Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Raymond Terrett, a prisoner at HMP Manchester, on 5 May 2021

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*

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. Mr Raymond Terrett (also known as Ray Terret) died on 5 May 2021 of colon and rectum cancer at HMP Manchester. He was 79 years old. We offer our condolences to Mr Terrett's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Terrett received at Manchester was equivalent to that he could have expected to receive in the community. She made no recommendations.

5. We found no non-clinical issues of concern. We make no recommendations.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer, to review Mr Terrett's clinical care at HMP Manchester. The clinical reviewer's report is attached as Annex 1.

7. The PPO investigator has investigated non-clinical issues, including Mr Terrett's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

8. The PPO family liaison officer wrote to Mr Terrett's next of kin, his partner, to explain the investigation. She had questions about hospital decisions, which do not fall within our remit, as well as the prison's management of his complex health needs following his stroke, and how the prison communicated with her throughout Mr Terrett's illness. These issues have been addressed in the clinical review and this report.

9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

10. We sent a copy of our initial report to Mr Terrett's partner. She pointed out some factual inaccuracies which we have amended in this report.

Previous deaths at HMP Manchester

11. Mr Terrett was the 14th prisoner to die at Manchester since May 2019. Of the previous deaths, eight were from natural causes, one was self-inflicted, two were drug-related and in two cases, the cause of death was unascertained.

Key Events

12. On 5 December 2014, Mr Raymond Terrett was convicted of sexual offences and sent to HMP Manchester. He was sentenced to 25 years in prison on 11 December.

13. On 13 December 2018, a prison GP reviewed Mr Terrett due to bleeding in the rectum. The GP referred him to hospital under the NHS pathway that requires patients with suspected cancer to be seen by a specialist within two weeks.

14. On 29 December, Mr Terrett was taken to hospital after having a stroke. He remained there until 11 January 2019. Due to his stroke, hospital surgeons decided to postpone Mr Terrett's colonoscopy (a test to check inside the bowels) until 31 January.

15. On 1 March, a hospital surgeon diagnosed adenocarcinoma of the sigmoid colon (cancer of the bowel). The surgeon explained to Mr Terrett that due to his recent stroke, surgery would not be appropriate, and advised Mr Terrett he would be reviewed again in three months.

16. Mr Terrett had a second stroke on 31 March. He remained in hospital until 15 April. The hospital surgeon subsequently advised him that due to his strokes, major surgery would not be appropriate.

17. In March 2020, prison staff contacted Mr Terrett's next of kin to update her on his medical condition. They provided regular and frequent updates.

18. On 6 August, healthcare staff observed Mr Terrett and noted he had raised blood pressure, was vomiting, and had a distended abdomen. The GP arranged for Mr Terrett to be transferred to hospital in an ambulance. The hospital administered antibiotics and told the prison that a scan on his stomach suggested that the cancer had progressed.

19. On 18 August, a multidisciplinary team meeting confirmed Mr Terrett's cancer had spread to his brain following an MRI scan. Mr Terrett returned to Manchester's healthcare facility on 21 August, to continue palliative treatment.

20. On 23 August, Mr Terrett's next of kin wrote to the Governor asking why she was not informed of Mr Terrett's hospitalisation until 14 August. She received a response from the Head of Mental Health and Inpatients on 4 September, which said that security protocol is to inform the next of kin after seven days unless the condition is life threatening.

21. In October, while the prison was in lockdown during the COVID-19 pandemic, the prison made an exception for Mr Terrett's next of kin and allowed her to visit him as part of his end of life pathway.

22. On 22 October, an application for Mr Terrett's early release on compassionate grounds was submitted to the Public Protection Casework Section (PPCS) of Her Majesty's Prison and Probation Service (HMPPS). The application was refused as there was no clinical evidence that his life expectancy was less than three months, he was not physically incapacitated, and they were not persuaded that his risk of reoffending was past.

23. Mr Terrett continued to be managed in the prison healthcare facility where he progressively deteriorated. He died in prison on 5 May.

Cause of death

24. The Coroner accepted the cause of death provided by a prison doctor and no post-mortem examination was carried out. The doctor gave Mr Terrett's cause of death as malignant disease (cancer) caused by sigmoid adenocarcinoma (colon and rectum cancer).

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Assistant Ombudsman

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