma (a form of malignant cancer in the hair follicle or skin) or a small cell lung cancer which had spread to the skin.
25. The clinical reviewer noted that the locum GP at Manchester had recorded in the man's medical record that he should be referred to a dermatologist, but that this referral was not made. However, she comments that

"It is not possible to say whether the delay in the referral and diagnosis of [the man's] Merkel cell carcinoma had a detrimental effect on his life expectancy due to his diagnosis of Myelodysplastic syndrome."
26. It is not clear from the records whether the original referral was made – and, if it was, whether it was chased up. We have been unable to interview the locum GP, and are therefore not able to determine whether his status as a

locum doctor meant that he was unaware of local procedures. As a result, we make the following recommendation:

The Head of Healthcare should ensure that all urgent referrals for secondary healthcare are recorded and monitored consistently, and that all staff, including locums, are aware of the referral process.

Informing the man about their condition and treatment

27. Shortly after his arrival at Manchester, the man was diagnosed with myelodysplasia. This diagnosis took place while he was in hospital. As we do not have his hospital records, it is not clear how he was told about this illness, or the effects it might have.
28. However, it is apparent from his medical record at Manchester that he was aware of the problems with his haemoglobin levels and was able to talk to prison doctors about this. On 11 December 2008, for example, he saw a prison GP as he had shortness of breath and fatigue. This was a week after leaving hospital, and he was able to tell the doctor that his previous haemoglobin level had been 10.5, whereas it had now fallen to 7.7. At this point, the doctor sent the man back to hospital for further blood tests.
29. It is not clear from the medical records when the man was told that he had either a Merkel skin carcinoma or small lung cell cancer that had spread to his lungs. Again, he was in hospital when this diagnosis was made and seems he was told then. On 13 July 2011, a prison GP spoke to a consultant haematologist at outside hospital. She told him about the diagnosis and that the man would not be able to have chemotherapy as he would not be able to tolerate it because of the myelodysplasia. Instead, they were planning a course of palliative radiotherapy on his chest and head. It was noted in the medical record that he had discussed the diagnosis and prognosis with his brother on 17 July.
30. It is apparent, therefore, that on both occasions, the man was fully informed of his diagnoses and the treatment options available.

The man's medical appointments and treatment of the prisoner

31. The man received monthly blood transfusions at the outside hospital. From his medical record, it would appear that there were no problems with these appointments, and that he did not miss an appointment during his time at Manchester. He also seems to have seen prison doctors quickly when necessary.
32. The clinical reviewer has noted that a prison doctor discussed, at length, with North Manchester the possibility of arranging for transfusions to take place in the prison. However, it was eventually decided not to pursue this, despite the benefits for the patient (not having to travel) and both the prison and hospital (savings in resources such as escorts or appointments). We are aware that at least one other prison, HMP Whatton, has successfully managed blood

transfusions in the prison when necessary. Although Whatton and Manchester are very different types of prisons which could have a bearing on the feasibility of blood transfusions being arranged at Manchester, both we and the clinical review believe that this possibility should be pursued. We make the following recommendation:

The Governor and Head of Healthcare, in partnership with local health providers should, subject to feasibility, establish a blood transfusion facility in the prison.

The man's pain relief and medication

33. The man spent much of his last month in hospital. However, he was in the prison from 25 – 27 July, and told two nurses that he did not have any issues with pain.
34. The Head of Healthcare discussed with the Macmillan nurse (who specialise in pain relief) at the outside hospital his appropriate care and pain relief. We are satisfied that he was given the correct pain relief and medication to treat his various medical conditions.

Liaison with the man's family

35. The man's family visited him while he was in hospital, and were aware of his diagnosis. The Head of Healthcare also spoke to the man's sister in law on 20 July to explain how they could visit him when he returned to Manchester and to give some reassurance.
36. During the man's final stay in hospital, the Governor authorised "open visits" for him, making it easier for his family to visit him. On 29 July, he asked that his family be told that he was in hospital, and this was done by the security department. His brother and sister in law visited later that day.
37. On 3 August, the man's brother was told of the severity of his condition while he was visiting. He was advised to contact any other family members who might want to see him before he died. Another brother and sister in law visited the hospital, and his family were with him when he died. A senior officer, who was part of the bedwatch at the time, noted in the record that "the family thanked the prison service for all their efforts and concern" before they left the hospital.

The man's location

38. While the man spent much of his last month in hospital, he did return to Manchester for a short period in July 2011. He said that he wanted to go back to a residential wing, rather than the healthcare unit, and staff at Manchester accommodated these wishes. Staff on C wing responded to this request by organising a prisoner carer for the man and the Head of Healthcare noted that he was "very supportive".

39. When the man was visited by the two nurses the day after he returned to the prison, he admitted that he was unable to cope on the wing and that he should have gone to healthcare. However, he asked to stay in the wing overnight so that he could say goodbye to friends and staff. The following day, he was due to go to outside hospital for a blood transfusion, and it was planned that he would return to a bed in the in patient unit in the healthcare centre. In the event, he was kept in hospital and did not return to Manchester.
40. We are satisfied that the man was fully involved in decisions about his location, and staff made every effort to accommodate his wishes.

Compassionate release

41. The Head of Healthcare and the man's Offender Supervisor first discussed compassionate release for the man on 20 July. The Head of Healthcare also contacted a local hospice, although she noted that "at the present time [the man] does not require this care but we are planning for the future". On 29 July, a member of staff began to contact various nursing homes to see if they could accommodate the man if he was released on compassionate grounds. The member of staff also planned to speak to the Offender Supervisor on 1 August.
42. However, the man's condition deteriorated quickly before compassionate release could be fully considered. Given the speed with which his deterioration occurred (for example, he returned to prison a week before his death and was not expected to return to hospital so quickly), we accept that it would have been difficult to arrange compassionate release for a life sentenced prisoner in that time.

Palliative care plans

43. The issue of palliative care was led, predominantly, by outside hospital, in conjunction with the Macmillan nurses there. As noted earlier, healthcare staff at Manchester remained in close contact with their colleagues at the hospital in order to ensure that they could continue his palliative care when he returned to Manchester.
44. During his short return to the prison in July, he was seen by a prison GP who visited him on the wing. They discussed whether the man should be resuscitated if he had a heart attack. The man said that he would like staff to attempt resuscitation if possible, so that he could "get things sorted". The GP agreed, although he said that this would be reviewed depending on the man's condition.

Restraints, security and bed watch

45. On 27 July, the man was taken to outside hospital for a blood transfusion. At the time, he was expected to return to Manchester, and he was accompanied by two staff who used an escort chain (a long chain with a cuff at either end)

as a restraint. As a life sentenced prisoner who was at that time expected to return to the prison, we accept that this level of restraint seemed appropriate.

46. However, the man remained in hospital, and the level of restraint remained the same. On 30 July, prison healthcare staff contacted the hospital who said that “remained comfortable”. The prison officers supervising him at the hospital recorded that he had been polite and “impeccably behaved” to both medical and prison staff.
47. On 1 August, at 12.20pm, the man saw a doctor and said he was not well enough for a planned appointment at the specialist cancer hospital that afternoon, which was subsequently cancelled. Ten minutes later, he asked staff if they could remove the restraints as he would “like to be treated like a human for [my] last couple of weeks”. Staff discussed this with the security department at Manchester and, at 4.20pm that afternoon, it was agreed that the escort chain could be removed while he remained in his room on the ward. Restraints were not reapplied before he died.
48. The conversation between the man and the doctor on 1 August seems to be the first indication that his condition had started to severely deteriorate. Almost immediately, he asked that restraints be removed, which they were later that afternoon. In the circumstances, the use of restraints and their removal seems appropriate and proportionate.

Other issues

49. The man’s family asked the Ombudsman’s Family Liaison Officer to establish what had happened to his wedding ring, as it was not returned with the rest of his property. The investigator asked the prison whether they knew what had happened to the ring. He was told that the Coroner’s Officer had confirmed that the ring was on the man’s finger (and had been taped up) during the post mortem. The funeral directors, however, said that the ring was not with him when he arrived at their premises.
50. We have spoken to the Coroner’s Officer, prison family liaison officer and the police to try and locate the missing ring. Unfortunately, we have been unable to do so. We do, however, bring this to the attention of the Coroner, who might wish to make his own enquiries into how the ring came to be missing between the mortuary and the funeral directors.

CONCLUSION

51. The man was taken seriously ill shortly after his recall to prison in 2008. Following a heart attack, he was diagnosed with myelodysplasia, a condition in which the bone marrow fails to produce blood cells in sufficient numbers.
52. In 2011, he was diagnosed with a malignant tumour on his forehead. Because of the myelodysplasia, doctors were unable to treat the tumour with chemotherapy. Although he was given palliative care, he remained in hospital following a blood transfusion because of concerns about his health, and died a few days later.
53. This investigation has found that a doctor noted in the medical record that a referral for an appointment to see a specialist about the tumour should be made. It is not clear whether the referral was made, or whether it was not followed up. Only following a further GP referral did the man obtain the appointment. However, the clinical reviewer is unable to say whether the six week delay would have affected the man's prognosis.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that all urgent referrals for secondary healthcare are recorded and monitored consistently, and that all staff, including locums, are aware of the referral process.

The recommendation was accepted. The prison now has electronic systems in place for emergency two-week referrals to the Pennine Trust.

2. The Governor and Head of Healthcare, in partnership with local health providers should, subject to feasibility, establish a blood transfusion facility in the prison.

The recommendation was accepted but was not possible to implement. HMP Manchester had an in-depth discussion with the haematology consultant at [outside hospital]. The proposal was put to the hospital's departmental meeting but was rejected.