

A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

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**Investigation into the death of a man at Salisbury  
Hospital Hospice in July 2012, while a prisoner at HMP  
Guys Marsh.**

## ***Our Vision***

*'To be a leading, independent investigatory body,  
a model to others, that makes a significant contribution to  
safer, fairer custody and offender supervision'*

This is the report of an investigation into the death of the man, while a prisoner at HMP Guys Marsh. The man died of oesophageal cancer which had spread widely. I offer my condolences to his family and friends.

The investigation was carried out by one of my investigators. A clinical reviewer carried out an independent clinical review of the man's care in prison. Guys Marsh cooperated fully with the investigation.

The man had been diagnosed as having cancer of the oesophagus in 2008. He received preoperative chemotherapy, followed by surgery in 2009. When he was remanded to prison in December 2011, his cancer was considered to be in remission.

The man first reported new symptoms in January 2012, complaining of lower abdominal pain and diarrhoea. Prison healthcare staff were unable to determine the source of the pain, and suspected that he might have kidney stones. Scans in March and June revealed nothing abnormal. However, a CT scan on 5 July, showed that the cancer had returned and had spread to the man's bowel and kidney. Only palliative treatment was possible.

I consider that the return of the man's cancer was properly and timely diagnosed and the man was kept fully informed of his condition. I am satisfied that overall staff at Guys Marsh did what they could to help and support the man through his last illness. However, I am concerned there were no satisfactory arrangements to manage his pain for a short period when he unexpectedly discharged himself from hospital. I am also concerned that restraints were used during the man's first hospital stay, which were not justified by an appropriate risk assessment.

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

**Nigel Newcomen CBE**  
**Prisons and Probation Ombudsman**

**February 2013**

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## SUMMARY

1. On 15 December 2011, the man was arrested. He was remanded into custody to HMP Bristol the next day. The man had been diagnosed as having cancer of the oesophagus in 2008. At the time of his arrest the cancer was considered in remission.
2. The man first reported new symptoms on 11 January 2012, when he complained of lower abdominal pain and diarrhoea. A prison doctor examined him and found no palpable masses in his abdomen. A doctor, who saw him on 20 January, was unable to determine the source of the pain and suspected kidney stones. An ultrasound appointment was made for 7 February, but this had to be rearranged for 7 March, when it showed that his liver, gall bladder, bile ducts, kidneys and spleen were all of normal appearance.
3. On 10 April, the man was sentenced to three years in prison, and transferred to HMP Guys Marsh on 26 April. On 2 May, a doctor saw the man after he reported abdominal pain and referred him to a colorectal surgeon for a gastroscopy (examination of the upper gut.)
4. On 8 June, the man said that he had been vomiting after eating for the previous two days. The man's condition deteriorated and by 18 June, he was unable to tolerate liquids and he was sent to hospital. He was discharged the same day and blood tests, and a chest and abdomen X-ray, detected nothing abnormal. On 27 June, the man attended hospital for his gastroscopy appointment. The consultant did not find anything of immediate concern.
5. On 4 July, after vomiting throughout the night, the man was admitted to hospital. He was taken in double handcuffs, which were changed to an escort chain at the hospital. A CT scan showed that his oesophageal cancer had returned and had spread to his bowel and left kidney.
6. The man remained in hospital until 13 July, when he discharged himself back to the prison. As it was a weekend and prison healthcare staff were unaware of his return the man did not have sufficient pain relief. He was readmitted to hospital on 16 July, and was released on temporary license on 17 July. Prison offices remained with him at the hospital until 22 July. He died in July, after being transferred to Salisbury Hospital Hospice.
7. We make a recommendation about the use of restraints and risk assessments. We also recommend that adequate pain relief should be available for prisoners, and make two recommendations about clinical practice.

## THE INVESTIGATION PROCESS

8. The investigator visited Guys Marsh on 25 July 2012, and collected copies of the man's prison files and medical records. She met the Governor, the duty governor, and Nurse A. The investigator visited the cell where the man had lived and spoke to his cellmate. Notices about the investigation were issued to staff and prisoners, asking anyone with relevant information to contact the investigator. No one came forward.
9. A clinical reviewer was commissioned to carry out a review of the man's clinical care while he was in prison. The review was received on 8 October.
10. A copy of this report will be sent to HM Coroner for his information. The coroner wrote on 1 August, to explain that a doctor at Salisbury Hospital certified the cause of the man's death as oesophageal carcinoma with widespread metastatic disease and that:

"I considered the application of Section 8(1) Coroners Act 1988 and on the basis that the cause of death was natural; that the man at the time of his death was "not in prison" and my coroner's officer having liaised with family in order to ascertain whether or not they had concerns, I was satisfied that it was not necessary to open an inquest and therefore I supported the doctors medical certificate as regards the cause of death."
11. One of the Ombudsman's family liaison officers contacted the man's ex-wife, his nominated next of kin. The Ombudsman's family liaison officer explained the investigation process and asked her if there were any issues she wished to be considered as part of the investigation. She explained that she had no real concerns, although she was aware that the man should have had a scan at outside hospital which had not taken place for six weeks. She also mentioned that the funeral had taken place a very long time (five weeks) after the man had died.
12. The investigation has assessed the main issues involved in the man's care including his diagnosis and treatment, liaison with his family, his location and security arrangements, whether compassionate release was considered and whether appropriate palliative care was provided.
13. The man's next of kin received a copy of the draft report and were given the opportunity to comment on the contents. The Ombudsman's family liaison officer contacted the man's next of kin who confirmed they had no issues or comments to make.

## **HMP GUYS MARSH**

14. Guys Marsh is a category C (medium security) training prison holding up to 578 adult men. The prison takes prisoners from a large catchment area including London, the Midlands and the South West. Healthcare services are commissioned by Dorset Healthcare University NHS Foundation Trust. A general practitioner (GP) provides seven sessions a week. Out-of-hours medical cover is provided by agency doctors. The healthcare department is open every week day from 8.00am until 6.00pm, until 5pm on a Saturday and 12.15 on Sunday.

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

15. HMIP conducted a full announced inspection of Guys Marsh in 2010. Inspectors reported that health services were very good with well trained staff. Prisoners were generally content with most health services. Primary care was good, with speedy access to a GP. NHS hospital appointments were well managed, but too many routine appointments were cancelled because of a lack of escorts when urgent treatment took priority.

### **Independent Monitoring Board (IMB)**

16. The IMB is made up of unpaid volunteers from the local community who monitor the day-to-day life in the prison to help ensure that proper standards of care and decency are maintained. In their 2011 report, the IMB said:

“In general co-operation across complex issues between the Prison Service and Healthcare continues to be satisfactory. The establishment of quarterly Health Action Group meetings has created an effective forum for all providers concerned with prisoners’ health and drug issues. It is to be hoped that attendance at these meetings becomes a priority for all parties so that there can be a greater understanding of the wider issues of health needs for what is a particularly needy group.

“There have been two deaths in custody this year [2011]. Both deaths took place in hospital and are associated with longstanding medical conditions. The Board recognises the professional care and attention given to these two men by Prison Officers and Healthcare staff prior to their transfer to hospital.”

17. The IMB also noted that a “well man” clinic had been established for prisoners over the age of 50. Diabetic and coronary care clinics had also been established.

### **Previous deaths in custody**

18. The man’s death was the fourth at Guys Marsh since 2009. None of the issues raised from earlier investigations are relevant to the circumstances of this case.

## ISSUES

### The diagnosis of the man's terminal illness

19. The man was remanded into custody at HMP Bristol on 16 December 2011. In 2008, the man had been diagnosed with cancer of the oesophagus, for which he received preoperative chemotherapy and surgery. By 2011, the man was considered in remission.
20. On the man's arrival at Bristol, Nurse B conducted a reception health screen. He was assessed as fit for normal location. His medication on arrival was omeprazole (for acid reflux), domperidone (anti nausea), zapain (pain relief) and fluconazole (an anti fungal).
21. On 11 January 2012, Dr A, a prison doctor, saw the man who had lower abdominal pain and diarrhoea. The doctor found the man's abdomen to be soft with a slight tenderness below his navel. "No masses palpable". The doctor said he would review the man in a week if symptoms did not improve.
22. Dr B examined the man on 20 January, after he complained of continued abdominal pain. The doctor suspected he might have kidney stones. An appointment was made for an ultrasound scan on 7 February, but this had to be cancelled as no one told the man he should not eat or drink on the day of the scan. The scan took place on 7 March, at Southmead Hospital where his liver, gall bladder, bile ducts, kidneys and spleen were described as "of normal appearance".
23. On 10 April, the man was sentenced to three years in prison, and transferred to HMP Guys Marsh on 26 April. At his reception health screen he was assessed as being fit for normal accommodation, work and cell occupancy. He weighed 9st 13lbs.
24. Dr C, a prison GP, saw the man on 2 May, as he still had abdominal pain. The doctor noted that the man's abdomen was "soft with slight tenderness". The man did not have any other symptoms such as diarrhoea or weight loss. The doctor suspected diverticular disease (a disorder relating to the muscle layers in the colon wall). The doctor did not perform a rectal examination but referred the man to a colorectal surgeon (who deals with disorders of the rectum, anus, and colon).
25. The man did not meet the criteria for an urgent referral (within two weeks) for suspected cancer and a routine appointment was made for him to be seen at Salisbury Hospital. The clinical reviewer explained that for an urgent referral a person must score five or more points on a NHS proforma, and the man would not have had any points.
26. On 30 May, Nurse C saw the man, who said that he had coughed up black blood that morning. He was asked to collect a blood sample if it happened again, and to return to healthcare the next day.

27. The next day, the man told Nurse D that he had not had any further problems. There is no record to show that either Nurses C or D reported to the doctor that the man had coughed up blood. The clinical reviewer commented that

“Coughing or vomiting blood is always a symptom to be treated very cautiously. Often it is of no significance. Sometimes the next occasion is catastrophic ... as a GP I would expect any nurse who knew of a patient coughing up blood to tell me themselves at the earliest opportunity”

28. In his review, the clinical reviewer recommends that Dorset Healthcare University NHS Foundation Trust should ensure that their nursing staff are clear what they should do when a patient reports coughing up blood. We make the following recommendation:

**The Head of Healthcare should ensure that nurses inform a doctor when a prisoner reports coughing up blood.**

29. The nurse manager saw the man eight days later, on 8 June. He explained that for two days he had been vomiting after eating and was only able to tolerate liquids. He was still suffering with abdominal pain and had lost 8lbs. He was prescribed Fortisip, a nutritional ‘build-up’ drink.
30. Dr D noted in the man’s prison medical record on 9 June, he was “awaiting referral to gastroenterology department”. Dr C reviewed the man on 13 June. The man said that he was now having difficulty swallowing and Dr C asked that his gastroenterology referral be changed to urgent.
31. Dr C saw the man again on 18 June, when he said he was now vomiting up his Fortisip drinks. The doctor sent the man to Salisbury Hospital and he was discharged back to the prison the same day. The discharge summary noted that blood tests, and chest and abdomen X-rays, revealed nothing abnormal. He was given a diagnosis of ‘dysmobility’, a condition in which the the muscles of the digestive system work less efficiently.
32. On 27 June, the man attended Salisbury Hospital for his gastroscopy appointment. He was examined by a consultant colorectal surgeon. In a letter to the prison the colorectal surgeon explained that the man appeared cachectic (physical wasting with loss of weight and muscle mass) and after examination there were “no obvious masses to feel [and his] rectal exam was also unremarkable”.
33. The colorectal surgeon recommended a CT scan (a scan showing cross-sectional images of the body) of the man’s chest and abdomen. He also said that a further endoscopic evaluation (using a flexible tube that has a small camera on the end) of both the upper GI (gastrointestinal) tract and the large bowel might need to be done depending on the scan results.
34. After he vomited throughout the night on 4 July, Dr C sent the man to hospital for assessment. The man was later admitted to hospital, and had a CT scan the next day which showed that his cancer had returned. Hospital records

show that the cancer had spread to his bowel and left kidney. In a letter to the prison, a consultant gastroenterologist noted “I think his prognosis is extremely poor. At best his prognosis will be a few months”.

35. The man remained in hospital until 13 July, when he discharged himself. After his health worsened, he was readmitted to Salisbury Hospital on 16 July. He died on 23 July, after being transferred to Salisbury Hospital Hospice.
36. The clinical reviewer noted that Dr C had acted promptly in making his original referral, and in making that referral urgent when the man reported that he was having difficulty swallowing. Although the clinical reviewer felt that Dr C should have performed a digital rectal examination, this would not have altered the outcome for the man as the consultant colorectal found nothing abnormal when he performed the same test six weeks later. The clinical reviewer concluded:

“I am sorry to say that given the speed with which he went downhill I believe the man’s cancer was already widespread when he first complained of pain and there was little the medical profession was going to be able to do to halt its progress.”

37. We are satisfied that the man’s cancer was appropriately diagnosed. An earlier digital rectal examination would not have led to a quicker diagnosis in the man’s case, but the clinical reviewer suggests that doctors should be reminded to perform the test when a prisoner reports abdominal pain, especially when other tests are inconclusive. We make the following recommendation:

**The Head of Healthcare should ensure that doctors perform a digital rectal examination for a prisoner with abdominal symptoms when the diagnosis is not clear.**

### **Informing the man about his condition and treatment**

38. The man received his diagnosis on 6 July, when he was an inpatient at Salisbury Hospital. He was told that his cancer was “widespread” and “not curable”. He was told that his life expectancy was uncertain and that if he had any surgery to try and remove the cancer he would spend a long time in hospital and the quality of his remaining life would be impaired.
39. On 13 July, a consultant oncologist saw the man and wrote to the prison and explained that he did not think that the man was fit enough for chemotherapy. He also thought that chemotherapy was unlikely to improve his prospects of survival and might make his quality of life worse.
40. After seeing the consultant oncologist, the man discharged himself back to the prison. The man did not discuss this with his cell mate, and a reason was not given on his discharge summary. Three days later, on 16 July, Dr C saw the man in his cell. He had been unable to keep any food or fluids down since leaving hospital and Dr C spoke to him at length and explained that he

needed full nursing care which was only available in hospital. The man agreed to return to hospital where he remained until he died seven days later.

41. We consider the man was fully informed about his treatment options by prison and hospital staff.

### **The man's medical appointments and treatment of the prisoner**

42. Prison medical records show that, while at Bristol, the man was due to attend an ultrasound appointment on 7 February 2012. This appointment had to be re-scheduled as he does not appear to have been informed by prison healthcare staff that he should not eat or drink on the day of the scan. This appointment was rearranged for 7 March, and the postponement did not affect the diagnosis or long-term outcome for the man.
43. The clinical reviewer considered Dr C acted promptly in making his original referral to Salisbury Hospital on 2 May, and then when in making that referral urgent when the man reported that he was having difficulty swallowing. After his diagnosis he did not receive any treatment which required his attendance at hospital appointments.

### **The man's pain relief and medication**

44. Before the man was admitted to hospital on 4 July, his pain was managed with ibuprofen and paracetamol. On 10 July, the man's consultant spoke to Dr C to ask if the prison could use a syringe driver (a machine that is used administer small amounts of medication continuously). Dr C said that as the man was in a shared cell and there were no nurses available after 5.00pm this would not be possible. We consider that arrangements should have been made to provide a syringe driver. In the community they are used in patients' homes without nurse presence and a risk assessment and appropriate management plan should have allayed any security concerns.
45. When the man discharged himself from hospital on Friday 13 July, he arrived back at the prison at 6.15pm, after the prison healthcare centre had closed. The escort officers handed the man's discharge paperwork to staff in the communications room. When healthcare staff arrived the following morning, they did not know that the man had returned from hospital. It was only when the man's cell mate complained to officers on the wing that his friend was in severe pain, that healthcare staff were called to attend.
46. Before he left hospital, the man was prescribed oramorph to be taken four times a day. Because he arrived at the prison after the healthcare centre had closed, he was unable to obtain any pain relief for at least 15 hours.
47. This should not have happened. Prison records show that Senior Officer A gave permission for a car to be ordered at 1.45pm that day, as he was aware that the man would return to the prison. However, the transport did not leave to collect him until 4.00pm and so he arrived after healthcare staff had left the prison. Healthcare should have been informed that the man was coming back

from hospital as soon as the prison was informed. This would have allowed them to liaise with the hospital and make appropriate arrangements for his pain management.

48. Guys Marsh does not have GP cover at weekends when it uses an out of hours service. Nurse A who was on duty on Saturday 14 July, was unable to get a response from the out of hours service to discuss the management of the man's pain. She therefore decided to administer oromorph on the basis of the discharge letter from the hospital. The clinical reviewer commented that this was "entirely correct", although he did not think that all nurses would be prepared to make this decision as the oramorph had not been prescribed on the appropriate form."
49. On 14 July, the man had his last dose of oromorph when Nurse A went off duty at 5.15pm. He was then without any pain relief until 8.35am the next day, 15 hours later. The healthcare centre shuts on Sundays at 12.15pm and the man had his last dose of oramorph at 12.30pm when Nurse A went off duty. He was then without pain relief until 8.00am the following morning, 20 hours later. This is unacceptable.
50. The man was fortunate that Nurse A was prepared to take responsibility for issuing him with pain relief without having the appropriate prescription. However, Nurse A should not have been put in this position and we are concerned at the lack of response from the out of hours service. While we accept that the man chose to discharge himself from hospital that weekend, the prison had a duty of care towards him and to ensure that he received appropriate care.

**The Head of Healthcare should ensure that there are arrangements to allow prisoners who are ill access to appropriate levels of pain relief at all times.**

51. On 16 July, after he saw Dr C, the man agreed to go back into hospital. Once there, his pain seems to have been managed appropriately.

### **Palliative care plans**

52. After the man received his cancer diagnosis at Salisbury Hospital, he was referred to the palliative care team. Hospital records show several entries by a consultant and nurse specialist in palliative care. He transferred to Salisbury Hospital Hospice on 18 July, and was started on the Liverpool Care Pathway (LCP) three days later. (The LCP is an integrated care pathway that is used to ensure quality of care in the last hours and days of life.) Hospital records show that the man, his next of kin and his current partner were aware of his diagnosis and prognosis and were informed when he was placed on the care pathway.

## **The man's location**

53. The Governor of Guys Marsh, was aware that HMP Leyhill, an open category D prison near Bristol, was about to open a new palliative care suite. The Governor therefore decided to re-categorise the man from category C to D to enable a transfer there. This was done on 12 July.
54. The man was an inpatient at Salisbury Hospital between 4 and 13 July, until he discharged himself back to the prison. The man did not explain why he decided to discharge himself but this coincided with being told that no treatment for his condition was possible. He was very unwell all weekend. When Dr C visited him in his cell on 16 July, he had been told that the man would be transferred to Leyhill in the next day or so. Dr C considered that the man should return to hospital as he needed full time nursing care and pain relief and the man went back that day.
55. On 18 July, the man was moved to Salisbury Hospital Hospice (attached to the hospital) to have a syringe driver inserted as the hospital were unable to control his symptoms. Hospital records show that he was expected to remain there for two days while hospice staff waited to hear if he was still to be transferred to Leyhill's palliative care unit.
56. The next day, 19 July, the man was reviewed by hospice staff who decided that he was not fit to travel. They hoped that after a few days his symptoms would be under control and he could then transfer back to the hospital or to Leyhill. However, his condition deteriorated quickly and he was placed on the Liverpool Care Pathway on 21 July. The man died two days later at the hospice. .
57. The clinical reviewer commented that the man was transferred to hospital and then to the hospice in an appropriate and timely fashion. We are satisfied that prison staff did what they could to ensure that the man was appropriately accommodated during his illness.

## **Compassionate release**

58. After the man received his diagnosis on 6 July, the governor considered an application for early release on compassionate grounds. The man's pre-sentence report showed that after being remanded into custody in 2011, he lost his accommodation and therefore he had no home to go to.
59. The man's ex-wife, his next of kin did not feel able to cope with managing his health needs. His current partner asked to be allowed to care for him if he was released. However, her landlord would not give permission for the man to move in. Compassionate release was therefore not pursued because of the lack of a suitable address. We consider that appropriate consideration was given to the man's release on temporary licence.

60. After the man was readmitted to Salisbury Hospital on 16 July, the governor arranged for him to be released on temporary license to the hospital. The man was released on temporary licence from 17 July until he died.

### **Restraints, security and bed watch**

61. The Prison Service has a duty to protect the public when escorting prisoners to hospital, and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. 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, the prisoner's category and which also takes into account factors such as the prisoner's health and mobility.
62. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that medical opinion regarding the prisoner's ability to escape must be considered as part of the assessment process.
63. The man was taken to Salisbury Hospital on 4 July, and remained there until 13 July, when he discharged himself. The escort risk assessment listed the man as low risk. The assessment indicated that there was no medical objection to the use of restraints, rather than an assessment of his medical condition. We are concerned that, despite being regarded as low risk, double handcuffs were used to take the man to hospital. Double cuffing entails the prisoner having his hands cuffed in front of him and then having one wrist attached to a prison officer by an additional set of handcuffs. This is usually required for moving category A or category B prisoners in good health. When, exceptionally, double cuffs are used for a category C prisoner the Prison Service requires that reasons should be recorded in writing. There is no evidence to support the decision to use double cuffs and we can see no reason how it could be justified.
64. On arrival at hospital, the handcuffs were replaced by an escorting chain (a single handcuff attached to the man with a length of chain connected to the prison officer.) The risk assessment was later amended to say that handcuffs were not required. It is not clear when this was amended as the new instruction was not dated.
65. On 6 July, the man was diagnosed with terminal cancer. Four days later, he said that he was finding it hard to breathe and was given oxygen by hospital staff. Despite the man's diagnosis, problems breathing and being assessed as low risk, he remained restrained until the evening of 11 July, when a senior manager authorised that restraints be removed. This was the day before the man was recategorised to Category D, the lowest level of security for a prisoner. While we do not consider the earlier decision to restrain the man was justified, the change in his diagnosis and condition should have prompted

further risk assessment to consider whether he should remain restrained. We make the following recommendation:

**The Governor should ensure that escort risk assessments accurately reflect the prisoner's actual risk at the time, take account of a prisoner's medical condition and are regularly reviewed to take account of changes in circumstances.**

66. The man was readmitted to hospital on 16 July. His escort risk assessment completed the same day showed that he was still deemed low risk. Restraints were not used and he was accompanied to the hospital by one officer.
67. On 17 July, the man was released on temporary licence, which meant that prison escorts were no longer required. However, escorts remained until the day before he died, 22 July. The governor explained to the investigator that the man did not have any family nearby and his next of kin and partner were almost 100 miles away. The man received few visits while he was in hospital. The governor asked that an officer remained with him as a means of support. On 22 July, after the man moved to the hospice, the escort officer was removed. The man died the next day.

#### **Liaison with the man's family**

68. After he received his diagnosis on 6 July, hospital staff offered to speak to the man's relatives. Prison records show that the man received a visit from his ex-wife, his nominated next of kin the next day. Before he died, prison staff confirmed with the man that this was correct. The Governor spoke to the man's ex-wife on 16 July, at the man's request and offered his support. Bedwatch officers were told that if his condition deteriorated significantly it had been agreed that the man's ex-wife could be contacted directly by them. There were no restrictions on visits while he was in hospital.
69. A prison family liaison officer was appointed. She spoke to the man's ex-wife on 22 July. She explained her role and what would happen after the man died. The man's ex-wife said that a family friend was trying to contact his daughter to let her know her father was in hospital.
70. The man died at 9.20am the next day, 23 July. Hospital staff spoke to the man's ex-wife and his partner before the prison was notified. The governor contacted the man's ex-wife at 9.50am to offer his condolences. The prison family liaison officer twice attempted to contact her that day and was unable to speak to her until two days later, on 25 July. The man's daughter has still not been contacted.
71. The man was cremated on 30 August. The man's ex-wife, his next of kin, told our family liaison officer that she was concerned that there was a delay in arranging the funeral. The delay appeared to have been caused by some confusion by the funeral directors about who could register the death. At first they thought the man's ex-wife would not be able to do so as she was not directly related. The prison family liaison officer contacted the local registrar,

who then told her that they were trying to contact the man's ex-wife to ask her to register the death. This was done on 16 August. We are satisfied that the prison's family liaison officer did what she could to expedite proceedings. Guys Marsh contributed to the cost of the funeral and cremation.

## CONCLUSION

72. The man had previously suffered from cancer before he was sentenced. He soon became ill again and was re-admitted to hospital in July 2012, as the cancer had returned. The clinical reviewer concluded that “The man’s cancer was already widespread when he first complained of pain [in January 2012] and there was little the medical profession was going to be able to do to halt its progress.” We are satisfied that the man received appropriate and timely care, although we are concerned that when he discharged himself back to prison on 13 July, he was left too long without satisfactory pain relief. We do not consider that he should have been restrained during his initial hospital admission, but note he was not restrained during his last stay. Appropriate consideration was given to his possible release on compassionate grounds and there was good contact with his nominated next of kin.

## RECOMMENDATIONS

### To the Governor

1. The Governor should ensure that escort risk assessments accurately reflect the prisoner's actual risk at the time, take account of a prisoner's medical condition and are regularly reviewed to take account of changes in circumstances.

The National Offender Management Service responded with,

**Accepted** - The Governor accepts the need to apply national policy and ensure that escort risk assessments accurately reflect the prisoner's actual risk at the time, take account of a prisoner's medical condition and are regularly reviewed to take account of changes in circumstances. However, the Governor feels that the application of restraints in this case was reviewed daily, as are all bedwatches from Guys Marsh. This is a dynamic process and it is his view that the restraints were removed at the appropriate time following risk assessments which took into account issues such as the man's behaviour in the hospital setting.

Although the risk assessment indicates the use of double cuffs, this was a clerical error. The Governor has spoken to Officer A (one of the escorting officers) who confirms that, in his 4 year service career, he has never been on an escort where double cuffing was required. He is, of course, available for interview.

Para 63 of the report makes reference to the risk assessment being amended but not dated however, in Para 64 it is clear that the decision to remove the cuffs was made on 11 July 2012

### To the Head of Healthcare

2. The Head of Healthcare should ensure that nurses inform a doctor when a prisoner reports coughing up blood.

The National Offender Management Service responded with,

**Accepted** - Discussion held at team meeting to ensure GP is updated through use of tasks and discussions. All these will be noted on SystemOne

3. The Head of Healthcare should ensure that doctors perform a digital rectal examination for a prisoner with abdominal symptoms when the diagnosis is not clear.

The National Offender Management Service responded with,

**Partially Accepted** - GP accepts PR examination is good clinical practice however, in this case there were no symptoms suggestive of a presence of

rectal mass on the history. It was subsequently proven that this sign remained negative when seen by other health professionals.

4. The Head of Healthcare should ensure that there are arrangements to allow prisoners who are ill access to appropriate levels of pain relief at all times.

The National Offender Management Service responded with,

**Accepted** - Guys Marsh are looking at how to manage in cell possession in the case of terminally ill patients in order that pain relief can be provided when required outside of HCC opening times.