

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Alan Hendry a prisoner at HMP Manchester on 14 October 2017

A report by the Prisons and Probation Ombudsman

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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Alan Hendry died on 14 October 2017 of lung cancer while a prisoner at HMP Manchester. He was 52 years old. We offer our condolences to Mr Hendry's family and friends.

Mr Hendry was diagnosed with a terminal illness before arriving at HMP Manchester, and we consider that, overall, the care he received there was of a good standard. However, we are concerned that healthcare staff failed to use medical tools promptly to monitor his weight loss and pressure sores.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Elizabeth Moody
Acting Prisons and Probation Ombudsman

May 2018

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Summary

Events

1. On 22 December 2010, Mr Alan Hendry was convicted of sexual offences. On 4 February 2011, he was given an indeterminate sentence for public protection, with a minimum term of eight years and six months imprisonment. He was initially sent to HMP Manchester, but was transferred to HMP Wakefield on 21 June 2011.
2. In July 2014, Mr Hendry was diagnosed with terminal lung cancer. Towards the end of 2014, he had chemo-radiotherapy which reduced the size of the tumour. During 2015, the tumours in Mr Hendry's lungs increased in size but he declined further treatment. In December 2015, Mr Hendry agreed to palliative chemotherapy, but stopped this in mid-cycle after suffering a reaction.
3. On 7 September 2016, Mr Hendry was transferred back to Manchester to be closer to his family. At his reception health screen, Mr Hendry confirmed that he did not want to be resuscitated if his heart or breathing stopped.
4. Mr Hendry was located on a normal wing at his own request. In October, Mr Hendry was referred to the MacMillan cancer service, and received palliative care support.
5. By December, nurses observed that Mr Hendry had sores on his skin. On 11 February 2017, a nurse noted that he had a pressure ulcer which had caused an open wound. The following day, she started a screening tool to monitor it.
6. In March 2017, Mr Hendry's condition deteriorated, and he was transferred to a hospice in Manchester. By the end of March his condition improved and he returned to the prison. He was immediately located on the healthcare wing, and granted an open-door status to allow unhindered access for nursing staff.
7. Mr Hendry suffered gradual weight loss following his transfer to Manchester in 2016 and, by April 2017, he had lost a third of his body weight. In July, a nurse noted that he had suffered unplanned weight loss, and started a tool to monitor it.
8. Mr Hendry remained on the healthcare wing until his condition deteriorated during the summer. On 3 October, he was transferred back to a hospice.
9. On 14 October Mr Hendry died at the hospice.

Findings

Mr Hendry's clinical care

10. We agree with the clinical reviewer that, overall, the care Mr Hendry received was equivalent to that which he could have expected to receive in the community. He was supported well in respect of his cancer diagnosis, and his wishes regarding treatment were respected. Following his cancer diagnosis, healthcare staff cared for him appropriately, and sought specialist advice and support where necessary.

11. However, we share the clinical reviewer's concerns that healthcare staff did not monitor Mr Hendry's weight loss or pressure sore risk appropriately.

Mr Hendry's location

12. We consider that Mr Hendry was appropriately located during his time in prison. He was transferred to Manchester to be closer to his family. Prison staff then respected his wishes by accommodating him on a regular wing for as long as possible. He was sent to a hospice when his condition deteriorated, and only accepted back when healthcare staff were sure they could care for him adequately. He was then accommodated on the healthcare wing before being sent back to the hospice when his condition deteriorated again.

Liaison with Mr Hendry's family

13. Despite some complicated circumstances in this case, we find that the prison acted appropriately in their contact with Mr Hendry's family throughout his time in prison and while at the hospice.

Compassionate release

14. Mr Hendry had been denied release on compassionate grounds in late 2016. In September 2017, the prison made a fresh application when it was clear that his condition had deteriorated. We are satisfied that the prison acted appropriately in making the compassionate release application when it did.

Restraints, security and escorts

15. We consider that the prison acted appropriately in not restraining Mr Hendry during his last few months at Manchester, including his time at the hospice.

Recommendations

- The Head of Healthcare at HMP Manchester should ensure that staff employ an appropriate weight management tool such as MUST promptly to identify and manage prisoners who are at risk of weight loss or malnutrition.
- The Head of Healthcare at Manchester should ensure that staff are aware of the risk of pressure sores for prisoners with limited mobility, and that they use an appropriate monitoring tool as early as possible

The Investigation Process

16. The investigator issued notices to staff and prisoners at HMP Manchester informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
17. The investigator obtained copies of relevant extracts from Mr Hendry's prison and medical records.
18. NHS England commissioned a clinical reviewer to review Mr Hendry's clinical care at the prison.
19. We informed HM Coroner for Manchester City of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
20. The investigator wrote to Mr Hendry's wife to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. She did not respond to our letter.
21. The investigation has assessed the main issues involved in Mr Hendry'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.
22. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Manchester

23. 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 provides 24-hour nursing care and the healthcare centre includes an inpatient unit

HM Inspectorate of Prisons

24. The most recent inspection of HMP Manchester was conducted in May 2015. Inspectors reported that health services were reasonably good, and most prisoners were satisfied with the quality of healthcare. They also commented that staff on the inpatients' unit provided compassionate care for patients with complex needs.

Independent Monitoring Board

25. 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 2017, the IMB noted that a lack of prison officers on the healthcare wing sometimes hampered access to prisoners in need of medical assistance. However, the Board commended the "continued dedication of individual prison service and NHS staff in providing excellent medical services to prisoners in difficult circumstances."

Previous deaths at HMP Manchester

26. Mr Hendry was the seventh prisoner to die of natural causes at Manchester since January 2016. There are no similarities between his death and the previous ones.

Findings

27. On 22 December 2010, Mr Alan Hendry was convicted of sexual offences. On 4 February 2011, he was given an indeterminate sentence for public protection, with a minimum term of eight years and six months imprisonment. He was initially sent to HMP Manchester, but was transferred to HMP Wakefield on 21 June 2011.

The diagnosis of Mr Hendry's terminal illness and informing him of his condition

28. A nurse reviewed Mr Hendry at a health screen on his reception at Wakefield. She noted that he had no outstanding health concerns, and was fit for a normal cell location and employment.
29. In April 2014, a prison GP examined Mr Hendry after he complained of chest pain. He noted that Mr Hendry had had a heart attack five to six years earlier, and sent him to hospital with suspected angina. Mr Hendry had an x-ray at the hospital, but discharged himself the following day and returned to Wakefield. The hospital informed Wakefield that the x-ray revealed a mass in Mr Hendry's lungs which was consistent with lung cancer. Mr Hendry was due to have a CT scan while he was in hospital, but chose to leave before this could be done. Mr Hendry subsequently underwent his scan as an outpatient, and, on 9 May, a consultant respiratory physician informed healthcare staff at Wakefield that Mr Hendry had a malignant mass in his lungs. He advised that further investigations were needed to determine its extent and to devise long-term management plans for Mr Hendry's condition.
30. Over the next few months, Mr Hendry had a series of tests which confirmed he had a squamous cell carcinoma of the right lung. (This is a type of slow growing cancer that develops in the large airways of the lungs.)
31. On 25 July, a prison GP and a nurse explained this diagnosis to Mr Hendry, and that it was not possible to operate due to the proximity of the mass to his heart. The prison GP explained to Mr Hendry that he would have to see oncologists at the hospital to discuss chemotherapy and radiotherapy.
32. On 7 August, a consultant clinical oncologist reviewed Mr Hendry and confirmed that his lung cancer was inoperable. He explained that without treatment, Mr Hendry's prognosis would be of less than 12 months to live but that he could survive for two to three years with radical chemo-radiotherapy. Mr Hendry agreed to this course of treatment, which was concluded by the end of October. In November, a CT scan revealed that his tumour had reduced in size.
33. On 23 April 2015, a follow up CT scan revealed further shadowing in Mr Hendry's right lung. On 21 May, a consultant clinical oncologist confirmed that Mr Hendry had experienced a relapse in his lung cancer, which had spread. He advised Mr Hendry that without treatment, his prognosis could be measured in months, but that palliative chemotherapy could increase that to between six months and a year. On 26 May, Mr Hendry stated he did not want to receive palliative chemotherapy.

34. By autumn, the masses in Mr Hendry's lungs had increased in size, and a consultant clinical oncologist again offered him palliative chemotherapy. On 23 December, Mr Hendry agreed to the treatment but, on 11 April 2016, he declined to continue, mid-cycle, after suffering a reaction. On 19 April, a consultant clinical oncologist wrote to Wakefield to confirm that Mr Hendry had made a reasonable decision to stop treatment, and advised that he had a prognosis of six to 12 months to live.
35. We are satisfied that Mr Hendry's diagnosis was appropriately recorded and acted on by the prison. Mr Hendry was involved in the decisions relating to this throughout, and his wishes were respected.

Mr Hendry's clinical care

36. On 3 June 2015, while Mr Hendry was at Wakefield, he informed a prison GP that he did not want to be resuscitated if his heart or breathing stopped. A 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) order was completed.
37. On 7 September 2016, Mr Hendry was transferred back to Manchester. A nurse reviewed him at a health screen on his reception, and noted that he had an active DNACPR from Wakefield. Two days later, a prison GP saw Mr Hendry and confirmed his intention not to be resuscitated.
38. On 11 September, a nurse visited Mr Hendry in his cell, and explained her role as an 'over-50s' nurse. She recorded that he was happy on his wing, and did not want to be in the healthcare unit. She conducted a number of health assessments for Mr Hendry, and created relevant care plans.
39. Mr Hendry had initially declined a referral to the MacMillan service for palliative care input but, on 13 October, he consented to a nurse making a referral. On 22 November, a prison GP discussed Mr Hendry's care with his palliative care consultant. Mr Hendry continued to receive palliative care supervision from the MacMillan service.
40. Mr Hendry experienced significant weight loss following his return to Manchester. On 9 September, a prison GP renewed Mr Hendry's prescription for the supplement drinks he was getting at Wakefield. On 27 September, a prison GP recorded Mr Hendry's weight as 82kg. On 13 October, a pharmacist recorded that staff should be aware of the "Unintended weight loss policy" and the "re-feeding policy after food and fluid refusal". On 28 November, a prison GP noted that that the MacMillan service had referred Mr Hendry to a dietician.
41. Mr Hendry continued to lose weight and, by 9 April, his weight had fallen to 53kg, a loss of 29kg (4.5 stones) in a little over six months. On 3 July, a nurse recorded that Mr Hendry had "unplanned weight loss in past 3-6 months (%): 5-10". She started Mr Hendry on a 'Malnutrition Universal Screening Tool', known as MUST. (MUST tools monitor adults who are at risk of malnutrition.) On 13 September, Mr Hendry's weight was recorded as 49kg, indicating that his weight loss had stabilised since April.
42. We share the concerns of the clinical reviewer that Mr Hendry's weight loss was not managed appropriately. During the first six months he was at Manchester, he lost over a third of his body weight. Despite this, the MUST tool was not used

by healthcare staff for a further three months. While we accept that during this period, Mr Hendry was receiving nutritional supplements and was under the supervision of a MacMillan dietician, we would have expected healthcare staff to have implemented this tool much sooner:

The Head of Healthcare at HMP Manchester should ensure that staff employ an appropriate weight management tool such as MUST promptly to identify and manage prisoners who are at risk of weight loss or malnutrition

43. Pressure ulcers are injuries to the skin and underlying tissue resulting from prolonged pressure on the skin. They typically arise when people are confined to the same position for any length of time, such as when they are ill, elderly or otherwise have limited mobility. The National Institute for Health and Care Excellence (NICE), advises healthcare staff to use a screening tool, such as the Waterlow Score, to manage patients who are susceptible to pressure sores.
44. On 20 December 2016, a nurse observed that Mr Hendry had developed a small area of redness on his left hip. She advised him to change his position regularly, and to alert nurses if his skin got worse. On 9 January 2017, a nurse recorded that Mr Hendry's left hip appeared red but was not broken. On 11 February, a nurse noted that Mr Hendry had a grade 2 pressure ulcer on his left hip, approximately 1cm in diameter. (This is a sore below the surface of the skin, leaving an open wound.) The following day, staff started using the Waterlow Score to assess Mr Hendry's skin condition.
45. We acknowledge that healthcare staff correctly advised Mr Hendry to change his position regularly, and to inform nurses if his skin condition deteriorated. We also acknowledge that from 12 February, they used the Waterlow Score tool, and appropriately assessed and managed Mr Hendry's pressure sores from that point. However, we share the clinical reviewer's concerns that this tool should have been used sooner, given the risk posed to Mr Hendry:

The Head of Healthcare at Manchester should ensure that staff are aware of the risk of pressure sores for prisoners with limited mobility, and that they use an appropriate monitoring tool as early as possible

46. Mr Hendry became increasingly unsteady and prone to falling as his condition deteriorated. NICE guidelines advise that risk assessments should be completed for older people, or those at risk of falling. Mr Hendry was still relatively young but, on 18 April 2017, a nurse completed a falls risk assessment for him. This was then reviewed on a regular basis.
47. As Mr Hendry's cancer progressed, he was subject to increasing levels of pain. NICE guidelines recommend a three step approach for dealing with cancer pain relief, designed to regulate and manage the strength of pain killers, particularly opioids (drugs derived from opium, which target the nervous system to relieve pain). Initially, non-opioids (such as aspirin or paracetamol) should be taken orally. If necessary, mild opioids such as codeine may be used. As a last resort, strong opioids such as morphine may be administered, but should be increased or decreased according to the individual patient's changing needs.

48. During his time at Manchester, Mr Hendry received of a variety of pain killers, including strong opioids. The clinical reviewer noted that cancer pain is notoriously difficult to manage, and recognised that healthcare staff occasionally had problems optimising Mr Hendry's pain relief. However, she concluded that they managed Mr Hendry's pain relief appropriately, and kept good records to confirm he was properly assessed.
49. Mr Hendry's condition deteriorated steadily during 2017 and, on 3 October, he was transferred to a hospice. On 14 October, at 4.45am, Mr Hendry was pronounced dead.
50. We agree with the clinical reviewer that overall the care Mr Hendry received in prison was of a good standard. He was regularly reviewed by healthcare staff, and care plans were in place to deal with all of his needs. From November 2016, Mr Hendry received support from the MacMillan service, as well as a specialist palliative care consultant. Mr Hendry was involved with decisions about his care, and his wishes were respected as much as possible
51. Apart from the recommendations outlined above, we are satisfied that Mr Hendry was well looked after in prison, and agree with the clinical reviewer that his care was equivalent to that which he could have expected to receive in the community.

Mr Hendry's location

52. On 7 September 2016, Mr Hendry was transferred back to Manchester to be closer to his family. At his reception health screen, a nurse informed Mr Hendry that the controlled drugs he was receiving at Wakefield could only be provided in the healthcare unit. Nevertheless, Mr Hendry declined the offer of an inpatient location and stated he wanted a normal cell location. He was immediately located on E Wing.
53. During the following months, Mr Hendry reaffirmed his desire to remain on E Wing. On 21 November, a prison GP advised the MacMillan service of his wish, and extra steps were taken by the prison to enable them to visit him on the wing.
54. By March 2017, Mr Hendry's health had deteriorated and, on 10 March, he was transferred to a hospice. His condition improved and, on 21 March, a prison GP visited the hospice, where staff advised him that Mr Hendry would have been discharged if he had been a regular patient. On 31 March, Mr Hendry was transferred back to Manchester but was immediately located in the healthcare wing. He was granted open door status, which meant that nursing staff could gain unhindered access to his cell at any time.
55. Mr Hendry remained in the healthcare wing, but his condition deteriorated during the summer. On 3 October, he was transferred back to a hospice, where he remained until he died.
56. We agree with the clinical reviewer that Mr Hendry was appropriately located during his final few months in prison. Staff at Manchester respected his wish to remain on a regular wing for as long as possible, and took extra steps to accommodate him there. Following Mr Hendry's transfer to a hospice in March 2017, prison healthcare staff resisted the hospice's decision to transfer him back to Manchester until they were convinced that that they could safely

accommodate him. On his return to Manchester, Mr Hendry was immediately located on the healthcare wing and given an open door status to enable healthcare staff to have 24-hour, unhindered access. The prison constantly reviewed Mr Hendry's location, and we consider its decision to transfer him back to the hospice in October was appropriate.

Restraints, security and escorts

57. When prisoners have to travel outside of the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk, taking into account factors such as the prisoner's health and mobility.
58. Mr Hendry was not restrained during his last months at Manchester, and we consider that the prison acted appropriately in deciding not to restrain him.

Liaison with Mr Hendry's family

59. Mr Hendry's nominated next of kin was his wife. He also had several daughters and grandchildren, but contact was forbidden with children due to the nature of his offence.
60. Mr Hendry was at Wakefield when he was first diagnosed with lung cancer. On 25 July 2014, a nurse spoke to Mr Hendry's wife at his request, and explained the diagnosis and the management plan for him.
61. On 3 October 2016, Manchester appointed two family liaison officers (FLO). That day, a FLO introduced herself to Mr Hendry on the wing, and to his wife on the telephone.
62. On 9 March 2017, a FLO informed Mr Hendry's wife that her husband's condition had deteriorated and he was being transferred to a hospice. Two days later, Mr Hendry's wife asked whether their young daughters would be allowed to visit him there. The duty governor confirmed that this would not be possible due to the court order restricting Mr Hendry's contact with children.
63. On 21 March, staff at the hospice voiced their concerns to a FLO and the governor about the number of visitors at Mr Hendry's bedside. They raised these issues with Mr Hendry's wife, and reminded her that the younger family members were not allowed to visit. On 2 April, Mr Hendry's wife expressed her disappointment that her husband was being transferred back to Manchester.
64. On 4 October, a FLO informed Mr Hendry's wife that he had been transferred back to the hospice, and that a maximum of three people were allowed to visit at any time. She enquired whether their 16 and 17-year-old daughters would be allowed to visit but, following contact with social services, this was again refused.
65. Mr Hendry's wife was by his bedside when he died on 14 October. Shortly after his death, a FLO spoke to Mr Hendry's wife on the phone and offered his condolences and support. Two days later, he visited her in person.

66. Mr Hendry's funeral was held on 22 November. The prison contributed to the costs in line with national guidance.
67. We recognise that Mr Hendry was not able to see his two youngest daughters or grandchildren before he died but we accept that the prison acted properly given the nature of his offence and a court order preventing child contact. The prison explained their reasons to Mr Hendry's wife and engaged with her throughout his time at Manchester and a hospice. We consider that the prison acted appropriately in their contact with Mr Hendry's family.

Compassionate release

68. 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. The criteria for early release for indeterminate sentenced prisoners are set out in Prison Service Order (PSO) 4700. 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 Her Majesty's Prisons and Probation Service (HMPPS).
69. Shortly after Mr Hendry's return to Manchester, he applied for compassionate release. On 30 December 2016, a probation officer noted that "due to the nature and severity of Mr Hendry's offending, a multi-agency approach would be required to safely manage him in the community...". There is no further record of a renewal of this application until later in 2017.
70. On 22 September 2017, the Head of Healthcare emailed Safer Custody to initiate an application for compassionate release for Mr Hendry. This application was submitted but on 28 September was refused. The panel stated that Mr Hendry still posed a risk to the public that was unmanageable.
71. Although a renewed application for compassionate release was not submitted when Mr Hendry's condition deteriorated in March 2017, we recognise that an application had only recently been declined. We acknowledge that when his condition deteriorated in September, a fresh application was completed within a week. We find that the prison acted appropriately and in a timely manner in making this application for compassionate release.

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