

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Bernard Fisher, a prisoner at HMP Manchester, on 13 September 2020

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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Summary

1. 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.
2. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
4. Mr Bernard Fisher died of a bowel obstruction caused by colon cancer on 13 September 2020 while a prisoner at HMP Manchester. He was 89 years old. We offer our condolences to those who knew him.
5. The clinical reviewer concluded that the clinical care that Mr Fisher received at Manchester was of a reasonable standard and was at least equivalent to that which he could have expected to receive in the community.
6. The clinical reviewer said that prison GPs and healthcare staff assessed and reviewed Mr Fisher's bowel cancer in a timely manner and that he had appropriate investigations and referrals to specialists.
7. However, the clinical reviewer said that healthcare staff did not consider advanced care planning (a process that supports adults at any age or stage of health in understanding and sharing their personal values, life goals and preferences regarding future medical care) for Mr Fisher. He also said that staff did not complete a Respect form (a national patient held document completed during the advanced care planning process).
8. We did not identify any non-clinical issues of concern.

Recommendations

- **The Head of Healthcare should ensure that advanced care planning is offered to prisoners nearing end-of-life and that a Respect form is completed as part of this process.**

The Investigation Process

9. NHS England commissioned a clinical reviewer to review Mr Fisher's clinical care at HMP Manchester. The clinical review is attached to this report at Annex 1.
10. The PPO investigator has investigated the non-clinical issues in Mr Fisher's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
11. We shared the initial report with the Prison Service. There were no factual inaccuracies and their action plan has been appended to this report.
12. This version of the PPO report, published on the PPO website, has been amended to remove the names of the staff and prisoners involved in the investigation.

Previous deaths at Manchester

13. There were seven deaths from natural causes (one of which was related to COVID-19), four self-inflicted deaths and three drug related deaths at HMP Manchester in the two years before Mr Fisher's death. There are no significant similarities between our findings in this investigation and those of the other deaths.

Key Events

14. On 8 April 2016, Mr Bernard Fisher was convicted of sex offences and was sentenced to eleven years in prison. He was sent to HMP Manchester.
15. On 6 June 2017, Mr Fisher went to hospital for a colonoscopy (a fibre-optic examination of the large intestine) and a gastroscopy (a gastroscope is an instrument used to examine or view the interior of the stomach) after a prison GP locum saw that he was anaemic. The colonoscopy and gastroscopy showed that Mr Fisher had colon cancer.
16. On 10 July, Mr Fisher went to hospital where hospital staff fitted a colonic stent (a procedure to widen a blocked area of the bowel).
17. On 24 September 2018, Mr Fisher went to hospital because he had severe pain in his abdomen and vomiting. Hospital staff found that he had a large bowel obstruction and that his colon cancer was worsening and fitted another colonic stent.
18. On 11 April 2019, Mr Fisher transferred to the enhanced care suite in the healthcare in-patient unit and a prison manager authorised that his door could be open 24-hours so that healthcare staff could see him easily.
19. On 8 September 2020, a prison GP, sent Mr Fisher to hospital because he was vomiting and had severe abdominal pain. Mr Fisher's condition deteriorated in hospital and on 13 September, he died of a bowel obstruction caused by colon cancer.

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