A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in September 2014 while in the custody of HMP Manchester

Our Vision

*‘To be a leading, independent investigatory body,
a model to others, that makes a significant contribution
to safer, fairer custody and offender supervision’*

This is the investigation report into the death of a man, who died of prostate cancer on 16 September 2014, while in the custody of HMP Manchester. He was 70 years old. I offer my condolences to the man's family and friends.

The investigator carried out the investigation. The clinical reviewer reviewed the clinical care the man received at Manchester. The prison cooperated fully with the investigation.

The man was serving a 20-year sentence and had been in prison since 2011. In July 2012, the man complained of urinary incontinence and a locum GP noted he should have a blood test to check for prostate problems. This did not happen, apparently because the doctor was unfamiliar with the prison's system for requesting tests and no one followed this up. In March 2014, the man reported further symptoms and tests revealed he had cancer of the prostate and secondary bone cancer, which could not be cured. The man's condition gradually deteriorated. In September, he was taken to a hospice, where he died five days later.

I am satisfied that the man received good care at the prison after his diagnosis. However, although it is not possible to say whether this would have affected the outcome for the man, I am concerned that there was a missed opportunity to test for prostate problems in 2012. I am also concerned that the man was restrained for hospital appointments without fully considered risk assessments, which took into account how his health and mobility affected his ability to escape.

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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **March 2015**

CONTENTS

Summary	5
The investigation process	6
HMP Manchester	7
Issues	8
Recommendations	15
Action Plan	16

SUMMARY

1. On 27 June 2011, the man was remanded to HMP Forest Bank, charged with serious sexual offences. He transferred to HMP Manchester in September 2011 and, in April 2013, he was sentenced to 20 years in prison.

2. The man took medication for diabetes, but often did not attend routine appointments and his condition was poorly controlled.

3. The man began to suffer from urinary incontinence in July 2012, and healthcare staff gave him incontinence pads. A locum GP noted that the man needed a blood test to check for prostate problems but did not formally request a test. There is no record that the man had one at the time and no one noticed this subsequently.

4. Over the next two years, healthcare staff saw the man periodically about his diabetes and long-term pain in his hip, for which he took opiate pain relief but noted no other concerns.

5. In February 2014, the man complained of swollen testes and an ultrasound scan showed he had a prominent prostate. A blood test on 1 April indicated prostate problems. A GP referred the man for additional tests, which showed he had cancer of the prostate and secondary bone cancer that was incurable.

6. The escort risk assessments for the man's hospital appointments, considered him a high risk to the public and a medium risk to hospital staff and of escape, despite his age and frailty and reliance on a wheelchair. Two officers escorted the man to his appointments and he was restrained using an escort chain.

7. The man had regular palliative care reviews with the prison GPs and healthcare staff. GPs kept his medication under review and controlled his pain effectively. Staff supported the man well and involved him in regular multidisciplinary reviews about his care. His condition slowly deteriorated and he was taken to a hospice on 11 September. He died at 5.35pm on 16 September.

8. The clinical reviewer was concerned that an earlier opportunity to test for prostate problems was missed in 2012, apparently because a locum GP did not use the required system to request tests. It is not possible to tell whether an earlier test would have affected the outcome for the man. We are not satisfied that the prison fully took into account the man's health when assessing his risk for hospital escorts. We make three recommendations.

THE INVESTIGATION PROCESS

9. The investigator issued notices to staff and prisoners at HMP Manchester informing them of the investigation and inviting anyone with relevant information to contact her. No one responded.

10. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison records. On 8 January 2015, the investigator interviewed two members of healthcare staff at Manchester.

11. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.

12. We informed HM Coroner for the City of Manchester of the investigation, who provided the cause of death. We have sent the Coroner a copy of this investigation report.

13. One of the Ombudsman's family liaison officers left telephone messages and wrote to the man's brother to explain the investigation. The man's brother did not respond.

14. The investigation has assessed the main issues involved in the man's care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.

15. The draft report was shared with the Prison Service. There were no factual inaccuracies and the action plan has been added to the end of the report.

HMP MANCHESTER

16. HMP Manchester operates as both a high security prison and as a local prison serving the courts of the Greater Manchester area. It can hold more than 1,200 men. Manchester Mental Health and Social Care Trust provide 24 hour nursing care and the healthcare centre includes an inpatient unit.

HM Inspectorate of Prisons

17. The report of the most recent inspection of HMP Manchester in November 2014 has yet to be published. At the previous inspection in September 2011, inspectors reported that the quality of healthcare was generally very good and there were a number of points of good practice. There was a designated senior nurse to lead the care of older prisoners over 55. Patients with life-long conditions and inpatients had good care plans. The palliative care and end-of-life care policy was compassionate and partnership working with local NHS and hospice services was good.

Independent Monitoring Board

18. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to February 2014, the IMB noted that the health and welfare of prisoners was given high priority. However, they were concerned with delays in appointing new healthcare staff.

Previous deaths at Manchester

19. The man’s death was the third from natural causes at Manchester in the last year. There were no significant similarities with the circumstances of the previous deaths.

ISSUES

The diagnosis of the man's terminal illness and informing him of his condition

20. The man was remanded to prison on 27 June 2011, charged with serious sexual offences. From September 2011, the man was held at HMP Manchester. On 15 April 2013, the man was sentenced to 20 years in prison.

21. The man took medication for diabetes, but often did not attend appointments to monitor his condition and his diabetes was poorly controlled. In July 2012, the man said that he had to urinate frequently during the night and was often incontinent of urine in the day. Nurses gave him incontinence pads and a locum GP noted that the man should have a blood test to check the level of prostate-specific antigen. (PSA - a protein produced by the prostate gland. A high PSA level can indicate cancer.) The man would not have a rectal examination to allow the doctor to check his prostate. The GP did not use the task facility in SystmOne (the electronic prison healthcare record) to request a blood test and there is no record that the man had one. Doctors at subsequent GP appointments do not appear to have reviewed his record and therefore did not note that this had not been done.

22. Over the next two years, healthcare staff saw the man periodically about his diabetes, associated complications and hip pain for which he took opiate pain relief. There is no record of continued urinary incontinence problems.

23. On 12 February 2014, a locum GP noted that the man had lost weight. The man said his testes were swollen and the GP referred him for an ultrasound scan, which he had on 12 March. On 28 March, a prison GP reviewed the scan results with the man. These showed he had cysts and fluid collection in the scrotum and that his prostate was prominent. The GP referred the man for a PSA blood test.

24. On 31 March, another prison GP reviewed the man who said he had lost about two and a half stones in the previous two months and had more pain in his hip. He noted the man had an umbilical hernia and a hard mass in his rectum and referred him urgently to Manchester General Hospital, under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks. He told the man that he might have cancer.

25. The man had a blood test on 1 April. The next morning, the results showed his PSA level was 57.1. The normal level of PSA present in blood is under five.

26. A prison GP reviewed the man's medical notes on 3 April. In the light of the test results and the man's increasing pain, he considered that the man needed to be seen more quickly than under the two-week referral and arranged an urgent urology triage. The GP explained to the man that it was likely he had prostate cancer. The man went to hospital that afternoon and was admitted for additional tests.

27. In hospital, the man had a scan, X-ray and biopsy. On 10 April, hospital staff explained to him that he had prostate cancer and secondary widespread bone cancer. Active treatment was not possible.

28. The clinical reviewer noted that the lack of a PSA test in 2012 was a missed opportunity for a possible earlier diagnosis. The PSA test alone cannot detect prostate cancer, but it is an indicator of potential prostate problems, which can lead to further investigation. Without test results from the time, it is not possible to know whether this would have affected the outcome for the man. It appears the locum doctor did not request a test using the SystmOne procedure, because he was unfamiliar with the operation of the system. In the absence of a SystmOne request, nurses did not know that a blood test was required. It is important that all clinicians understand and use SystmOne effectively to ensure appropriate care. We would also have expected the next GP who saw the man to have reviewed the record of his last consultation and checked that any issues had been resolved and that any tests had been carried out. This clearly did not happen. We make the following recommendations:

    The Head of Healthcare should ensure that all clinicians working in the prison understand how to use SystmOne and the procedures for requesting tests.

    The Head of Healthcare should ensure that all clinicians seeing patients adequately review their records and check whether issues have been resolved and any outstanding actions have been carried out.

The man's medical treatment

29. The man remained in hospital for some time and healthcare staff from the prison visited him there. They kept in contact with hospital staff for updates about his condition. Hospital staff referred the man to the palliative care team and, after discussion, The man decided he did not want resuscitation to be attempted if he had a cardiac or respiratory arrest. He signed an order to that effect. No active treatment was possible and the main aim was to keep the man as pain free as possible.

30. On 30 April, the man was discharged from hospital. Healthcare staff implemented a care plan to ensure they met the man's care and medical needs, including appropriate pain relief. On 1 May, a prison GP discussed the man's diagnosis with him and explained that he would probably have less than a year to live.

31. The man had regular palliative care reviews with the prison GPs and nurses. GPs reviewed his medications frequently and his pain was well managed. Healthcare staff supported the man well and spent time discussing his condition with him.

32. During May, the man's condition deteriorated after he developed a chest infection and, on 18 May, staff admitted him to the prison's inpatient unit for

oxygen treatment and to allow healthcare staff to monitor him. A prison GP prescribed antibiotics and nurses began a care plan to monitor the man's weight.

33. The man continued to suffer shortness of breath and GPs prescribed antibiotics and oxygen. On 2 June, a doctor told the man that the results of a recent chest X-ray showed that the cancer had spread and he had fluid on his lungs, which affected his breathing. His prognosis was now weeks to months. The man said he understood and the doctor prescribed a low dose of an antidepressant to relieve his anxiety and possibly help his breathing. Staff put a fan in his cell, which the man said helped.

34. Nurses monitored the man every day and he said he was grateful for their support. On 26 June, security staff agreed to leave the man's door open at all times to allow unrestricted nursing care.

35. On 30 June, the doctor spoke to the man's consultant who said his condition had deteriorated and Macmillan nurses should review him. The doctor referred the man for another chest X-ray. On 2 July, the man's breathing deteriorated and he was admitted to Manchester General Hospital. He had an X-ray and the hospital changed his pain relief to a slow release opiate-based patch. He returned to the inpatient unit at the prison on 8 July.

36. On 9 July, a nurse spoke to a Macmillan Nurse for advice about the man's care. The Macmillan nurse was aware of the man's case and said she would visit him when needed. The nurse said that he was comfortable and still able to dress and wash himself.

37. The man continued to lose weight and had no appetite. Doctors prescribed supplement drinks, but on 24 July, he said he did not like them and refused to drink them.

38. The consultant wrote to the prison GPs on 28 July. He said that the man's prognosis was anything between a couple of months or years. He did not consider he was in the last weeks of life, but said his condition could change quickly at any time.

39. On 14 August, nurses were concerned that the man appeared confused and disorientated. He was frequently incontinent of urine, so nurses inserted a catheter and the doctor prescribed antibiotics for a possible urinary infection. The man now needed one to one nursing care and full help with washing and dressing.

40. The man often became agitated and panicky during the night and said he could not breathe, although he was able to speak in full sentences and his blood oxygen saturations were relatively normal. Against staff advice, he would not stay in bed and often walked about his cell without using his crutches as he said he needed air. As a result, he fell in his cell three times in August, but did not suffer any injuries. Staff completed a falls risk assessment and advised the man how to stand and move around his safely.

41. The man sometimes complained of breakthrough pain during the night. (Temporary flares of severe pain despite prescribed pain relief.) On 27 August, a nurse spoke to the community palliative care team, who advised prescribing oramorph (liquid morphine) as well as the pain relief patch and to continue the antidepressant medication.

42. On 8 September a Macmillan Nurse, visited the man and discussed his care with healthcare staff at the prison. The nurse said he was entering the terminal stage of his illness (he was confused and hallucinating) and she would try to get a hospice bed urgently. Doctors changed the antidepressant to diazepam, a relaxant, for a more even and longer-term benefit, which appeared to have a good effect. The man moved to St Ann's Hospice, Bolton, on 11 September and died there on 16 September.

43. The clinical reviewer concluded that the man's clinical care was equivalent to that he might have expected to receive in the community. We are satisfied that he received good care and healthcare staff treated him with dignity and respect. Healthcare staff involved the man in discussions about his care and held frequent multidisciplinary reviews to ensure he received good quality care.

The man's location

44. On 30 April, after the man returned from a long stay in hospital, he stayed briefly in the prison's healthcare inpatient unit, but asked to go back to his wing where he received good support from his friends. The GP agreed he was fit to return to the wing.

45. On 18 May, when the man's condition deteriorated, he moved back to the healthcare unit for regular monitoring and care. He said he felt more comfortable in the healthcare unit than in hospital, where he could not rest properly. On 11 September, the man moved to St Ann's Hospice for end of life care.

46. We are satisfied that the prison appropriately took into account the man's preferences about his location during his illness and that he had suitable accommodation to meet his needs.

Restraints, security and escorts

47. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital, and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes into account factors such as the prisoner's health and

mobility. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

48. The risk assessments for the man when he attended hospital appointments in March, April and July indicated that he was infirm and could not move well as he was in a wheelchair. The assessments indicated that he was a high risk to the public and a medium risk to hospital staff and of escape. Officers used an escort chain for the four appointments. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer). The risk assessment did not change over the four months that the man's condition deteriorated. There was insufficient healthcare input into the assessment. Healthcare staff noted that there were no objections to restraints being used and that he was attending outpatient appointments, but there was no information about his condition or how it affected his risk of escape, as the 2007 High Court judgement requires. While he was in hospital in April 2014, officers removed the escort chain, but reapplied it for the return journey to the prison. We are pleased to note that, when the man moved to the hospice in September for the last few days of his life, restraints were not used.

49. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances, which must be fully considered, taken into account and balanced against the security risks. The man was an elderly and frail man who was known to be suffering from advanced cancer by the time of his later appointments. It is not apparent from the risk assessments how staff concluded that he remained a high risk to the public and needed to be restrained to prevent his escape when he was dependent on a wheelchair to mobilise.

50. There is a need for managers at the prison to ensure that decisions about risk assessments are based on all the available evidence about how a prisoner's health and mobility at the time impact on his risk of escape, rather than when he was fit and healthy. Ultimately, it is the Governor's responsibility to ensure that the process is managed properly, but the Head of Healthcare also needs to ensure that healthcare staff understand their responsibilities and have appropriate and considered input into the risk assessment process. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

Liaison with the man's family

51. After the man’s diagnosis, a Supervising Officer (SO) acted as the prison’s family liaison officer. Throughout his illness, the SO helped the man keep in contact with his brother (his next of kin) and two friends. She kept the man’s brother and his friends informed of his condition and facilitated visits, including when he was in hospital and in the hospice.

52. On 16 September, the SO told the man’s brother that he was in the final stages of his life and offered to arrange a visit. The man’s brother was unable to attend at the time. Later that evening, the SO and a colleague visited the man’s brother and broke the news of his death. They informed his friends by telephone. The man’s funeral was on 15 October and the prison offered a financial contribution towards the costs, in line with national guidelines. We are satisfied that family liaison was appropriate.

Compassionate release

53. Release on compassionate grounds is a means by which prisoners who are seriously ill, usually with a life expectancy of less than three months, can be permanently released from custody before their sentence has expired. A clear medical opinion of life expectancy is required. Among the criteria is that the risk of re-offending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner’s care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of the National Offender Management Service (NOMS).

54. On 14 June, a doctor started a compassionate release application. Because the hospital consultants were not able to give a definitive prognosis, the doctor was unable to be specific and said that the man had a life expectancy of three to nine months. He noted that, due to the cancer spreading and the man’s condition deteriorating, he was less likely to be able to reoffend. The prison submitted the application to the PPCS on 10 July. On 18 July, the PPCS informed the prison that the man was not eligible for release as his life expectancy did not meet the required criteria.

55. The doctor updated the medical section and resubmitted the application on 9 September. He said that the man had deteriorated significantly and was reliant on oxygen. He was not capable of reoffending and he would be suited to hospice care as he was in the terminal phase of his condition. The man moved to a hospice two days later and died on 16 September. The prison did not receive a reply before the man’s death.

56. We are satisfied that the prison appropriately considered compassionate release.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that all clinicians working in the prison understand how to use SystmOne and the procedures for requesting tests.

2. The Head of Healthcare should ensure that all clinicians seeing patients adequately review their records and check whether issues have been resolved and any outstanding actions have been carried out.

3. The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

ACTION PLAN

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible
1	The Head of Healthcare should ensure that all clinicians working in the prison understand how to use SystmOne and the procedures for requesting tests.	Accepted	The Head of Healthcare will provide training and expectations for any non-directly employed staff using SystmOne.	31 March 2015 Head of Healthcare
2	The Head of Healthcare should ensure that all clinicians seeing patients adequately review their records and check whether issues have been resolved and any outstanding actions have been carried out.	Accepted	The Head of Healthcare will provide the necessary training and support clinicians to allow them to review their records, and check if any outstanding actions still need to be addressed and completed.	31 March 2015 Head of Healthcare
3	The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.	Accepted	The Head of Healthcare and Head of Security will identify training for security Band 4 staff to complete risk assessments that take account of both the individual's health and potential risk they present to the public at the time of treatment when attending outside hospital, particularly if the patient is terminally ill.	31 March 2015 The Governor Head of Healthcare Head of Security