

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Buchan a prisoner at HMP Manchester on 23 October 2018

A report by the Prisons and Probation Ombudsman

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.

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

Mr David Buchan died on 23 October 2018, of lung cancer at HMP Manchester. He was 64 years old. I offer my condolences to Mr Buchan's family and friends.

I am satisfied that the standard of care Mr Buchan received first at HMP Buckley Hall and later at Manchester was equivalent to that which he could have expected to receive in the community.

I am concerned however, that risk assessments lacked information about why it was considered necessary to use restraints when Mr Buchan attended hospital, and assessments were not informed by medical information. It is also disappointing that important documents relating to restraints (between August and October 2018) have been lost, and I am having to remind HMP Manchester and HMP Buckley Hall of the importance of transferring and retaining prisoners' documentation safely and securely.

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

Sue McAllister CB
Prisons and Probation Ombudsman

June 2019

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Summary

Events

1. On 2 August 2007, Mr Buchan was sentenced to life imprisonment for murder. He received a minimum tariff of 15 years.
2. On 4 September 2013, Mr Buchan was transferred to HMP Buckley Hall then on 4 September 2018, to a hospice. He later transferred to HMP Manchester 1 October 2018.
3. In August 2017, Mr Buchan told a nurse he had a pain in his right side and a productive cough. A doctor made a referral for him to have an X-ray and the results showed a shadow on his lung. He had a bronchoscopy, and the results confirmed he had lung cancer. In October 2017, further investigations indicated his condition was terminal.
4. In November, Mr Buchan signed a DNACPR order, but his mental capacity was not assessed as part of the process. In December, staff from a local hospice visited Mr Buchan to explain how they could contribute to his care.
5. Mr Buchan took Spice (a psychoactive substance) on two occasions following his diagnosis (December 2017 and April 2018) but he refused support from the Drug and Alcohol Recovery Service.
6. As Mr Buchan's health deteriorated, he attended counselling sessions and was given a wheelchair and a walking frame. He was sent to a hospice in August 2018, but was discharged and transferred to HMP Manchester's palliative care suite on 1 October.
7. On 23 October 2018, Mr Buchan died at HMP Manchester.
8. The coroner gave the cause of death as lung cancer.

Findings

9. We are satisfied that the standard of healthcare Mr Buchan received at Buckley Hall and Manchester was equivalent to that which he could have expected to receive in the community.
10. From December 2017 to August 2018, Mr Buchan was restrained with a single cuff or escort chain when he attended hospital for treatment. We could not establish whether this was appropriate or proportionate because the risk assessments lacked information about how Mr Buchan's medical condition affected his risk or why restraints were considered necessary.
11. We are concerned that following Mr Buchan's transfer to Manchester, important paperwork went missing relating to his hospice stay, particularly the restraints arrangements.

Recommendations

- The Governor and Head of Healthcare at HMP Buckley Hall should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints 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.
- The Governor of HMP Buckley Hall should revise the prison's escort risk assessment form to ensure that it requires:
 - healthcare staff to say whether the prisoner's current state of health has an impact on his mobility; and
 - prison staff to show that they have taken this information into account in assessing the prisoner's current level of risk,and should send the Ombudsman a copy of the revised form.
- The Governors of HMP Buckley Hall and HMP Manchester, should ensure that when prisoners transfer between establishments, prisoners' documentation is forwarded to the receiving establishment and on receipt, is stored securely and can be retrieved, as necessary.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Manchester informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
13. The investigator obtained copies of relevant extracts from the prison and medical records.
14. NHS England commissioned a clinical reviewer to review Mr Buchan's clinical care at the prison.
15. We informed HM Coroner for Manchester City Area of the investigation. A post-mortem examination was not conducted but the coroner gave us the cause of death. We have sent the coroner a copy of this report.
16. The investigator wrote to Mr Buchan's named next of kin to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond to our letter.
17. The investigation has assessed the main issues involved in Mr Buchan'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.
18. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HM Prison Buckley Hall

19. HMP Buckley Hall is a medium security prison holding just over 400 men. There are four residential blocks, one of which is a dedicated drug recovery wing. Greater Manchester Mental Health NHS Foundation Trust provides healthcare seven days a week with a multidisciplinary team of GPs, general and mental health nurses.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Buckley Hall was in June 2016. Inspectors reported that an advanced nurse practitioner was the Head of Service and provided effective leadership to a small team of healthcare professionals with a reasonable range of competencies. Not all healthcare staff were in date for mandatory training, and not all received regular, documented clinical supervision. Primary care services were appropriate for the prison population and met their needs.
21. The prison introduced a well man screening clinic to attract new patients. Access to the GPs had improved since the last inspection and was similar to that in the community, with out-of-hours cover. Patients in the segregation unit were visited daily by healthcare staff. The prison had developed palliative care policies but these were rarely needed.

Independent Monitoring Board

22. 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 ending 31 July 2016, the IMB reported that primary care services at Buckley Hall were considered generally good. It noted the waiting time for prisoners to see a doctor or dentist was low and much improved compared to the figures recorded in the Board's previous Annual Report. The healthcare department had policies in place for adult safeguarding and for managing prisoners needing palliative care.

Previous deaths at HMP Buckley Hall

23. Although Mr Buchan did not die at Buckley Hall, he received most of his care there. There have been three other deaths at Buckley Hall, two were from natural causes and one was a self-inflicted death. There are no similarities with Mr Buchan's case.

HM Prison Manchester

24. 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

25. The most recent inspection of HMP Manchester took place in June and July 2018. Inspectors reported that compared to their last inspection in 2014, where the prison achieved reasonably good outcomes against their healthy prison tests, at this inspection there had been a deterioration on most outcomes. However, the Inspectors observed professional interactions between healthcare staff and prisoners, and clinical records and care plans were very good. Continuity of care was also good with most locum GPs and agency nurses working at the prison regularly. A dedicated nurse provided annual health checks and age-related screening.

Independent Monitoring Board

26. In its latest annual report, for the year to February 2018, the IMB noted that 50% of residential wings did not have the desired levels of staff on duty and the fabric of the building was generally in poor condition. They commended plans to improve cells so that they would be fit for wheelchair users and described the healthcare provision as excellent.

Previous deaths at HMP Manchester

27. Mr Buchan was the nineteenth death at HMP Manchester since October 2015. Ten of the previous deaths were from natural causes and nine were self-inflicted deaths. There has been one further natural causes death since Mr Buchan's death. There are no similarities between those cases and Mr Buchan's.

Findings

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

28. On 2 August 2007, Mr Buchan was sentenced to life imprisonment for murder. He received a minimum tariff of 15 years. He was transferred to HMP Buckley Hall on 4 September 2013.,
29. Between March 2016 and September 2017, Mr Buchan presented with symptoms including dizziness, coughing up small amounts of blood and weight loss. Healthcare staff appropriately investigated his symptoms and a chest X-ray taken in May 2016 was normal. Mr Buchan's weight was checked and he had not lost a significant amount. Spirometry tests showed that his breathing was normal. He was offered smoking cessation advice, which he declined.
30. In August 2017, a nurse saw Mr Buchan. He had had a productive cough and a right sided pain. He was not short of breath and could communicate in long sentences, but the nurse discussed his symptoms with a GP. The GP made a referral for another chest X-ray and this took place the following day.
31. On 29 August, Mr Buchan had an appointment with a GP, to discuss the X-ray results. The scan showed a shadow on the left-hand side of his lung and there was concern that it was cancer. Further tests were needed to confirm a diagnosis. An urgent referral was made for a bronchoscopy (a procedure where a camera is inserted via the nose or mouth into the lungs to aid diagnosis).
32. On 27 September, a GP received the bronchoscopy results which confirmed that Mr Buchan had lung cancer. He discussed the findings with Mr Buchan. Further investigations were needed and on 6 October, Mr Buchan had an MRI (Magnetic Resonance Imaging) scan.
33. On 13 October, a nurse recorded that she had attended a Multi-Disciplinary Team (MDT) meeting to discuss Mr Buchan and the impending scan results. Mr Buchan had been made aware that he could ask staff questions about his diagnosis and treatment at any time.
34. On 18 October, Mr Buchan attended a hospital appointment to receive the scan results. An oncologist, told him that the cancer had spread to his brain and liver, and was terminal.
35. The clinical reviewer found that the care Mr Buchan received in terms of his diagnosis was equivalent to that which he could have expected to receive in the community. We agree. Healthcare staff appropriately investigated Mr Buchan's symptoms, made timely referrals to secondary care providers and discussed his diagnosis with him.

Mr Buchan's clinical care

36. On 18 October 2017, after Mr Buchan received his terminal diagnosis, a nurse reviewed him and reiterated that staff were there to help him. She made an appointment for him to see a GP the next day. The GP said that Mr Buchan would be having a course of radiotherapy to deal with the spread to his brain, followed by chemotherapy for the rest of his body. Mr Buchan seemed dazed but he said his pain was well controlled.
37. MDT meetings were held regularly to discuss Mr Buchan's treatment plan and the possibility of early release.
38. On 15 November, the oncologist told Mr Buchan that his prognosis was 6-12 months and on 17 November, a GP discussed A Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order (which means that, in the event of cardiac or respiratory arrest, no attempt at resuscitation will be made) with Mr Buchan. Mr Buchan said that he did not want to be resuscitated and signed the DNACPR order. This information was shared at an MDT meeting on 23 November.
39. In December 2017, staff from a hospice visited Mr Buchan to discuss what care and support they could offer. Mr Buchan also began his radiotherapy treatment. Between December and August 2018, when Mr Buchan attended hospital for treatment, he was escorted by two officers and was restrained using single cuffs, and an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer).
40. On 15 December, staff administered oxygen therapy to Mr Buchan after he had taken an illicit substance. He said he took the drugs because of lower back pain (which he had previously suffered from). He was advised against self-medicating and was referred to the Drug and Alcohol Recovery Service (DARS), although he declined their support.
41. On 18 December, Mr Buchan was admitted to hospital with suspected pneumonia and a possible pulmonary embolism (a blood clot in the lung). He was discharged from hospital and returned to the prison after two days.
42. On 16 January 2018, Mr Buchan had a follow up visit from the DARS team and again, he declined additional support from them and said that he only had 6-12 months to live. On 6 April, staff suspected he had taken PS. A nurse discussed the incident with Mr Buchan the next day. She asked him to think and talk to her about the impact his actions had on himself and others. On 10 April, the DARS team reviewed him again, and again, Mr Buchan declined their support.
43. Mr Buchan attended counselling sessions between May and July, and he appeared to value the time and opportunity to talk.
44. On 14 May, Mr Buchan was assessed by a 'Falls Prevention Team' and on 25 May, he received a wheelchair, followed by a walking frame on 5 July.
45. On 27 July, a GP logged a letter from the hospital which said that they were stopping Mr Buchan's treatment plan as it was of no benefit to him, and his life expectancy was reduced to three months. The GP noted that they were to plan

for both palliative and end of life care and arrange anticipatory medicine (medication that might be needed to manage distressing symptoms in the last days of life). On 6 August, Mr Buchan had an appointment at the hospital to explain this to him.

46. Arrangements were made for Mr Buchan's interim transfer to a hospice for respite care as Buckley Hall could not offer 24-hour nursing care and his condition was deteriorating. On 17 August 2018, he was moved to the hospice.
47. On 1 October, when his condition stabilised, Mr Buchan was returned to prison but this time, to HMP Manchester which has a palliative care unit. Staff from the hospice remained in contact with prison staff. Staff at Manchester conducted appropriate assessments when Mr Buchan arrived, including checks for deep vein thrombosis, malnutrition and pressure sores. A nurse created care plans for pain control, breathing, mobility, skin integrity and diets. Regular reviews were scheduled and carried out.
48. By 13 October, Mr Buchan's condition had deteriorated. He had difficulty swallowing and developed new pains in his side. A GP from the hospice agreed he should be re-referred to their facility and that a move could take place when a bed became available (it was thought this might be on 24 October).
49. However, on 23 October, Mr Buchan deteriorated further and began coughing up blood. At 7.44am, it was confirmed that Mr Buchan had died.
50. We are satisfied that the clinical care Mr Buchan received was equivalent to that which he could have expected to receive in the community. Staff appropriately monitored Mr Buchan and responded to any deterioration in his condition. Clinical notes were also of a good standard.

Mr Buchan's location

51. Buckley Hall does not have 24-hour healthcare but Mr Buchan asked to stay at that prison for as long as possible. He was moved to a residential wing that was much nearer to the healthcare unit in March 2018. When his condition deteriorated, he was transferred temporarily to a hospice and once his condition had improved, he was transferred to HMP Manchester's palliative care suite.
52. We are satisfied that Mr Buchan was located appropriately while staff simultaneously took into account his wishes.

Restraints, security and escorts

53. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. 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 takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment 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.

54. The investigation found that Mr Buchan was restrained from December 2017 to August 2018 when he attended hospital for treatment. He was escorted by two officers and was restrained using single cuffs and an escort chain. All risk assessments during this period contained the same minimal information that he was a category C prisoner, a high risk of harm to the public and a low risk of escape. There was no indication that he had any mobility issues in the majority of risk assessments.
55. We are aware that subsequent compassionate release paperwork said that security concerns were raised about Mr Buchan's behaviour, including his use of PS, attempting to procure alcohol and being abusive towards staff during this time. However, we are concerned that there was no recorded information about these concerns on the risk assessment paperwork at the time and no explanation for why restraints were considered necessary.
56. None of the risk assessments recorded medical objections to restraints being used, and only one risk assessment (on 12 June) referred to his mobility. This said that, due to Mr Buchan's possible wheelchair use to mobilise, he may need to be restrained using single cuffs.
57. We recognise that Mr Buchan was not restrained on his hospital visit on 6 August because of his of his current health and lack of capacity to escape. We are satisfied that the prison's risk assessment on this occasion fully considered the medical implications for use of restraints.
58. It is the Governor's responsibility to ensure that the risk assessment process is managed properly, and all prison managers need to show a clear justification for any use of restraints when they complete an escort risk assessment. Healthcare staff also need to understand their role in assessing the impact the prisoner's current state of health has on his mobility. We are concerned that Buckley Hall's escort risk assessment form does not make this sufficiently clear.
59. We are also concerned that neither Buckley Hall nor Manchester could provide us with a copy of the escort risk assessments relating to Mr Buchan's stay at the hospice between August and October 2018.
60. We make the following recommendations:

The Governor and Head of Healthcare at HMP Buckley Hall should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints 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.

The Governor of HMP Buckley Hall should revise the prison's escort risk assessment form to ensure that it requires:

- **healthcare staff to say whether the prisoner's current state of health has an impact on his mobility; and**

- **prison staff to show that they have taken this information into account in assessing the prisoner's current level of risk,**
- and should send the Ombudsman a copy of the revised form.**

The Governors of HMP Buckley Hall and HMP Manchester, should ensure that when prisoners transfer between establishments, prisoners' documentation is forwarded to the receiving establishment and on receipt, is stored securely and can be retrieved, as necessary.

Liaison with Mr Buchan's family

61. Following Mr Buchan's diagnosis, HMP Buckley Hall appointed a family liaison officer (FLO). The FLO visited Mr Buchan and discussed his role and available support. He contacted Mr Buchan's next of kin the following day to organise a visit and to make himself known as the family's point of contact. He stayed in contact with the family and HMP Manchester's FLO. After Mr Buchan's death, the FLO informed the family of his death, and he visited the family in person to deliver the news.
62. Mr Buchan's funeral was held on 13 November 2018. The Prison Service contributed to the funeral costs in line with national policy.

Compassionate release

63. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months.
64. In January 2018, the Public Protection Casework Section (PPCS) received an application for Mr Buchan's compassionate release. On 15 July 2018, the application was rejected because although it was clear his prognosis had significantly shortened, PPCS considered that his risks had not sufficiently reduced in order to release him early from a life sentence. We are satisfied that the prison appropriately considered and applied for compassionate release.

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