PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the circumstances surrounding the death of a man in September 2011, at the Bury Hospice, while in the custody of HMP Manchester

Report by the Prisons and Probation Ombudsman for England and Wales

January 2014

This is the report of the investigation into the death of a man in September 2011 at Bury Hospice while in the custody of HMP Manchester. He had been diagnosed with pancreatic cancer in July 2011 at North Manchester General Hospital. He was transferred to the hospice for palliative care in September and died with his family at his bedside. The man was 41 years old. I extend my sincere condolences to his family and friends.

Her Majesty's Coroner for City of Manchester District ordered a post mortem examination of the man which found that he died of natural causes, due to pancreatic cancer

The investigation was carried out by an investigator and Manchester prison co-operated fully. A review of the man's health treatment during his time in HMP Manchester's care was commissioned from NHS Manchester. .

The man was admitted to hospital on 26 July, after receiving treatment for two months from healthcare staff at the prison for severe abdominal pain. He immediately underwent tests for suspected cancer and a firm diagnosis of pancreatic cancer was made on 2 August. The clinical reviewer concludes that, despite delays in the man's diagnosis, his care was equitable with that which he might have received in the community. However, his family were unaware of the man's transfer to hospital and the seriousness of his illness until the day of his diagnosis.

The report makes three recommendations to the Governor, one about the need to ensure information is passed to families when a prisoner is admitted to hospital with a suspected severe illness. The second recommendation is intended to strengthen arrangements to escort prisoners to healthcare appointments in the prison. Finally, it is recommended that a prisoner's medical condition be taken into full account when applying for compassionate release.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **January 2014**

CONTENTS

SUMMARY

1. In September 2010, the man was remanded to Manchester and prescribed medication for his mental health, following a suicide attempt prior to his arrest. He was sentenced to life imprisonment on 10 February 2011 for murder.

.

2. In March, the man reported abdominal pain and constipation to a doctor and was prescribed medication. Six weeks later, he again saw a doctor as he was still experiencing abdominal pain. Further medication was prescribed and on 6 May, the man was examined by a doctor who diagnosed an inflammation of the stomach.

3. The man was seen by doctors regularly between May and July when he reported pain and diarrhoea. Blood tests did not show any abnormalities however, a stool sample indicated that a bacterium found in the sample was linked to ulcers, and he was treated accordingly. He lost three kilograms (kgs) of weight between June and July. During consultations with doctors, the man continued to complain of severe pain and felt that his symptoms were not being treated appropriately.

4. The man was taken to North Manchester General Hospital (NMGH) on 25 July. He was very unwell, in acute pain and jaundiced and was admitted for assessment and medical investigations.

5. A week later, the man was told that he had inoperable pancreatic cancer with secondary cancer in his liver. Following a multi disciplinary review by prison healthcare staff, hospital staff and a palliative care nurse, it was agreed that the prison would be unable to care for the man's complex clinical needs. On 13 September, the man was transferred to Bury Hospice. He was not restrained and the escorting officers wore civilian clothes. The man's family were able to visit him daily and during the last few days of his life, they were at his bedside. He died on 30 September.

6. The clinical reviewer describes pancreatic cancer in those under 45 years as "rare and difficult to diagnose" until the disease is advanced. The investigation found that the man's treatment was equitable to that which could have been expected in the community but makes one recommendation about the need to ensure that families are kept informed when a prisoner is admitted to hospital in a serious condition. The arrangements to apply for compassionate release were examined and found that too much emphasis was placed on the man's offending history, rather than the risk he presented at the time of the application. A further recommendation was made to strengthen arrangements for prisoners to be escorted to hospital.

THE INVESTIGATION PROCESS

7. The investigator began the investigation into the man's death on 10 October 2010 at Manchester prison when she reviewed the man's prison file and arranged for relevant documents to be forwarded to her. She visited the healthcare unit and E wing where the man had been living and discussed the case with the Governor.

8. The Ombudsman's terms of reference and notices of the investigation had been publicised in the prison in advance of the investigator's visit but no-one asked to speak to her about the man's treatment. .

9. A review of the man's healthcare was commissioned with Manchester NHS. I am grateful to the Associate Clinical Director at NHS Salford for that review.

10. Our investigation assesses the following aspects of the man's care and treatment:

    - Whether his diagnosis was made in a timely fashion?
    - Whether he was told about his condition and the treatment which followed?
    - Whether he was treated properly and attended hospital appointments as necessary?
    - Whether the liaison with the family was appropriate?
    - Whether he was accommodated in the most appropriate part of the prison?
    - Whether consideration was given to compassionate release from prison?
    - Whether appropriate palliative care was provided?

11. A review of the man's healthcare while in Manchester prison was commissioned from NHS Manchester. We are grateful to the clinical reviewer for that review which was received on 8 February 2012 and is annexed to this report.

12. One of the family liaison officers spoke to the man's sister, his nominated next of kin. The family liaison officer explained the process of the investigation and invited her to raise any issues for consideration during the investigation. On 14 November, the investigator and family liaison officer visited the man's sister who raised the following points.

    - Why were the man's family not told that he had been admitted to hospital until a week later?
    - Why was the referral made on 7 July for the man to been seen at a hospital not urgent, given his poor health?
    - Why did it take up to a week for the man to get an appointment with a doctor at the prison?

- Why was the man not escorted to the healthcare unit for two appointments?
- Why did the man have to ask healthcare staff to be weighed?
- The man's family were also concerned about the actions of the doctor overseeing his care.

13. We have aimed to answer the man's family's concerns under the relevant headings in the issues section of this report

14. On 12 and 13 December, the investigator returned to Manchester to interview prison staff and a prisoner. The clinical reviewer joined the investigator for healthcare staff interviews. The investigator fed back the initial findings of the investigation to the Head of Healthcare and a Principal Officer (PO). A letter confirming this initial feedback was sent to the Governor.

15. The liaison officer at Manchester was unable to contact one of the man's wing officers at Manchester who had recently retired from the Prison Service. On 13 January 2011, another investigator interviewed the man's cellmate from Manchester at HMP Dovegate.

16. The man's family received a copy of the draft report. The solicitor representing his family wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

HMP MANCHESTER

17. HMP Manchester is a category A prison located in the centre of the city. (A category A prison holds prisoners who would be highly dangerous to the public, police or national security if they were to escape.) In addition to its function as a category A prison, Manchester also operates as a local prison, serving the courts of the Greater Manchester area. It holds up to 1,269 adult male remand, convicted and sentenced prisoners.

18. Healthcare at HMP Manchester is commissioned by NHS Manchester. The prison has 24 hour nursing care and the healthcare centre includes an in-patient unit. Primary care services include access to a range of in-house and visiting specialist clinics. The healthcare team is a nurse-led service, with a full time doctor on the team, supported by a part time doctor and locums. Qualified general and mental health nurses and healthcare assistants make up the permanent healthcare team. Specialists in mental health, dental care, opticians and areas of secondary visit the prison on a regular basis.

Her Majesty's Chief Inspector of Prisons

19. HM Chief Inspector of Prisons (HMCIP) last carried out an inspection of Manchester in September 2011. It reported that health services were generally good and had improved since the previous inspection in July 2009. Primary care services and provision for prisoners with life long conditions were judged to be good. Prisoners had good access to a wide range of clinics run by visiting specialists and were able to have consultations with some external hospital specialists using tele-medicines (appointments by video link).

20. The inspectorate found that although GP appointments were allocated promptly when applications were received many prisoners complained that they were not taken to appointments. Inspectors found a high rate of recorded non attendance at GP and other healthcare appointments which needed investigation. External hospital appointments were not cancelled often and there were good palliative care arrangements. .

Independent Monitoring Board (IMB)

21. Each prison in England and Wales has an Independent Monitoring Board (IMB) members of which are volunteers from the local community who monitor day-to-day life in the prison to help ensure proper standards of care and decency. The latest IMB report for the year ending February 2011, reflected,

> "that the continuing requirement to make savings is having an adverse effect upon prisoners. In spite of the efforts of staff to maintain the normal regime, a reduction in the availability of overtime covering for staff absences is resulting in a deterioration of some aspects of prison life."

22. The man's is the sixth natural cause death to have occurred at Manchester prison in the last twelve months. Only one other of those deaths was linked to cancer. Some are still being investigated but so far, none have raised similar issues to this case.

ISSUES

23. The man was born on 24 March 1970 in Manchester and was a father of twin boys. On 28 September 2010, he was remanded to Manchester. On 10 February 2011, he was sentenced to life imprisonment with a minimum term of 18 years, for the murder of his wife.

24. On arrival at Manchester on 28 September 2010, the man was originally held in the healthcare unit for observations as he had committed an act of serious self-harm before his arrest by the Greater Manchester Police. He was moved to E wing, part of the vulnerable persons' unit on 3 December, where his mental health was assessed on a regular basis. The man was prescribed medication for mental health issues.

The diagnosis of the man's terminal illness

25. On 3 March 2011, the man complained of abdominal pain and constipation, and was prescribed a laxative. Over a month later, on 15 April, he complained of a similar pain to a doctor. He told the doctor he had been in pain for around six to eight weeks. The doctor prescribed Omeprazole, used to treat gastric disorders and ulcers. Three weeks later, he saw a nurse on his wing and told her he was in severe abdominal pain during the evenings and had not eaten for three days. The nurse noted that the man seemed tired and made appointment for him to see the doctor.

26. The doctor examined the man's abdomen on 6 May, but did not find any swelling or abnormality. The doctor diagnosed gastritis, an inflammation of the lining of the stomach, and increased the man's dosage of Omeprazole. Six days later, 12 May, the man submitted a complaint saying that he was still in pain and would like to be seen by a hospital doctor. The nurse responded to the complaint and told the man that he should discuss his concerns with the doctor, who was the only member of healthcare staff authorised to make a hospital referral.

27. On 23 May the doctor examined the man and wrote,

> "Discussion about disorder - advised on pathway for Rx [treatment]. If test and/or medication ineffective will need referral for endoscopy. [An endoscopy is a procedure where a camera is inserted into the stomach via the mouth and throat.] Try change to Lansoprazole."

28. The doctor prescribed Lansoprazole, a medication that stops the stomach producing gastric acid and treats ulcers. The doctor sent a stool sample for analysis which was found to be positive for Helicobacter pylori (H. pylori), a type of bacteria and germ that can cause infection. H-pylori causes more than half of the peptic ulcers worldwide therefore, two days later, the doctor treated the man for a suspected ulcer. He prescribed co-codamol for pain relief, alongside amoxicillin and

Clarithromycin, (both antibiotics used for the treatment of bacterial infections). The man's prescription of Lansoprazole was continued.

29. The docor examined the man's abdomen again on 10 June. The doctor noted that the bowel sounded normal and that the man looked well. However, he told the doctor he was unhappy about his treatment and that he would be speaking to his solicitor about it. The doctor noted that the man should continue with the Lansoprazole and he would review him again in one week. On 17 June the doctor saw the man and noted he weighed 63kgs. The man told the doctor he had pain in his back and some diarrhoea. The doctor arranged for a blood test to be taken two weeks later and again prescribed co-codamol for pain relief.

30. Another doctor saw the man on 24 June and noted the previous history of abdominal pain. The doctor arranged for another stool test and prescribed ranitidine, used to treat peptic ulcers. Three days later, the man failed to attend for a blood test and, according to his medical record, his stool sample had been rejected, although no reason was given. On 30 June, the man failed to attend another doctor's appointment. (It was later recorded that the man complained that he was not collected for either appointment.)

31. On 1 July, the man saw another doctor in the healthcare unit, the doctor noted that the man continued to have abdominal pain and watery stools. His weight was 63.1kgs. The doctor prescribed Mebeverine, an antispasmodic medication often used to treat irritable bowel syndrome. The doctor wrote that the man should be referred to a gastrology clinic (a specialist hospital department for stomach and abdominal conditions), requested another stool sample and suggested that the man might need an ultrasound scan to examine the internal body organs. The man was referred to North Manchester General Hospital (NMGH) on 4 July, for a scan. The doctor noted in the man's medical record that a second stool culture had been analysed and no abnormalities were found.

32. A letter referring the man to a hospital gastrologist was sent by the healthcare administration on 7 July. (This was not an urgent referral letter and the appointment was in the process of being arranged when the man was admitted to hospital as an emergency.) The following day, the man had a blood test. On 8 July, the test result indicated an abnormality and recommended that he should have another blood test a week later. The doctor saw the man and noted that the man was "in agony" with pain in his back. The doctor wrote that the man looked well and prescribed co-codamol and paracetamol medication for pain relief. His weight was recorded as 61.7kgs.

33. The nurse was called to see the man in his cell at around 2.17am on 20 July. The man told the nurse that he had severe abdominal pain and on examination, his lower abdomen was sore to touch. His temperature was slightly raised at 37.5 degrees celsius and his blood pressure was 129/89, (an average reading is 130/80). The nurse advised the man to

ask for a sample pot from the wing medication hatch in the morning, collect a stool sample and hand this to healthcare staff. The nurse told the man and the night duty staff to contact her if the symptoms persisted. Two hours later, the nurse rang the wing and the night duty staff told her that the man was settled and sleeping.

34. The next afternoon, the man's weight was recorded by the doctor as 61kgs. The doctor examined the man's abdomen, carried out a rectal examination and collected the stool sample. He advised the man that the stool sample would be analysed and his blood tests repeated. The results of the stool sample indicated nothing of concern.

35. A nurse was called to E wing around 8.00am on 25 July because the man was unwell. Officers told the nurse that the man "was in agony and could not move." The man told the nurse he was concerned that his abdominal pain was not being taken seriously by healthcare staff. The nurse told the man that she would ask the doctor for a review of his symptoms.

36. The man was still in pain, so two officers referred their concerns to the unit manager. The unit manager contacted healthcare staff and an officer escorted the man to the healthcare unit. During interview for this investigation, the officer told the investigator that the man was obviously unwell. He left the wing to walk unaided to the healthcare unit however, he was slow in his pace.

37. The nurse weighed the man and recorded that his weight was 60kgs, his blood pressure was high at 148/103, and he had a regular pulse rate of 93 beats per minute. He was jaundiced (a condition where someone's skin is yellow), so she referred him to the doctor. The doctor wrote that the man had more back pain over the last few days and had become jaundiced. Medical investigations had centred on a diagnosis of ulcers and a referral was underway for him to be seen by a gastrologist. However, the man's condition was cause for concern and he should be referred to a hospital again. The doctor spoke to staff at NMGH and arranged for the man to be transferred to the hospital's surgical assessment unit. An ambulance was called at 12.57pm and the man was escorted to the hospital by two officers at 1.52pm on 25 July. The man was admitted to the hospital for medical tests and observations

38. Two days later, on 27 July, the man was told that it was likely that he had cancer and this was confirmed on 2 August.

39. The man's family were concerned that his illness was not diagnosed until he was admitted to hospital. The clinical reviewer, The clinical reviewer said in his review:

> "Cancer of the pancreas is a notorious difficult cancer to establish, it also has the worst survival rates of any cancer. Diagnosis is made on many occasions when the cancer is advanced. At diagnosis,

78% of all patients already have spread of disease. The one year survival for pancreatic cancer is only 24% and the 5 year survival is 5%. The average age of a diagnosis is 69. Cancer of the pancreas is very rare under the age of 45 years. The man did not meet the criteria in the early stages of his illness. The clinical suspicion of malignancy would have been extremely low. Thus it is entirely reasonable that medical staff at HMP Manchester did not refer the man for specialist investigation at an earlier point."

40. The man repeatedly complained of abdominal pain. Nurses responded to his complaints, examined him on the wing and referred him to the doctor. He was seen by the doctor on a number of occasions, and tests were carried out on his blood and stool samples. The man's symptoms were consistent with digestive disorder and he was treated accordingly. His weight was monitored by staff, and he lost three kilograms during this time.

41. The man's cancer was not detected until he was admitted to hospital. It is the clinical reviewer's opinion that pancreatic cancer is extremely difficult to diagnose in its early stages. There is no evidence that staff did not take the man's complaints seriously, or carry out appropriate and timely investigations. While the man was not diagnosed until a late stage in his illness, we agree with the clinical reviewer that this was the result of the difficulty of diagnosing pancreatic cancer, rather than any shortcoming in the treatment he received at HMP Manchester.

Informing the man about his condition and treatment

42. On 27 July, doctors told the man that the results of the tests carried out over the previous two days indicated that he might have cancer. Four days later, the doctors spoke to the man and informed him that medical investigations showed that he had pancreatic abnormalities and there was a shadow on his liver.

43. On 2 August the lead doctor at Manchester, spoke to a Macmillan nurse working at NMGH. (Macmillan nurses specialise in the care of patients with cancer-related illness.) The nurse told the doctor that the man had been diagnosed with a malignant tumour at the head of the pancreas with secondary cancer in his liver. (A malignant tumour is a cancerous growth and secondary cancer the area to where the cancerous cells have spread.) The nurse said that the man's prognosis was 12 months if he had chemotherapy, shortened to six months if he did not. Either way, the prognosis was terminal. The doctor and nurse discussed options for the man's ongoing medical care.

44. An officer who was supervising the man at the hospital that day, recorded that doctors confirmed to the man that he had pancreatic cancer and tumours in his liver. The man was clearly distressed by the news of his terminal illness and treatment options had been discussed

with him. The man decided against chemotherapy but was agreeable to treatments to make him comfortable.

The man's medical appointments and treatment

Doctors' appointments

45. Manchester has an application system for prisoners to access healthcare appointments. The prisoner completes a healthcare application form, (available on each wing), which are collected daily for assessment by a nurse. For minor treatments such as a change of dressing, an appointment is made for the prisoner to be seen in a nurse-led clinic. All other applications result in a routine doctor's appointment at either a morning or afternoon surgery.

46. A prisoner can request an emergency medical appointment through wing staff who will contact the healthcare centre. The prisoner will then be assessed in a nurse-led clinic, known as 'special sick', and if necessary will add the prisoner to the doctor's patient list for that day. Nurses can be called to the wing in an emergency. An officer based on the man's wing, said she thought she might have referred him for healthcare appointments but was unable to recall exactly when, and there is no record of her doing so in his files.

47. At interview the nurse explained that appointment slips are passed under prisoners' cell doors during the night to inform or remind them of healthcare appointments. The prisoners are then called by officers to be escorted to the healthcare unit. If a prisoner has not been called for a healthcare appointment when they expected to be, they can raise this with an officer, who would then check with the healthcare centre.

48. The man's family were concerned that he had difficulty getting doctors' appointments. They told the investigator that he often had to wait up to one week to see the doctor and because of this the man would make his next application for an appointment immediately after seeing a doctor to avoid delay.

49. The nurse the healthcare application system to the investigator during the investigation and this was shared with the clinical reviewer. The clinical reviewer concludes that the healthcare appointment system works well in Manchester and he said in his review:

> "The appointment system at HMP Manchester is not of a concern. Medical appointments appear to be issued within a matter of days at the most. This is better than could be observed within a community general practice setting."

50. By contrast, an extract from the HMCIP 2011 report said of healthcare appointments,

> "Prisoners told us there were problems in accessing health care and too many failed to turn up for appointments, the reasons for which needed examination. Dedicated health application boxes on the wings were emptied daily by the nurses. Prisoners were also able to see triage nurses on the wings. Triage algorithms were in use. Waiting times were generally within NHS Manchester targets."

51. According to the man's medical record, he missed two healthcare appointments in June: one for a blood test on 27 June and the other to see the doctor on 30 June. He was sent appointment letters, but not collected from E wing. On arrival at the healthcare unit, prisoners are checked in via a computer appointment system. If they have not attended, the non-appearance is recorded into their medical notes and the appointment is rebooked. In a statement the man made to his solicitor, he complained that he had not been escorted for those appointments.

52. If a prisoner refuses to attend his appointment, officers record the reason on the back of the appointment slip and return it to the healthcare unit. (There may be occasions when an appointment for healthcare is at the same time as a social or legal visit.) There is no evidence that the man refused to attend his appointment, or complained to wing staff that he had not been escorted. His appointment was rebooked and the man was seen by a doctor within 24 hours of his missed appointment. This was confirmed by the clinical reviewer who says,

> "He [the man] also missed two appointments on the 27 and 30 June 2011 respectively. This would not have had any negative impact on the outcome of his condition. I note also that he was seen on 1 July 2011, i.e. shortly after these missed appointments."

53. On 17 August, the Governor responded to a letter from the man's Member of Parliament (MP). The MP had written to the governor about the quality of healthcare the man had received at Manchester. The governor responded to the MP by outlining the dates of the man's appointments with the doctor and the treatments prescribed. The Governor did not comment on the quality of healthcare, but there was no further correspondence from the man's MP upon receipt of the Governor's response.

54. At the beginning of this investigation, the investigator received correspondence from the man's solicitor indicating that they previously acted for the man, but on his death, they were now acting on behalf of his sister. The correspondence included a statement made by the man while he was being nursed in the hospice, complaining about the healthcare services he had received at Manchester. It is not for the Ombudsman to become involved in ongoing legal disputes. However, it is the clinical reviewer's opinion that the man received adequate healthcare and access to healthcare services while at Manchester.

55. Nevertheless, the issue of the man's missed appointments fits squarely with what the inspection found with a high rate (20%) of prisoners not turning up for GP appointments. Many prisoners told inspectors that they missed appointments because they were not escorted from the wings. We make the following recommendation to the Governor.

The Governor should ensure that prisoners are escorted to their healthcare appointments.

Referral to hospital

56. The doctor referred the man for further medical investigation to a gastrology clinic at a hospital following his appointment on 1 July. The letter of referral to the gastrology clinic was sent by the healthcare unit administration staff on 7 July. The doctor also ordered an ultrasound scan and a letter requesting an appointment was sent to NMGH on 4 July. Neither of these appointments was deemed urgent by the doctor. They were appropriately dealt with as routine referrals for secondary health care and superseded by later events.

57. The clinical reviewer considers whether the man should have been referred for specialist hospital investigations earlier. He said in his review:

> "NICE guidelines issued in 2005 make recommendations of when to refer a patient with a suspected an upper gastrointestinal cancer. There are no specific guidelines for cancer of the pancreas. The indications for urgent referral for assessment include presence of a mass, iron anaemia, persistent vomiting, progressive unintentional weight loss, problems swallowing and gastrointestinal bleeding. The man did not meet the criteria in the early stages of his illness. The clinical suspicion of malignancy would have been extremely low. Thus it is entirely reasonable that medical staff at HMP Manchester did not refer the man for specialist investigation at an earlier point."

(NICE – National Institute of Clinical Excellence develops evidence-based guidelines on the most effective ways to diagnose, treat and prevent disease and ill-health.)

58. As the man did not meet the criteria set out by the NICE for further medical investigations, we are satisfied that there was no unreasonable delay in his referral to hospital.

The man's weight

59. The man's sister asked the investigator why her brother had to ask healthcare staff to be weighed. The man told her he was not eating because it caused him stomach pain. The man's sister said that she had noticed that he had lost weight when she visited him.

60. According to the man's medical record, he lost three kilograms between 17 June and 25 July. Officers and healthcare staff described the man to the investigator as being of "slim build". The officer said at interview that she "noticed a lot of weight loss" in the man between June and July. While three kilograms is not a significant amount of weight, it could have made a noticeable difference to the man's already slim frame.

61. The man's clinical records show that he was weighed five times from 17 June to 25 July. It is not clear whether he was weighed at his own request, or as a matter of routine. The doctor said at interview, that he recalled the man had told him he had lost weight and had said he was finding it difficult to eat. The man believed he had had lost weight because he wasn't eating properly and the doctor said that he checked his weight when he saw him later.

62. Whether at his own request or not, it is evident that the man's weight was regularly measured for five weeks until he was admitted to hospital.

The man's complaint about a doctor

63. The man's sister said her brother was unhappy about the quality of care that a particular doctor was giving him at Manchester. The man told his sister that he had challenged the doctor and that he was going to get a solicitor, as he was dissatisfied with his healthcare. The man claimed that when he asked the doctor for his name, the doctor refused to give it.

64. From the man's medical record, it is evident that the majority of his doctor's appointments were with the doctor. On 10 June, the man had told the doctor he would seek advice from a solicitor as he did not think he was receiving appropriate healthcare. At interview, the investigator asked the doctor if he recalled that conversation and invited him to comment. The doctor said:

> "Well, I simply refuse to talk to patients about solicitors because it's unhelpful. An aspect of reflection of practice is that I have practised in accident and emergency and in general practice and I still practice in general practice outside the prison. I can't think of one incident where a patient has said directly to me that I'm going to my solicitors, it just doesn't happen. Here, it happens to me every week and so I think it's an unfortunate reflection of, unfortunately some of our patients, not all of them, see the need to talk about solicitors very, very early on and I think it's my job to try and empower them in a different way without talking about legal practice so just say look, I'm not here to talk about legal practice or

solicitors, I'm here to help you, so I just don't engage with talking about solicitors or legal facts."

65. The investigator asked the doctor if the man knew his name and the doctor replied, "yes, absolutely". The investigator asked the doctor if he had ever refused to give his name. The doctor said:

> "No, I don't, I don't see that I can. I mean I know some locums feel unhappy about giving a patient their name but ultimately they are entitled to know my name. But they're not having any other details about me. My registered address of the General Medical Council is here, not my home address."

66. The clinical reviewer raises no concerns about the level of care that the man received at Manchester. The investigator found nothing in the clinical review, in the man's medical record, or from her interview with the doctor's to suggest that the doctor was unprofessional towards the man.

The man's pain relief and medication

67. The man was prescribed medication for his mental health as soon as he arrived at Manchester in September 2010. In March 2011, the man first complained of abdominal pain and was prescribed a laxative. From April to July, the man was prescribed medication for suspected ulcers, paracetamol and Co-codamol for pain relief, plus an anti-spasmodic medication. In May, antibiotics were prescribed when a stool sample indicated an inflammation of the stomach associated with ulcers.

68. In his medical record, the man was described as "in agony" as a result of abdominal pain. His sister told us that when she visited her brother at Manchester he was in obvious discomfort and complained of pain on numerous occasions.

69. The man's cellmate at Manchester, spoke to the investigator, the cellmate told the investigator that the man was in considerable pain and would double up in agony. It was the cellmate's opinion that the man did not receive appropriate medication to address his pain and that healthcare staff had failed to provide satisfactory care for his friend.

70. The clinical reviewer concludes that the medication prescribed to the man Manchester was appropriate for his symptoms. The clinical reviewer is also of the opinion that the man received appropriate levels of pain relief when a patient in hospital and at the hospice. The severity of the man's condition was not known until his diagnosis in hospital. He was prescribed appropriate medication to manage his symptoms at the time of the doctors' examinations.

The man's location

71. The man spent his first three months in custody in the healthcare unit following his serious self-harm before his arrest. In December 2010, he transferred to E wing until his admission into NMGH on 25 July 2011.

72. After he was diagnosed with terminal cancer, the man wanted to return to E wing at Manchester so he could be in the company of his friends. He did not want to be admitted to the healthcare unit. On 6 September, the nurse who has undergone training in palliative care, and two members of the prison staff met the palliative care consultant and a palliative care nurse at NMGH. The man was taking morphine orally to control his pain, and the palliative care consultant indicated that a syringe driver, used to administer morphine directly into the man's blood stream, would be the next step to ensure that he was pain free.

73. The nurse told the meeting that prison nurses would need training to administer syringe driven medication. The man had already indicated that he would like to spend more time with his family and was grateful that he could have open visits from them in hospital. The nurse said that it would not be possible to allow open family visits in the prison because of the security implications. It was agreed that the man's emotional and spiritual needs could not be met by the prison within the guidelines of palliative care nursing.

74. The nurse and the palliative care consultant visited the man on the ward to discuss his future care with him. He told his visitors that he did not want to die in prison. It was agreed that a hospice was the preferred option where his pastoral and medical needs could be met. The man was transferred to Bury Hospice on 13 September.

75. It is evident from the records that the man's needs were taken into consideration when deciding his most appropriate location. Staff also consulted the man, once they had agreed his needs could not be met effectively in the prison. It was appropriate to transfer the man to the hospice for the last stage of his illness.

Compassionate release

76. Prison Service Instruction (PS1) 29/10 referring to compassionate release for prisoners serving a life sentence, sets out the following requirements:

> "the Secretary of State may at any time release a prisoner on licence if he or she is satisfied that exceptional circumstances exist which justify early release on compassionate grounds. Before exercising this power, the Secretary of State is required to consult the Parole Board, unless the circumstances make such consultation impracticable. Each case is considered on its own individual merits. Compassionate release must be approved

personally by a Minister; it is not a decision which is delegated to officials.”

77. All prisoners with a life expectancy of less than three months should be considered for release on compassionate grounds. The man was considered for compassionate release in line with this guidance.

78. In an email exchange on 5 September, between the Head of Custody and the probation district manager, who described an application for early compassionate release as “not an avenue we can or could support at this time”. He was concerned about the nature of the man’s offence and how recently he had been sentenced, and therefore that the man had not addressed his offending behaviour. In response the head of custody wrote,

> “I am also of the view that the possibility of him getting early release on compassionate grounds is remote in the extreme”.

In consultation with his probation officer it was agreed that the man’s risk of reoffending remained too high for the application to be successful. Nevertheless, the application still needed to be completed so that “when [the man]’s condition and physical capacity is significantly limited and/or impaired”, it could be revisited because his risk would have reduced.

79. On 9 September, the doctor completed the medical section of a release on compassionate grounds application form. The doctor suggested that the man’s life expectancy was “four to six weeks” and summarised the man’s condition,

> “the patient is very weak and almost bed-bound. He is only able to mobilise a few metres, and doing so exhausts him.”

80. When completing her part of the compassionate release form his probation officer concluded:

> “I must conclude that the risk of re-offending and risk of serious harm both remain high when the man’s health is well.”

She went on to suggest that the man’s application for compassionate release should be reviewed when he became bed-bound and “unable to move from his bed”. The Governor’s section of the application form was not completed, and there was no record that it was submitted for the consideration of the Secretary of State.

81. The man’s probation officer dated her contribution to the application as 14 September. Despite the man’s health deteriorating significantly over the following two weeks, there was no evidence that the decision not to pursue the application for compassionate release was revisited, as his probation officer, the head of custody and the probation district manager had agreed.

82. The nature of the man's offence was very serious and he had no opportunity to address his offending behaviour work in the short time he spent in custody. However, a medical assessment recorded that he was "nearly bed-bound" and had a very short life expectancy. It appears that too much weight was given to his history of offending, rather than the risk the man presented at the time of the application. The application was never completed, or submitted on the man's behalf.

The Governor should ensure that applications for compassionate release appropriately reflect the risk that the prisoner presents at the time of the application, and is revisited when that risk changes.

Palliative care plans

83. Plans for the man's palliative care were discussed when he was a patient in NMGH. The meeting between healthcare, hospital staff and palliative care specialists, including a Macmillan nurse indicated that his return to Manchester would not be appropriate. The resources, nursing care and family support could not be satisfactorily arranged within the prison healthcare setting. A nurse accepted that the man would have liked to return to Manchester so he could see his friends and be in familiar surroundings. However, if he wanted his family to have open visits this could not be facilitated due to the prison's security arrangements.

84. It was agreed that Bury Hospice was the most appropriate setting to deliver a high standard of care for the man. His family and friends would be able to visit him freely without compromising prison security. Furthermore, they would be able to be at his bedside as his condition deteriorated and experienced hospice staff would be there to support them. This was the most suitable accommodation for the man with good liaison by the agencies involved in his palliative care.

Restraints, security and bed watch

85. When the man was first taken to hospital on 25 July, he was appropriately restrained on an escort chain, which is 1.8 metre length with one cuff attached to the prisoner and another cuff to a prison officer. As the man had been convicted of a serious offence, a risk assessment indicated that he should be restrained for public protection. There was no recorded medical reason not to restrain the man at that time. (A risk assessment considers the risk of the prisoner and the security of the public when they are being escorted away from the prison.)

86. A doctor recorded that the man's life expectancy was four to six weeks, after visiting him in hospital on 8 September. The doctor examined the man and wrote that he also had a deep vein thrombosis in his leg, was extremely weak and not eating or drinking very much. The following day, a security risk assessment was undertaken and the doctor's view

that the man's medical condition had deteriorated was taken into consideration. Accordingly, a governor authorised the removal of the restraints unless the man left his room, in which case an escort chain should be re-applied. (At this stage the man was being cared for in a private room adjacent to a hospital ward.) This was a timely and appropriate decision.

87. That afternoon, the nurse noted in the man's medical record that a security assessment of Bury Hospice had been undertaken and it was confirmed that the man could be transferred there. In order to complete the assessment, the police and probation service were consulted to ensure public protection and victim issues would not be compromised. The man would have two officers at his bedside in civilian clothes.

88. The man's family told the investigator that escorting officers on duty at the hospice were sensitive to the needs of The man and his family. The prison made thoughtful and sensitive arrangements for the man's transfer and stay in the hospice.

Liaison with the man's family

89. On 31 July, six days after he was admitted to hospital, the man's sister rang the prison and spoke to a chaplain. She was worried because the man had not telephoned his family that week as he usually would. The chaplain made enquiries on her behalf and telephoned her back to tell her that her brother was being looked after, but did not mention his admission to hospital.

90. According to the bed watch notes, the security department had made contact with the bedwatch officer, asking for details of the man's next of kin. He had been in hospital for seven days by this time. The bedwatch officer telephoned the security department and passed on the contact details of the man's sister. Later, the bedwatch escort was given notice that a visit had been arranged the following day for the man's sister, brother-in-law and mother.

91. The man's family visited him on 2 August, a few hours after he was told that there was a firm diagnosis of pancreatic cancer. The man's sister was distressed that he had spent seven days in hospital undergoing tests for a terminal illness without the support of his family. Furthermore, she was shocked to see the deterioration in his health.

92. A Senior Officer from the security department, told the investigator that it was prison practice not to inform relatives of a prisoner's admission to hospital for seven days, unless their condition becomes "life-threatening". He confirmed that there was no written policy to that effect, but it is in line with the bed watch assessment, which stipulates that a prisoner should not be visited by his family for seven days. Although the man's bed watch assessments prohibited his family from visiting him for seven days, it did not forbid contact with his family.

93. Although the man was in poor health and undergoing tests for cancer, his situation was not assessed as sufficiently serious to contact his family.

94. Prison rules set out the requirements for notifying a prisoner's next of kin when a prisoner is seriously ill:

> "22. - (1) If a prisoner dies, becomes seriously ill, sustains any severe injury or is removed to hospital on account of mental disorder, the governor shall, if he knows his or her address, at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed."

95. Staff followed Manchester's practice and did not contact the man's family until he had been an inpatient at hospital for seven days. However, it was documented in the man's medical record and noted in the bedwatch notes that he was undergoing tests for a terminal illness, which was confirmed on 2 August. In light of the potential consequences of those tests, the man's family should have been told of the seriousness of his illness, given information on his condition and arrangements made for them to visit him. We therefore make the following recommendation.

The Governor should ensure that unless there are properly documented serious and over-riding security implications, and subject to the prisoner's consent, families should be informed when a prisoner is admitted to hospital for a suspected serious medical condition.

96. The man's sister and family were grateful for the sensitivity of the prison's family liaison officer. It was recorded in the bedwatch notes that the family liaison officer visited the hospice and supported the family during the final hours of the man's life. The support provided was commendable.

CONCLUSION

97. Pancreatic cancer is an extremely difficult condition to diagnose and unusual in people of the man's age. Following medical tests, he was treated for ulcers and prescribed appropriate pain relief for his presenting symptoms. A routine referral to a gastrology clinic was made, but the man's condition deteriorated and he was admitted to hospital. A week later and after extensive medical tests it was confirmed that he had cancer of the pancreas which had spread to his liver.

98. The clinical reviewer summarises his report as follows:

> "Tragically the man died at a very young age from carcinoma of the pancreas. There was some delay in establishing his diagnosis but this is common place with carcinoma of the pancreas. This was compounded by the fact at such a young age carcinoma of the pancreas is rare. If his diagnosis had been established several weeks earlier, it is not likely in my professional opinion that this would improve substantially his prognosis. Unfortunately survival rates for this type of cancer remain very poor despite advances in medicine. I was impressed by liaison between HMP Manchester and medical staff outside the prison in the man's case. This was better than would have been expected in the community."

99. The man's family should have been informed of his admission to hospital sooner. While we recognise that the prison must maintain security it is both humane and important to the prisoner's mental health that the support of his family is facilitated when a terminal illness is strongly suspected.

100. We note that the man missed two healthcare appointments. This was quickly rectified but should not have happened. We make a recommendation, similar to one made in the last HMCIP report of 2011.

101. Once contact was made we are satisfied that the man's family was well looked after and we noted the sensitive support offered by the liaison officer during the final days of the man's life.

RECOMMENDATIONS

For the attention of the Governor

1. The Governor should ensure that unless there are properly documented serious and over-riding security implications, and subject to the prisoner's consent, families should be informed when a prisoner is admitted to hospital for a suspected serious medical condition.

2. The Governor should ensure that applications for compassionate release appropriately reflect the risk that the prisoner presents at the time of the application, and is revisited when that risk changes.

3. The Governor should ensure that prisoners are escorted to their healthcare appointments

ACTION PLAN:

Recommendation	Accepted/Partially accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
The Governor should ensure that unless there are properly documented serious and over-riding security implications, and subject to the prisoner's consent, families should be informed when a prisoner is admitted to hospital for a suspected serious medical condition.	Accepted	There is a protocol in place with regards to visits whilst a prisoner is in hospital. If the illness is not a serious medical condition then no visits are permitted within the first week of a hospital stay. If the illness or injury is serious or life threatening then an individual risk assessment will be completed by the Head of Security to allow close family members to visit if the prisoner consents to this. The risk assessment will consider whether there are any documented over riding security implications to prevent this from occurring.	In Place.	
The Governor should ensure that applications for compassionate release appropriately reflect the risk that the prisoner presents at the time of the application, and is revisited when that risk changes.	Accepted	It is accepted that applications for compassionate release should appropriately reflect the risk that he prisoner presents at the time, and should be revisited if the risk changes. The application for compassionate transfer must also consider implications for victims within the assessment.	In Place.	
The Governor should ensure that prisoners are escorted to their healthcare appointments.	Accepted	HMP Manchester is undertaking regular audits to ascertain the reasons for non attendance. The healthcare department has now established a dedicated team of officers for continuity. With the introduction of Unlink (an electronic system) it will enable patients to book their own appointments.	In Place. Date still to be confirmed for the introduction of Unlink.	