Investigation into the circumstances surrounding the death of a man at a local Hospice whilst in the custody of HMP & YOI Gloucester in June 2010

Report by the Prisons and Probation Ombudsman for England and Wales

October 2010

This is the report of an investigation into the circumstances surrounding the death of a male prisoner at HMP & YOI Gloucester. The man died on 12 June 2010. A post mortem showed that his death was caused by cancer.

I would like to offer my sincere sympathy and condolences to the man's family for their loss.

The investigation was carried out by an investigator from my office. Both he and I would like to thank the Governor of Gloucester and all his staff for their full co-operation during the course of our enquiries.

Gloucestershire Primary Care Trust (PCT) were commissioned to conduct a clinical review of the healthcare the man received whilst in custody. I would like to thank them for appointing a doctor from the local PCT as the clinical reviewer. I would like to thank the clinical reviewer for his timely report.

As the man died from natural causes the findings of the clinical review play an essential part of my report. I am pleased that the review shows that the man received an exemplary standard of care. Neither I, nor the clinical reviewer, make any recommendations but I do recognise the efforts made by the Governor to obtain compassionate release for the man.

Thea Walton
Acting Deputy Prisons and Probation Ombudsman **October 2010**

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SUMMARY

On 9 June 1980 the man was convicted of murder and remanded into custody. He was sentenced to life imprisonment on 19 June 1980. In the years that followed the man moved to several establishments across the prison estate until he was transferred HMP Gloucester on 20 January 2009. The man had a history of illicit drug use whilst in custody.

A prison doctor saw the man on 2 February 2009 as he complained of rectal bleeding. The doctor wanted to refer him to the specialist at the local hospital but the man refused.

The man saw a prison doctor on 17 June, complaining of bleeding piles. He told the doctor that he had experienced this off and on for the previous six months. The doctor referred him to the hospital for further assessment.

Initial examination by a consultant colorectal surgeon at the local hospital indicated the likely presence of a malignant tumour in the rectum. A biopsy on 10 August, confirmed that the man did have rectal cancer and he remained in hospital for surgery.

The man was discharged from hospital back to Gloucester on 20 August. The hospital precribed appropriate pain relief and made arrangements for the man to have a course of chemotherapy treatment. However after only three sessions of chemotherapy the man refused any further treatment.

On 12 February 2010, the man was referred back to the hospital as he had complained of worsening abdominal pain and vomiting. Further tests were undertaken which confirmed the man had cancer in the liver and lungs. He was offered further chemotherapy but he refused.

The man was admitted to the local hospice on 11 April to receive pain relief management. He returned to Gloucester on 10 May but refused to stay in the healthcare centre as it operates a no smoking policy. The man insisted he return to his original wing (where smoking is allowed in designated cells).

On 1 June, a nurse saw the man as he felt his pain relief was not effective. He was admitted to the local hospice two days later. His condition deteriorated and he died on 12 June.

The prison followed the guidance given in Prison Service Order (PSO) 2710, “Follow up to death in custody” maintaining contact with the man’s family and offering assistance towards the funeral expenses.

I am satisfied that the care and attention the man received at Gloucester was equitable to what he could have expected to receive in the community. I recognise the good practice in family liaison, the effective and sensitive assessment of the use of restraints and the efforts made to attempt to obtain compassionate release.

THE INVESTIGATION PROCESS

1. I appointed an investigator to investigate the man's death on 12 June 2010. Notices were issued to staff and prisoners, inviting those who wished to submit information relating to the man's death to make themselves known to the investigator, however no one came forward.

2. The investigator visited Gloucester on 24 June to collect copies of relevant documentation relating to the man. The investigator also saw where the man lived during his time at the prison. In addition the investigator met with a member of the Independent Monitoring Board (IMB) who wished to have placed on record the recognition of the efforts made by the Governor and his staff in attempting to obtain compassionate release for the man and the care that he received during his time at Gloucester.

3. The Chief Executive of Gloucester Primary Care Trust (PCT) commissioned a doctor to review the man's clinical care. The investigator and the clinical reviewer discussed the man's care. I am grateful to the clinical reviewer for his timely report.

4. The investigator contacted Her Majesty's Coroner for Gloucestershire, to inform him of the nature and scope of my investigation and request a copy of the post mortem report. Upon completion, the investigation report will be sent to the Coroner to assist with his enquiries into the man's death.

5. One of my family liaison officers contacted the man's sister at the beginning of the investigation and offered the opportunity to raise questions and concerns for consideration. The man's sister did not formally raise any issues for the investigation to consider in regards to the care her brother received in prison. I hope this report offers more insight of the events leading to her brothers death.

At the consultation stage of the report the man's sister, wished it noted within the report that she disagrees with certain points as outlined in the report. The man's sister found it very distressing and upsetting to be asked to look after her terminally ill brother. She also wished it noted it was her belief that due to the length of time her brother had been in custody he should have been released. She found the security arrangements that were in place whilst he received care outside of prison ultimately resulted in additional upset and distress being caused to her. She also stated that she felt the way her brother's belongings were returned in prison service bags was insensitive. The investigation found that HMP Gloucester appropriately followed PSO 2710 'Follow up to death in custody', which included the return of the man's belongings.

HMP & YOI Gloucester

6. HMP& YOI Gloucester is an adult male prison and young offender remand centre. It is an old Victorian prison in the centre of Gloucester and has an operational capacity of 315 prisoners. Part of the accommodation dates back to the eighteenth century. The prison is established to serve the Crown Courts of Gloucester and Hereford together with the associated magistrates' courts. In practice, prisoners come to HMP Gloucester from a far wider area.

7. Gloucester provides 24 hour healthcare cover with inpatient facilities for eight prisoners. At night healthcare is staffed by nurses supported by on call doctors. Healthcare is located in a separate two-storey building, equipped by Gloucestershire PCT. It has an assessment and treatment unit, including the inpatient facilities upstairs, outpatient facilities downstairs, and a hot food servery for inpatients.

8. HM Chief Inspector of Prisons last conducted an announced inspection of the prison in April 2007. The Chief Inspector noted that the prison was "safe and respectful" and that the health services that were provided "were good".

9. The Independent Monitoring Board (IMB) (a body of local people who independently monitor and report on the prison) monitors day-to-day prison life to ensure proper standards of care and decency for all prisoners. In their latest annual report for the period ending November 2009, the IMB at Gloucester made the following comments regarding healthcare:

> "The progress and work of the Healthcare and Primary Mental Health teams have been acknowledged by awards from the local Criminal Justice Board and the winning of the Chief Executive's award for 2009. The low incidence of Swine Flu in the prison, only 2 suspected cases up to the end of the report year, is attributable to a rigorous and well promoted awareness and hygiene campaign.
>
> "The concern over GP access and waiting times, expressed in last year's report, has been allayed: an audit in the 2nd quarter of 2009 showed waiting times less than 24 hours.
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> "In line with the increase of prisoners over 50 in HMP Gloucester – there were 40 of them on a spot check - an Older Man's Care Pathway has been introduced (a plan that is adapted to the particular needs of individual older prisoners, both in prison and on release).
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> "HMP Gloucester is the first prison in the area to take part in the 'Productive Community Workplace' project, part of the productive community hospital programme looking at working efficiency. This showed that the healthcare team spend a higher proportion of their time in direct patient care than local community hospitals (32% am; 25% pm). This is all the more encouraging as there is a lack of space for 1:1 contact."

10. On each occasion a prisoner is escorted outside of the prison to hospital a risk assessment is completed which considers the risk to the public, potential for escape and likelihood of outside assistance. The assessment informs the decision about the number of escorting officers and the type of restraint to be used (single cuffs or two metre long escort chain with cuff at either end). It also determines the circumstances and the authority required for the restraints to be removed. The risk assessment is reviewed each day that a prisoner is in hospital and amended where necessary.

11. Early release on compassionate grounds is subject to the instructions contained in Prison Service Order (PSO) 6000 which states that:

> "Early release may be considered where a prisoner is suffering from a terminal illness and death is likely to occur soon. There are no set time limits, but three months may be considered to be an appropriate period. It is therefore essential to try to obtain a clear medical opinion on the likely life expectancy. The Secretary of State will also need to be satisfied that the risk of re-offending is past and that there are adequate arrangements for the prisoner's care and treatment outside prison."

12. Since the Ombudsman office took over responsibility in 2004 for investigating all deaths in custody, there had been eight deaths at Gloucester prior to that of the man. Five of these were apparently self inflicted with the others attributed to natural causes. There are no similarities between the previous natural cause deaths and the man's death.

KEY EVENTS

13. In June 1980 the man was convicted of murder and remanded into HMP Wandsworth. He was sentenced to life imprisonment in June 1980.

14. In the years that followed the man moved to several establishments across the prison estate until he was transferred HMP Gloucester on 20 January 2009. The man had a history of illicit drug use whilst in custody.

15. On arrival at Gloucester the man saw a nurse who conducted an initial healthscreen check. The man told the nurse that he had taken heroin within the previous 24 hours. The nurse did a urine test which was positive and referred the man to the detoxification (detox) team (specialised team dedicated to provide treatment and support to prisoners withdrawing from drugs or alcohol). The nurse also recorded that from his medical records the man had both Hepatitis B and Hepatitis C but had refused to have any treatment. The nurse also noted that the man had been previously prescribed tramadol (for moderate pain relief) for arthritic pain in his knees.

16. The next day the man saw an unidentified member of the detox team who placed the man on a Subutex detoxification programme. This was reviewed by a prison doctor, on 29 January who agreed with the man a reduction in the amount of Subutex (for drug withdrawal) every four days.

17. Another prison doctor, saw the man on 2 February as he was experiencing rectal bleeding. The doctor wanted to refer the man to the specialist at the local hospital but he refused. Despite the doctor's explanation for the referral and encouragement to seek further medical assistance the man signed a disclaimer stating that he refused further treatment. The doctor referred the man to the Mental Health Team.

18. On 13 February, a nurse from the Mental Health Team, (that conducted his initial screening) saw the man in his cell. He told the nurse that he had been in prison for 30 years and just wanted to sit in a corner, read his book and mind his own business. He told the nurse that occasionally arthritis flared up in his knees and tramadol was the only drug he would take for the pain, he also wanted to avoid taking any antidepressants.

19. The nurse saw the man two weeks later. He told the nurse that the reason that he refused to attend the hospital was due to the personal nature of the examination. He reiterated his refusal of any further treatment.

20. On 4 March, the man saw a doctor as he complained of pain in his knees and shoulder. The doctor prescribed tramadol at 100mg. Eight days later the doctor, saw the man to review the level of pain relief. The man said that he was still in pain so the doctor increased the prescription of tramadol to 200mg.

21. The doctor saw the man again on 9 April to review his pain relief. The doctor discussed with the man the benefits of physiotherapy but he said that he did not feel that he needed any at that time. The doctor made no changes to the man's medication.

22. On 13 May, the nurse that did his initial screening saw the man for a mental health review. The nurse recorded that there were no causes for concern and no mental health issues therefore the man was discharged from the Mental Health Team caseload.

23. Two weeks later the man saw another prison doctor, as he complained of bleeding piles. He told the doctor that he had experienced this off and on for the previous six months. The doctor also recorded that the man had varicose veins in his right leg. The doctor saw the man again on 17 June, and as he presented with the same symptoms, the doctor referred him to the hospital for further assessment.

24. As a result of the referral the man saw a consultant colorectal surgeon, at the Gloucestershire Royal Hospital (GRH) on 9 July. A risk assessment was completed which authorised an escort by two officers and the use of the long escort chain which was to be removed for treatment purposes as directed by hospital staff. Following his initial examination the consultant arranged for the man to have a flexible sigmoidoscopy (telescopic visualisation of the lower bowel). This was carried out on 23 July and the procedure indicated the likely presence of a malignant tumour in the rectum.

25. The man was admitted to hospital on 10 August for a biopsy with the same risk assessment arrangements put in place. The biopsy confirmed that the man did have rectal cancer and he remained in hospital for treatment. The consultant colorectal surgeon recommended that, due to the nature of the cancer, an anterior resection (part or whole removal of the bowel) was needed along with an ileostomy (surgically-created opening in the large intestine that allows the removal of faeces out of the body, bypassing the rectum, to drain into a stoma bag or other collection device).

26. Following the surgery the man was discharged from hospital back to Gloucester on 20 August. The hospital precribed methadone for pain relief and made arrangements for the man to have a course of chemotherapy treatment after he had received treatment for Hepatitis. A care plan was put in place to meet his needs which included regular observations to ensure appropriate pain relief management, dietry intake, and other personal needs.

27. Between 21 August and 5 October, the man had regular medical interventions with prison doctors and healthcare staff. There were no additional concerns raised during this period, although the man said that he had reservations about having the chemotherapy treatment.

28. On 6 October, a nurse saw the man to discuss the proposed chemotherapy treatment. The man said that he was concerned about the side effects. The nurse discussed with him the treatment and the plan for his treatment following

his chemotherapy session. This included his medication to be administered to him in his cell for four days, the correct procedure for the disposal of his stoma bags and a light diet of his choice. The man wished to have toast with either beans or scrambled egg. He also told the nurse that he did worry about the pain he might endure as time went by but would not consider taking his own life.

29. Three days later the man went to the GRH as an outpatient for his first session of chemotherapy. A risk assessment was completed which authorised an escort by two officers and the use of the long escort chain which was to be removed for treatment purposes as directed by hospital staff.

30. From 10 October to 29 October, the man continued to have regular interventions with healthcare staff. He told the Nurse that he had previously seen to discuss his chemotherapy treatment that he did not wish to continue with the chemotherapy treatment and would refuse to go to the hospital. It was explained to the man the importance of the treatment and he should attend the hospital appointment and, once he had talked it through with the hospital doctor, he could still exercise his right to decline treatment. The nurse made arrangements to accompany the man when he went for his appointment and he appreciated this.

31. The man saw a Consultant Clinical Oncologist, at a local hospital on 30 October, accompanied by the nurse he had previously seen to discuss his chemotherapy treatment and the escorting officers. (A risk assessment was completed which authorised an escort by two officers and the use of the long escort chain which was to be removed for treatment purposes as directed by hospital staff). At this consultation the man did agree to continue with his chemotherapy treatment, however nine days later he changed his mind and refused to continue with the treatment.

32. In the weeks that followed the man continued to receive frequent interventions with healthcare staff. On the 15 December, the man sent a letter addressed to the doctors and nurses at Gloucester in which he wrote:

> "I would like to thank you all for helping me face up to my recent diagnosis of bowel cancer, nursing me after my operation and generally putting up with my moods and sulks."

33. On 12 February 2010, the man was referred to the hospital by the doctor he had previously seen on the 2 of February, as he had complained of worsening abdominal pain and vomiting. The man attended the local hospital on 17 February. A risk assessment was completed which authorised an escort by two officers and the use of the long escort chain which was to be removed for treatment purposes. An abdominal ultrasound scan was conducted, the results of which, indicated the possibility that the man's cancer had spread.

34. The man attended the local hospital on 17 March for a computed tomography (CT) scan (a medical imaging method created by computer processing). The previous risk assessment conditions were applied. The results were examined

by his Consultant Clinical Oncologist who explained to the man that the cancer had spread to his lungs and liver and that the prognosis was poor. The consultant discussed the treatment options, but the man told the doctor that he did not wish to have any palliative chemotherapy, even though this would prolong his life. The consultant referred the man to another consultant a Colorectal surgeon at the hospital that same day. The initial consualtant wrote to healthcare at Gloucester to indicate the likely prognosis that the man had six months to live, though his health could deteriorate rapidly.

35. As a result of that referral the man was admitted to the local hospital for further surgery the following day. The same risk assessment conditions were applied. Whilst he was in hospital the man was visited by healthcare staff.

36. On 22 March the Governing Governor chaired a meeting to discuss the man's care once he was discharged from hospital. Based on the Consultant Clinical Oncologist prognosis that the man's death was not iminent it was agreed that when he was discharged from hospital he would be located in healthcare and healthcare staff would actively seek a place in a hospice. The Governor said that the current level of restraint would remain the same. A family liaison officer was appointed by the prison.

37. The man returned to Gloucester on 24 March, and was seen by a prison doctor. The doctor recorded that the man had made a good recovery following surgery but he was still weak and debilitated. The man told the doctor that he had six months to live as the cancer had spread to his lungs and liver. The doctor prescribed clarithromycin (for cellulitis – skin infection), tramadol, and increased the dosage of methadone (both for pain relief).

38. The same day the nurse that had previously discussed chemotherapy with him contacted the man's nominated next of kin, his sister as the man had given his permission for the prison to inform her of his condition. His sister said that due to her own ill health she would be unable to look after her brother if he was released from custody. The nurse asked if the man's sister had a preference for a local hospice, if a place could be secured. His sister said that there was a hospice near to where she lived.

39. Later that afternoon the nurse contacted the hospice near the man's sister and spoke to the Inpatient Manager. The hospice said that they did not accept patients from out of the area.

40. The nurse saw the man on each of the next four consecutive days. The nurse, in agreement with the doctor he has last seen, made a referral to palliative services at the the local Hospice and the community palliative care nurses. The nurse recorded that the man's operation wound had to be continually cleaned and redressed. The nurse also contacted the man's sister to give her an update on his well-being.

41. The Governor chaired another review of the man's care and well-being on 26 March. At this review it was decided, given the man's condition, if he was to go to outside hospital or hospice then no restraints would to be used. He

would be escorted by two officers to act as support to the man, liaison with the prison and support to each other.

42. On 29 March a prison doctor that had previously seen him on the 17 June saw the man to review his condition. The man told the doctor that he was still getting pain despite being on methadone. The doctor prescribed an increase in methadone, the addition of Oramorph (for severe pain), diazepam (for insomnia) and another seven day course of clarithromycin.

43. The next day the man was visited by the community palliative care nurses who also met with the doctor he had seen initially on the 2 February. The community nurses offered advice on the man's pain control, in particular, ensuring that methadone was not given more frequently than every three hours.

44. Over the next eleven days the man received regular interventions from healthcare staff. It was recorded that he still complained of pain despite having taken the prescribed amount of pain relief. As a result of this the nurse that initially discussed chemotherapy with the man contacted the local Hospice to arrange admission for the man to receive pain relief management.

45. The man was admitted to the local Hospice on 11 April. He was escorted by two officers but no restraints were used. A nurse contacted the man's sister to inform her of his admission to the hospice. His sister visited him later that day. In the days that followed healthcare staff visited the man in the hospice as well as visits made by his sister.

46. On the 14 April, the Governor of Gloucester chaired a further review of the man's condition. At this meeting it was recorded that the hospice near his family was unable to offer a place, and that the local Hospice would not give permission for their address to be given as a discharge address for the compassionate release application. Also as the man's sister was unable to look after him, due to ill health, compassionate release was no longer an option. It was agreed that when the man was discharged from the hospice he would be located in healthcare. A special mattress and air flow pillows were obtained to make him more comfortable.

47. The Healthcare Manager contacted the local Hospice to check on the man's progress and the potential date of return to the prison. A hospice doctor said that the man would return to Gloucester on 10 May.

48. The man returned to Gloucester on 10 May. The doctor provided the prison with the detail of the man's discharge medication which was as follows:
    - paracetemol
    - lansoprazole (for gastric acid)
    - diazepam (for insomnia and muscle spasms)
    - zopiclone (for insomnia)
    - cyclizine (for nausea, vomiting and dizziness)
    - methadone (for pain control)
    - dexamethasone (anti-inflammatory and immunosuppressant)

- nortriptyline (antidepressant)
- simple linctus (for throat & chest)

49. The Healthcare Manager, the prison's family liaison officer and a Principal Officer (PO) met with the man to explain the management of his care now that he had returned from the hospice. The man refused to be located in the healthcare centre as it had a no smoking policy. The man initially agreed to a compromise where by he would spend his daylight hours on C wing with his friends and peers, and then he would spend the night hours in a cell on A wing so that healthcare staff could easily be available to meet his night time pain control needs. A care plan was put in place to meet the man's needs and he was happy with this.

50. That evening, however, the man refused to go to A wing as previously agreed. The next morning the Healthcare Manager, the prison's family liaison officer and the PO met with the man to listen to his concerns for not spending the night on A wing. The man said that he "wanted to stay where he was". It was agreed that that he could remain on C wing and that he would be checked hourly by wing staff throughout the day and night. The man accepted that this arrangement would mean that there would be a small delay in nurses responding to any request for pain relief medication. It was stressed to the man that the arrangement for him remaining on C wing would be regularly reviewed and he accepted this.

51. The same day the prison's family liaison officer contacted the man's sister, who confirmed that she would still act as his next of kin. It was agreed that in the event of her brother's death occurring between the hours of 10.00pm and 7.00am they would not to be contact her until later the following morning.

52. From 12 May to 31 May, the man received care from healthcare staff through the day and night as required. His pain relief management was also reviewed by prison doctors and the community palliative care nurses. During this period the man was mobile and able to attend to his own personal needs.

53. On 1 June, the man saw a nurse as he complained that this pain relief was not effective. He told the nurse that he was pain free for ten to fifteen minutes before he required top up medication. The nurse contacted a doctor at the local Hospice who advised an increase in the prescribed nortriptyline and said that a place for the man could be available in two days if required. The nurse also contacted the community palliative care team to discuss the man's ongoing care and it was agreed that a place at the hospice was appropriate.

54. The next day the Governor wrote to the local Hospice to outline that due to the man's condition he posed no risk to the public. The Governor also confirmed that if the man was located in the hospice he would be accompanied by a single officer whose role was to offer support to the man and not for security purposes. The Governor explained that as the man was a life sentence prisoner it was not within his authority, as Governing Governor, to authorise release on temporary licence.

55. The man was transferred to the local Hospice on 3 June. He was accompanied by a single officer who was in plain clothes, as detailed in the risk assessment authorised by the Governor. In the days that followed the nurse he had seem about his pain relief regularly visited the man in the hospice. Healthcare staff continued to attempt to secure a nursing home or hospice place in north London without success.

56. By 8 June, the man's condition had deteriorated and he had become unconscious. The nurse that he had seen about pain relief contacted the man's sister to inform her of her brother's condition, and she visited later that day accompanied by his nephew.

57. On 12 June, a Nurse from the local Hospice, called Gloucester to say that at 7.00pm the man had died and his death had been certified by the doctor. Staff at the hospice had already contacted the man's sister to inform her of his death.

58. In the days that followed the prison's family liaison officer maintained regular contact with the man's sister to offer support and assist with organising the funeral arrangements, which was held in the area where the man's family lived. Financial assistance was offered towards funeral expenses.

ISSUES

Clinical care

59. Both the clinical reviewer and I are satisfied that the care the man received was equitable to what he could have expected in the community. The clinical review makes the following comments regarding the man's clinical care:

> "It is clear that the man had an aggressive Carcinoma of the rectum. There may have been a delay of up to 2 years before he revealed his symptoms of rectal bleeding, there was certainly a delay of 6 months while he initially refused to attend a Specialist appointment, and the man also declined chemotherapy at an early stage. Whilst all of these factors may have contributed to the failure to cure the problem, the rapid progression of the disease suggests that the outcome was (with hindsight) likely to be poor.
>
> "Following the diagnosis of terminal cancer specialist care teams were recruited and used extensively, and it is clear from the records that much effort was made by the prison healthcare team to ensure the man was given the best care possible during his final weeks of life.
>
> "In my opinion the medical and nursing care given to the man throughout his illness was exemplary.""

I am pleased that the prison made all the arrangements necessary for the man to receive the specialist care that he required.

Use of restraints

60. Unfortunately there have been too many reports in which the Ombudsman has criticised the use of restraints when prisoners are in hospital outside of the prison. It is pleasing therefore to recognise the good practice adopted by Gloucester. I believe that the Governing Governor effectively and sensitively assessed the use of restraints and put minimum levels in place. This ensured that the man was treated with dignity and respect during both his treatment and his last days.

Compassionate release

61. I do recognise the efforts made by the Governing Governor and his staff in their attempts to facilitate compassionate release for the man. As a discharge address could not be obtained either locally or near to the man's family a compassionate release application could not be submitted. In addition as the man was a life sentence prisoner he could not be considered for release on temporary licence. I do believe that the Governing Governor did everything possible within his authority to assist the man.

Family liaison

62. I also recognise the work as the prison's family liaison officer when the man was diagnosed as terminally ill. I also recognise the work of the Nurse that had initially discussed chemotherapy with the man who supported both the man and his sister. By appointing a family liaison officer to keep in touch with the man's sister at the end of his life, I believe that the prison exceeded the guidance given in PSO 2710, "Follow up to death in custody". It is good practice for family liaison officers to be appointed for the families of all terminally ill prisoners and I commend Gloucester for their initiative. The man's sister told my family liaison officer, that she was thankful for the care provided by the local Hospice.

Conclusion

63. During his time at Gloucester, the man had regular contact with healthcare staff and doctors which was well documented. I believe that the care the man received was of a good standard and was well co-ordinated with the hospital and the hospice. I judge that it was equitable to what he could have expected in the community. The clinical review confirms that his medical treatment was appropriate and that his death could not have been prevented.

64. I recognise the good practice adopted by Gloucester in the effective and sensitive assessment of the use of restraints, the early appointment of a family liaison officer and the efforts made in the attempt to obtain compassionate release.