

**Investigation into the circumstances surrounding the death  
of a man at North Manchester General Hospital in November  
2007 whilst in the custody of HMP Manchester**

**Report by the Prisons and Probation Ombudsman for  
England and Wales**

**July 2008**

This is the report of an investigation into the death of a man who died of natural causes in November 2007, at North Manchester General Hospital, whilst in the custody of HMP Manchester. He was 51 years old.

I would like to add my personal condolences to those already expressed to the man's family by one of my Family Liaison Officers.

This investigation was undertaken by one of my investigators. Both he and I would like to thank the Governor and his staff for their participation in the investigation. Manchester Primary Care Trust undertook a review of the man's clinical care, and I appreciate its assistance and report. However, the clinical review into the man's death was not received in my office until the middle of June 2008 and this has resulted in the delay in my issuing this report, for which I must apologise.

As is the case in many of my investigations following a death from natural causes, I am heavily influenced by the findings of the clinical review. The clinical reviewer finds that the man's health deteriorated while in prison, and he received prompt treatment of a good standard. There are some areas where performance could be improved, but they did not make a material difference to the man's health and certainly did not cause or hasten his death.

There have been 19 deaths of prisoners of HMP Manchester since I took over responsibility for investigating deaths in custody. This case is not comparable to any of the others, but two of my previous reports included recommendations about the use of individual nursing care plans. The clinical reviewer for this report again makes such a recommendation. I am pleased to see that the prison has since introduced an assessment tool to produce such plans. This being the case, I do not make a recommendation and I hope that the new tool is monitored to ensure that it is effective.

This report has been anonymised for publication on the website of the Prisons and Probation Ombudsman.

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## **SUMMARY**

The man who is the subject of this report was 51 years old when he died in November 2007, in North Manchester General Hospital whilst in the custody of HMP Manchester. He was received into custody in June 2007, when arrested at Manchester Airport whilst entering the country. He was subsequently convicted and sentenced to six years' imprisonment.

On reception into prison it was noted that the man suffered from ill-health, specifically diabetes which was controlled by tablets, and hypertension. Between reception into prison and his death, healthcare services monitored his known health problems and worked with outside health providers in North Manchester General Hospital.

By late October, the man's health had deteriorated and he was admitted into North Manchester General Hospital. He remained in hospital for seven days, the prison maintaining regular contact with the hospital in this time. The man had not provided any details for next of kin or anyone to be contacted in an emergency. As his condition was not thought to be imminently life-threatening, no attempts were made to contact his family. He returned to prison on 25 October.

On his return to prison the man was located as an in-patient in the healthcare wing. He remained there until the morning of 6 November, when one of the nurses, on checking patients, found him lying on the floor of his cell. An ambulance was called, and he was taken to North Manchester General Hospital. It was subsequently confirmed that he had suffered a stroke.

The man remained in hospital for a week, and appeared to be stable. However, at approximately 5.40pm on the evening of 13 November, he suffered a fit. Medical staff attended immediately, and attempted to revive him. Escorting officers removed the restraints on the man, and a crash team arrived and attempted to revive him. Sadly, they were unsuccessful, and at 6.00pm escorting officers were told that he had died.

The clinical review identified that broadly speaking, the man received good medical care in prison. His known medical conditions were treated, and he received regular monitoring and treatment as his health deteriorated. There is a need to ensure that there is a system that identifies actions requiring follow-up, but this did not materially affect the man's death. I make four recommendations.

## THE INVESTIGATION PROCESS

1. My investigator visited the prison. He spoke to a number of staff there, including the Governor, and was shown extensively around the prison. He formally interviewed two members of staff. These interviews were tape recorded and both interviewees signed a copy of their transcripts confirming the accuracy of the record. Notices were posted to staff and prisoners about the investigation, inviting contributions. No responses were received. My investigator studied all available relevant prison records relating to the man. These included his security record, medical records and statements made by staff. Unfortunately, the man's wing history file could not be found and despite staff's efforts to locate it, it remains missing.
2. Manchester Primary Care Trust carried out a review of the man's clinical care. I am grateful to it for undertaking this review. My investigator discussed aspects of the man's treatment with both healthcare staff at Manchester and the clinical reviewer.
3. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the Post Mortem report. Upon completion, my report will be sent to the Coroner to assist in his enquiries into the man's death.
4. The man was Nigerian, and his family live in Nigeria. One of my Family Liaison Officers contacted the representative of the man's family in the United Kingdom to offer the opportunity to raise any questions or concerns for the investigation to consider. They were also offered the opportunity to see my report at draft and final stages. The man's family said that he was a diabetic and suffered from high blood pressure (hypertension), and asked if the investigation could ensure that he received the appropriate care. They also wanted to know the exact cause of the man's death. I hope I have answered these questions to their satisfaction in my report. My Family Liaison Officer gave contact details for my office and advised them not to hesitate to contact us if they had any further points they wished to raise. The family requested a copy of my report when available.

## **HMP MANCHESTER**

5. HMP Manchester was originally opened in 1868. It is a category A local prison accommodating male adult prisoners. It holds those sent to custody by courts in the Greater Manchester area (remanded, convicted or sentenced) and allocates to training prisons if/when places are available.
6. Major disturbances in 1990 led to the prison being rebuilt, and in 2003 Manchester became part of the high security estate. The prison consists of two separate radial blocks, and its mix of single and double cells all have power points and integral sanitation. As of October 2006 it had capacity to hold 1,269 prisoners.

## **Healthcare**

7. Healthcare is housed in a self-contained two-level block. Out-patient provision is on the lower level, and in-patient facilities are on the upper level. There are 38 beds for in-patients. Including medical and discipline staff, there are approximately 70 members of staff who work in the healthcare department.
8. Healthcare provides 24-hour nursing cover. Doctors are on site from 8.00am until 9.00pm at night on weekdays, from 10.30am until 3.00pm on Saturdays, and for two hours on Sundays (the exact times are not set). Beyond these hours, emergency cover is provided from outside by the Primary Care Trust.

## **Foreign national prisoners**

9. In November 2007, there were 194 prisoners in Manchester who were foreign nationals. This included prisoners detained under immigration legislation. This amounts to just under 16% of the prisoner population. Of this number, 20 were of Nigerian origin.
10. There are no official support networks for foreign national prisoners, but the prison are aware of the particular difficulties such prisoners can face. The prison uses a telephone instant translation service for prisoners who cannot speak English. Induction packs contain information for prisoners who are foreign nationals, though this concentrates on immigration and repatriation issues. As noted above, the man spoke and understood English, and being a foreign national does not seem to have played a part in his death.

## **Previous deaths in Manchester**

11. There have been 19 deaths of prisoners at Manchester since I took over responsibility for investigating deaths in custody. The death of the man who is the subject of this report is not directly comparable to any of the

other deaths, so I will not list my previous recommendations here. But two of my previous reports do include recommendations about ensuring that patients are given nursing care plans. The clinical reviewer again draws attention to this in the report for this investigation.

### **Her Majesty's Inspectorate of Prisons (HMIP)**

12. Her Majesty's Inspectorate of Prisons last visited the prison in an unannounced visit in May 2007. The report showed the prison as improving from the time of the previous inspection. None of the issues raised in the report are particularly relevant to this investigation.

### **Independent Monitoring Board (IMB) report covering the period 1 March 2005 – 26 February 2006**

13. Each prison in England and Wales has an Independent Monitoring Board responsible for monitoring day-to-day life in the prison and to ensure that proper standards of care and decency are maintained. The last report published by the IMB when the man arrived in Manchester does not raise any issues which I consider need to be noted here.

## KEY FINDINGS

14. The man was arrested at Manchester Airport in June 2007 and he was remanded to HMP Birmingham. His reception notes show that he said that he had no previous experience of prison, and the Police National Computer confirms that he had no previous convictions in the UK. The man confirmed that as well as speaking Yoruba, he spoke English. He also confirmed that he took medication for diabetes. He did not provide details for a family contact as next of kin. He gave details of a solicitor to be contacted in the case of an emergency.
15. On 20 June, the man was transferred to HMP Forest Bank. His reception notes confirm that he controlled his diabetes by tablet, and that he needed to attend healthcare morning and afternoon for his medication.
16. After attending the doctor's clinic on 21 June, the man was admitted to healthcare suffering from hypertension. While in healthcare he was noted on one occasion to be having difficulty breathing, requiring oxygen to be provided. He remained in healthcare until 8 July, and was treated for a chest infection.
17. While in Forest Bank the man developed a facial nerve disorder and was referred to hospital. An appointment was made at the Hope Hospital TIA (Transient Ischaemic Attack) clinic but neither the man nor Forest Bank appear to have received the appointment. As he did not attend the clinic for his appointment he was discharged from the system.
18. The man was transferred to HMP Manchester on 17 July. His reception medical screenings noted his diabetes, hypertension, and shortness of breath. However, his outstanding referral to hospital was not identified by anyone. An appointment was made to see the prison doctor on 19 July. The man was diagnosed with a chest infection and prescribed medication. He was also prescribed medication for hypertension, as well as continuing his usual medication. A further appointment was made for one week's time. It was also made clear that he should be referred back to the doctor if he experienced any shortness of breath or chest pain.
19. On 20 July, Nurse A was on duty in the healthcare centre when she received a telephone call asking her to come to G wing to see the man. He had become short of breath at lunchtime. The nurse examined him and was satisfied that he was not suffering from a serious condition. She did discover, however, that he did not have any of his prescribed medications, which had been sent to A wing. The man was supposed to hold his medications in his own possession (known as "in possession" medication). Nurse A collected them, brought them to him, and explained that it was up to him to ensure that he collected his medication.

20. The man attended court and was convicted in July.
21. Medical records for him show that on 24 July, he saw one of the prison doctors, as had been arranged the previous week. He was again noted to be suffering from a chest infection, and was prescribed a salbutamol inhaler (commonly used by asthmatics) to use if he suffered any further breathlessness.
22. During the night of 18 August, Nurse B was on duty. He was called to see the man, who had complained of shortness of breath, and pain in his liver when he breathed in. The nurse examined the man and found that he was not in any severe distress, and had his inhaler to use. He asked discipline staff to observe him, and made an appointment for him to see the prison doctor the following morning. Nurse B subsequently checked with wing staff the following day and they reported that the man had had no further problems. The nurse therefore cancelled the emergency appointment, as the man had an appointment to see the doctor anyway on 22 August. The man had a court appearance on 20 August and was subsequently seen by Nurse A on his return to prison. No problems were found. The man did not subsequently attend the scheduled doctor's appointment.
23. Nurse C was on duty on 23 August, and answered an emergency call to the work area of the prison. She found that the man had collapsed and was short of breath. She gave him oxygen before arranging for him to be admitted to the healthcare centre. He was seen by a doctor, who confirmed that he should remain in healthcare and receive oxygen by way of a nebuliser. (A nebuliser is a machine which creates a mist of whatever medicine is being applied, which makes it easier for the medication to get into the patient's lungs.) A care plan was put in place, and the nebuliser treatment was discontinued on 28 August, when a doctor reviewed the man. The doctor also set in place arrangements for a review of the man's asthma medication. There had been no previous diagnosis of asthma, but as noted above he had been using a salbutamol inhaler.
24. The man attended an appointment to see the prison doctor on 30 August. He noted the man's medical history, including his diabetes, hypertension, and recent difficulties in breathing. He diagnosed the man with congestive cardiac failure (the presence of symptoms associated with congestion of the tissues and organs). He recommended that the man have an electrocardiogram (ECG, an electrical recording of the heart used in the investigation of heart disease). The ECG was completed the following day in the healthcare centre.
25. In September, the man was sentenced to six years' imprisonment.
26. A follow-up appointment with the prison doctor took place on 7 September. The ECG had indicated that the man had left ventricular failure, and he was prescribed medication to treat this. The prison

doctor wrote to North Manchester General Hospital on 13 September asking for the man to see a cardiologist. The man was also scheduled to have routine blood tests and to attend the diabetic clinic in healthcare. None of the blood tests showed any abnormalities. He attended the diabetic clinic on 20 September, and complained of breathlessness despite taking his medication. One of the nurses therefore made an appointment for him to see a prison doctor.

27. On 2 October, North Manchester General Hospital sent a letter confirming an appointment with the cardiologist for 7 November. A hand-written amendment on the letter shows that this was re-booked on 4 October for 5 December.
28. Following the appointment made subsequent to his visit to the diabetic clinic, the man saw a doctor on 3 October, and told him that he was still suffering from breathlessness. The doctor requested that the man have a chest x-ray. However, the man's records do not show that he was referred to hospital for this.
29. The man again sought treatment in healthcare on 11 October, for feeling short of breath. A healthcare officer advised him to rest and to use his inhaler, and said he would arrange for the man to see the doctor the following day. The man's notes do not show whether this appointment did in fact happen, but his scheduled appointment for 24 October, was brought forward by a week.
30. When he saw the prison doctor on 17 October, the man said that he was still short of breath and had pain in his chest. He had been ill since before he came to the UK and had been in an area of Nigeria where malaria was evident. The doctor thought it possible that the man might have malaria. He arranged for him to be transferred to hospital. He was taken to North Manchester General Hospital at 7.05pm that day.
31. A prisoner would usually be double-cuffed when attending hospital. This means that they would be wearing handcuffs themselves, then have a separate chain, known as an escorting chain, to a member of staff. This is only altered if a risk assessment deems it unnecessary. At lunchtime on 18 October, the man asked the officers escorting him to remove his cuffs. His request was refused. When staff made an equipment check that afternoon, they found that one of the inserts (an insert is a metal attachment inside cuffs to ensure a proper fit) was missing from the man's cuffs.
32. At 1.25pm a hospital doctor informed staff that he could not be sure that the man did not have tuberculosis (TB) and recommended that staff were not constantly in the room with him. The escorting arrangements were changed so that the two members of staff were located in a sterile area and two more were outside, but none were actually in the room with him. At this point, restraints were removed from the man. At 5.35pm

escort staff were told that he did not have TB. The escort was reduced back to two prison officers, and the restraints were reapplied.

33. The following day, 19 October, doctors advised that further tests and treatments would be required and that this might take “two or three weeks”. The man needed to have a cannula (a drip) inserted into his hand, so his cuffs were removed, leaving only an escorting chain. On 21 October he was transferred to E3 ward and the cannula was no longer required. Double cuff arrangements were then reapplied.
34. Records show that on 23 October, the man was still receiving oxygen to assist his breathing, but doctors told him that his heart was “fine”. A governor from the prison visited him in hospital the next day and found him to be in good spirits.
35. On 25 October, the man was told that he could be discharged. He did not have malaria, but had been treated for excessive fluid in the pericardium (the sac which surrounds the heart). He was diagnosed as suffering from cardiomyopathy (disease of the heart muscle), which needed ongoing out-patient treatment at the hospital. He was given an ECG, and left hospital to return to prison at 2.20pm. In addition to providing information in his discharge letter, staff at the hospital telephoned the prison and explained what had happened with the man, and that he would need follow-up care.
36. A care plan was put in place and the man saw a prison doctor the following day. The doctor noted that the man had been diagnosed with cardiomyopathy. North Manchester General Hospital sent the man’s discharge letter to healthcare at the prison on 30 October. It noted his enlarged heart.
37. The man saw a prison doctor on 4 November. He told the doctor that he was feeling unwell, with pain in the right side of his abdomen. The doctor advised that he would need to be reviewed and to be examined for potential problems with his liver. An appointment was made to see the prison doctor on 6 November.
38. However, early on the morning of 6 November, at approximately 6.30am, Nurse D was distributing medication when he found the man lying on his cell floor. He had no control over his movement, was unable to get up, his speech was slurred and he had right-sided weakness. It was suspected that he had had a stroke, and an ambulance was called. The man was taken to North Manchester General Hospital.
39. At the hospital it was confirmed that he had had a stroke. He was partially paralysed down his right side, his speech was poor and he had very little use of his right arm. The duty governor at the prison agreed that the man did not need to be double-cuffed but only have an escorting chain to one of the prison officers escorting him. Medical staff confirmed that he would find it almost impossible to walk at that time.

40. The man was moved to F3 Ward on 7 November, and was visited by the Head of Healthcare at HMP Manchester. The reason for the visit was twofold. Firstly, it was to check on his welfare. Secondly, it was to assess whether there were any areas of preparation the prison would need to make for his return, should he need any adaptation to the normal prison environment. This is good practice.
41. In the early hours of 8 November, the man became agitated and was biting his handcuffs. He was struggling with speech, and through the day appeared confused and incoherent, soiling his bed on a few occasions.
42. Nurses informed escorting staff on 9 November, that the man would have a brain scan the following week and would need to have his cuffs removed. On 12 November, the man's bedwatch log shows that a nurse said a brain scan would not be required, but the log for the following day shows that the scan results were clear. The prison medical record shows regular contact between prison healthcare and the hospital during this time.
43. At 2.00pm on 13 November, two officers began a shift of bedwatch duty for the man. The bedwatch log shows that there were no problems during the afternoon, with the man mainly sitting in his chair. He was sometimes asleep but the escort staff noted movement. At approximately 5.20pm one of the officers helped him to eat a meal then helped him go to the toilet. As they returned, the man sat on the edge of his bed, fell back onto his bed and began to suffer a fit. A nurse saw what was happening and immediately came to the bed. She put the man in the recovery position and tried to sedate him. She called a crash team.
44. The officer uncuffed himself from the man and moved out of the room, while maintaining a full view of what was happening. He informed the duty governor at the prison. The medical team attempted to resuscitate the man, but at approximately 6.00pm they told the escorting officers that he had died.
45. One of the officers telephoned the prison and passed on the news of the man's death, and the procedures to be undertaken following the death of a prisoner were begun. The two officers returned to the prison at 6.45pm. A debriefing meeting was held, and both officers were offered support from Staff Care and Welfare Services and the Samaritans if they felt they needed it.
46. The following day, 14 November, a Principal Officer sent a note round the prison instructing that all prisoners subject to suicide and self-harm monitoring were reviewed. On 16 November, notices to staff and prisoners were posted around the prison informing them of the man's death.

## **Contacting family**

47. The prison had difficulty tracing next of kin. The man had not provided any details, and the prison enlisted the help of the police in contacting his family. When the police did trace and speak to the man's wife and mother, language differences made this difficult. Eventually, they made contact with a representative of the family in England and arranged and paid for the man's funeral. This was attended by the prison imam.

## **Post mortem report**

48. The post mortem report showed the cause of death as:
- 1a. Pulmonary thromboembolism
  - 1b. Deep vein thrombosis
  - 1c. Immobility from cerebral infarction due to embolism from cardiac mural thrombosis
  - 2. Dilated cardiomyopathy  
Systemic hypertension.
49. This is consistent with a death from natural causes.

## ISSUES

### Clinical care

50. Overall, it is the view of the clinical reviewer that the man received proper medical treatment whilst in prison. His health worsened during that time, but he was regularly monitored and his symptoms were managed in a timely way.
51. There were several instances when treatment needs were not followed up. The first relates to reception. When at Forest Bank, the man was referred to a consultant who recommended that he should be given a hospital appointment. There is no indication that the prison received the subsequent appointment letter, but there should have been a system to ensure that any further required treatment was followed up. This should have been noticed on his arrival at Manchester but unfortunately it was not.

**The head of healthcare should consider systems to check whether prisoners transferred to Manchester have outstanding medical appointments or referrals.**

52. The second relates to actions planned which were not followed up. When at Manchester, the man saw a doctor on 3 October, and the doctor wanted him to have a chest X-ray. However, there is no indication that a referral was made. It may have been that the doctor, who was a locum, did not fully understand the process required to obtain an X-ray. I do not make a recommendation on this, but as a housekeeping point the head of healthcare will want to ensure that doctors working in the healthcare centre are aware of procedures which need to be followed. Nevertheless, there should be a system which would make it apparent that a recommendation had not been followed up, and the clinical reviewer writes that it delayed the treatment of some distressing symptoms. A third occasion was on 11 October, when the man saw a member of staff in healthcare, complaining of shortness of breath. This member of staff noted in the man's medical record that he would arrange a doctor's appointment for the following day. There is no indication that this happened but the man's scheduled appointment to see the doctor on 24 October was brought forward to 17 October.

**The head of healthcare should ensure that all follow-up referrals are made.**

53. When the man was admitted to healthcare on 23 August, the doctor made an assumption that he was asthmatic. There is no evidence of the man having been diagnosed as having asthma.
54. It is the clinical reviewer's opinion that neither healthcare in HMP Manchester nor North Manchester General Hospital followed the guidelines for someone with type two diabetes, specifically around the

prescription of medication. The National Institute for Health and Clinical Excellence (NICE) guidance recommends prescription of a statin for the management of type 2 diabetes. Manchester Primary Care Trust's guidance on the management of diabetes also recommends this. There is no evidence in the man's records that he was considered for such treatment. While it is unlikely that there was any effect on him in this instance, the head of healthcare will want to consider how the prison uses the guidelines.

**The head of healthcare should consider how the National Institute for Health and Clinical Excellence Diabetes Guidelines are followed.**

55. On one occasion it was discovered that the man had not collected his medication, as he was supposed to do. This only came to light when a nurse answered an emergency call when the man suffered a bout of breathlessness. Whilst it was the man's responsibility to collect his medication, healthcare should be aware of patients not doing so.

**The head of healthcare should review monitoring arrangements for patients who are supposed to collect "in possession" medication.**

56. The clinical reviewer recommends that nursing assessments should be developed and put in place, allowing robust person-centred care plans to be developed. Problems with the provision and maintenance of care plans also feature in two of my previous reports on investigations into deaths in Manchester. I am pleased to see that since the death of the man who is the subject of this report the prison have introduced a computer-based physical assessment tool that identifies the physical needs of anyone in healthcare. This being the case I do not repeat my earlier recommendations. But I hope that the head of healthcare will monitor the new assessment to ensure that it is meeting the need for which it was intended.
57. The head of healthcare visited the man in hospital to ascertain whether there were any adjustments that would be required when he returned to prison. I consider this to be an example of good practice.

### **Contacting family**

58. The man had not provided details for next of kin, family contacts, or anyone to contact in an emergency. This led to a delay in his family being informed of his death. This is a particularly traumatic time for families, and they really should be informed and involved as soon as is possible.
59. Prisoners may well, for a variety of reasons, not wish family to be contacted by the prison. In general circumstances this should be respected. But when the man was in hospital with a serious illness, it might have been helpful for the prison to have discussed with him who

would be his primary family contact and in what circumstances he would want them to be contacted.

60. The prison's decision to ask for this information in such circumstances would need to be assessed in each individual case. As such I do not make a recommendation. But the Governor will wish to consider at what point it might be prudent for such a discussion to occur.

## CONCLUSION

61. The man had existing health problems when he arrived in prison, and his health deteriorated whilst serving his sentence. His health problems were treated whilst in prison, and he spent some time in and out of hospital. In my view, he received good care whilst at Manchester
62. It is unfortunate that some actions and appointments fell by the wayside. Although it appears that they did not make a material difference to the man dying, prisoners are reliant upon healthcare services looking after their welfare. The clinical reviewer says that the man suffered some distressing symptoms which could have been treated earlier had he been given the X-ray the prison doctor recommended on 3 October.
63. I am pleased to see that the prison have put in place what they feel is a robust, computer-based physical assessment tool. This should identify the physical needs of anyone housed in healthcare or who presents with persistent medical issues. In line with the recommendation the clinical reviewer makes concerning the need for nursing assessments, I hope that the new system will be monitored to ensure that it is meeting its purpose.
64. It is to be commended that the head of healthcare visited the man in hospital with an eye to ensuring that if he needed any adjustments to the environment on his return to prison they would be made in advance. It did not transpire that it was necessary in this case, but it is an example of good practice.
65. It is important to remember how difficult a time this is for a prisoner's family. Delays in informing families should be kept to an absolute minimum. If a prisoner with failing health has not provided contact details, consideration should be given to discussing the issue with the prisoner.

## RECOMMENDATIONS

**The head of healthcare should:**

- 1. consider systems to check whether prisoners transferred to Manchester have outstanding medical appointments or referrals;**

The Prison Service has accepted this recommendation. The Head of Healthcare will review current procedures and ensure proper arrangements are in place for monitoring and checking whether prisoners transferred to Manchester have outstanding medical appointments or referrals. The target date is 30 November 2008.

- 2. ensure that all follow-up referrals are made;**

The Prison Service has accepted this recommendation. The Head of Healthcare will put in place proper procedures and systems ensuring that all follow up referrals are made. The target date is 30 November 2008.

- 3. consider how the National Institute for Health and Clinical Excellence Diabetes Guidelines are followed;**

The Prison Service has accepted this recommendation. The Head of Healthcare will consult with Manchester PCT and consider the protocol for following NICE guidance. The target date is 30 November 2008.

- 4. review monitoring arrangements for patients who are supposed to collect "in possession" medication.**

The Prison Service has accepted this recommendation. The Head of Healthcare will in consultation with Manchester PCT review the monitoring arrangements for the collection of in-possession medication. The target date is 30 November 2008.