Investigation into the circumstances surrounding the death of a man at HMP Frankland in August 2008

Report by the Prisons and Probation Ombudsman for England and Wales

April 2009

This is the report of an investigation into the circumstances of the expected death of a prisoner at HMP Frankland, on 23 August 2008. The man was 47 years old at the time of his death from lung cancer. I would like to offer my sincere condolences to the man's family, his friends and to all those who knew him and were touched by his passing.

My colleague conducted the investigation on my behalf. An independent review into the man's care was undertaken on behalf of the County Durham Primary Care Trust. I am grateful to the clinical reviewer for his valuable contribution. I would also like to thank the Governor and Deputy Governor of HMP Frankland for their cooperation with the investigation. I am particularly grateful for the high standard of liaison.

One of my Family Liaison Officers contacted the man's father who said that he was happy with the way in which the prison managed his son's terminal illness.

I conclude that the care the man received at Frankland was very good and his wishes were respected. Healthcare and prison staff provided a high level of care to him. I make one recommendation and three commendations. The recommendation relates to the need for timely applications for release on compassionate grounds when a terminal illness is diagnosed. Of the three commendations, the first relates to prison staff who, despite being in the restricted environment of a category A prison, were flexible about the man's care. The second acknowledges the support and care give to the man by his carer and fellow prisoner. The final commendation goes to healthcare staff who, through multi-disciplinary working, managed the man's care effectively and in accordance with his wishes for as long as was practical. It is pleasing to note that this report mirrors a previous investigation exemplifying the excellent partnership between healthcare at Frankland and external healthcare providers.

The prison service have accepted my recommendation and commendations and their detailed response is on the final page of this report.

Stephen Shaw CBE
Prisons and Probation Ombudsman **April 2009**

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SUMMARY

In 1999, the man was convicted and given a life sentence. He was not familiar with prison life and, during the early part of his imprisonment, found it difficult to cope with his transfer from one prison to another.

The man arrived at Frankland in early January 1999 as a category A prisoner. (Prisoners are risk assessed and given a category based on their offence and the risk that they pose to the public should they escape. There are four levels of category: A, B, C and D, with category A prisoners being the most dangerous.) He worked hard during his sentence to address issues specific to his offence and, before he died, had made sufficient progress to achieve category B status. (Prisoners for whom the highest security conditions are not necessary but for whom escape must be made very difficult.)

Records show that the man attended the healthcare unit at Frankland for minor matters until 2006. In 2002, he had managed to stop smoking with specialist help from healthcare. This was a huge achievement as he had been described as "heavily addicted" and a "chain smoker".

When the man attended healthcare in October 2006, he complained of coughing blood. After investigation, he was advised to tell staff if the condition worsened. By November 2007, the man's condition had deteriorated. Healthcare staff suspected he had tuberculosis and referred him for further tests. While awaiting the test results, prison staff reacted appropriately by carrying out infection control procedures. The man was confined to his cell and isolated from staff and other prisoners.

Test results proved that the man did not have tuberculosis, but an x-ray showed that he "had a clear mass on his lower right lung". In late December, the man suspected he had cancer but was reluctant to undergo any tests to confirm the diagnosis before Christmas 2007 and the New Year of 2008.

A number of full discussions between healthcare professionals and the man regarding the consequences of him not having treatment are documented in the clinical record. The man made an informed decision to have neither chemotherapy (chemical treatment to kill cancer cells) nor the recommended bronchoscopy (a procedure where a thin flexible tube is passed down the throat to examine the airways) or a computerised tomography (CT) scan (cross sectional x-ray of internal organs) in January 2008. His personal officer told my investigator that the man did not want his fear that he had cancer to be confirmed.

In May 2008, the Community Macmillan Team for Palliative Care were consulted and asked to assist with the management of the man's care. I believe that at this point, when it was recognised that the man was terminally ill, an application should have been made for release on compassionate grounds. However, no application was made until 7 August, following a letter from the Palliative Care Consultant to the Governor of Frankland. I have made a recommendation in this regard.

The prison made every effort to ensure that the man's wish to be allowed to die in the cell he considered his home was respected. In the final hours of his life, the Palliative Care Pathway for the dying was followed but the medication he needed could not be given appropriately in his cell. At this point, he was moved to the healthcare unit. I consider this appropriate. Healthcare staff ensured that his door was left open as he requested.

It was regrettable that the man's father, who lives in the South of England, was told of his son's death by telephone. My investigation found that, in this instance, it was understandable and reasonable due to the time and distance involved and the likelihood of the man's father being contacted by a prisoner before the prison could break the news appropriately. Every effort appears to have been made by Frankland's Family Liaison Officer to find a Family Liaison Officer within a local prison who could undertake the task on her behalf. There was no one available so the Family Liaison Officer telephoned the man and spoke with him at length.

THE INVESTIGATION PROCESS

1. I was notified of the man's death on 23 August 2008. Terms of Reference and Notices were issued to staff and prisoners at Frankland telling them that an investigation would be taking place, and inviting those who wished to see the investigator to make themselves known. My investigator requested copies of the man's core record, clinical record (CR), and other records relevant to his time in custody and to his death.

2. My investigator also contacted the Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. The report concludes that The man died of :

   1a. Pneumonia, due to
   1b. Squamous cell carcinoma of the right lung.

   The Coroner has requested a copy of my report upon completion and I am happy to comply.

3. My investigator visited Frankland on 13 October 2008. She met the deputy governor, acting head of healthcare, and members of healthcare staff. My investigator visited C1 wing, where the man had been located, and informally met the man's personal officer other wing officers and Mr Ken Jones, the prisoner who assisted the man during his illness.

4. My investigator telephoned the seconded probation officer at Frankland regarding the man's application for compassionate release.

5. A clinical review of the man's medical care was commissioned from County Durham Primary Care Trust. The clinical reviewer focussed on the medical care the man received at Frankland. His review appears as an annex to this report.

6. My family liaison officer telephoned the man's father. The man's father told her that he was satisfied with the manner in which his son had been cared for and raised no issues for my investigator to consider.

HMP FRANKLAND

7. HMP Frankland is part of the Prison Service High Security Estate. It holds prisoners convicted of serious offences including category A and B prisoners and those serving sentences of over four years. The maximum prison capacity is 732 men and the prison has been assessed as one of the Prison Service's high performing prisons.

8. In conversation with my investigator, the acting Healthcare manager described good links with the Primary Care Trust, with visiting consultants for orthopaedic clinics, a dental suite, digital x-ray facilities and two full time doctors. The manager acknowledged that at the time of the man's illness there was a 70 per cent nursing complement with five vacant nursing staff posts. My investigator noted that on the day she visited, new nursing staff were on an induction tour of the Healthcare centre apparently bringing the staffing levels to near full complement.

9. The prison's inpatient healthcare centre has 18 beds. The healthcare department has adopted 'telehealth' technology. This is a diagnostic service with a direct camera link between the prison and Airedale Hospital Accident and Emergency Department where a doctor within the prison can have a second opinion on a medical problem from a consultant at the hospital.

10. Prisoners who need end of life care are placed on the Durham & Chester Le Street Community Integrated Care Pathway. The man benefited from a multidisciplinary care package led by a Marie Curie consultant in palliative care. Healthcare staff meet regularly to discuss cases with an external palliative care team and have a named nurse who leads on this area.

11. In her inspection report dated June 2008, Ms Anne Owers, HM Chief Inspector of Prisons acknowledged the difficulties Frankland faced with the challenging, albeit relatively static population. Ms Owers assessed that healthcare provision was good, with well-maintained accommodation. There were no concerns raised that are relevant to the man's care.

12. In their last available report in 2006, the Independent Monitoring Board identified specific problems still prevalent today around overcrowding and difficulties in transferring prisoners to prisons where they are able to progress through their sentence.

13. Within my earlier report of the investigation into the death of another prisoner who died from natural causes on 29 November 2004, I made a recommendation that "All prisoners who are diagnosed with a terminal illness should be regularly reviewed by the multi-disciplinary team and considered for early Compassionate Release or Release on Temporary Licence in a timely manner". While I am pleased to see that effective working relationships are now established between the Macmillan team and the prison palliative care team, I am disappointed that the recommendation I made in the other prisoner's report has not been implemented. I repeat the recommendation.

KEY FINDINGS

14. The man was received into HMP Woodhill from HMP Belmarsh on 26 October 1998. He remained at Woodhill until he transferred to HMP Highdown on 3 November 1998. At Highdown, he expressed his anger at this transfer to the healthcare officer in interview on 12 November and records show an F2052SH document was opened. There is no evidence to show why this document was opened as his clinical record said that he did not have suicidal thoughts. Therefore, the investigator was unable to ascertain specific staff concerns about the man's behaviour and continuing upset at being transferred from Woodhill.

15. Further entries in the man's clinical record, in the early part of his sentence, chart his frustration at being unable to return to Woodhill. His preferred method of coping appeared to be to withdraw from mixing with others and refuse prison food and survive on snacks purchased from the prison shop. Referrals were made to the prison psychiatrist and, in an appointment on 8 December 1998, the man refused to talk, writing down his answers to the psychiatrist's questions as he asked them. The psychiatrist concluded that the man had no mental disorder.

16. An entry in the clinical record by a medical officer at Highdown, on 26 December 1998, indicates that the problems the man continued. After assessment, it was concluded that the man was not suffering from "depression or with any suicidal ideation". The man transferred to another prison on 1 January 1999 but it is not clear from the records which one it was.

17. On 20 May 1999, the man received a life sentence and he gradually became accustomed to prison life at Frankland. Having been described as a very heavy smoker, he attended healthcare for help to stop smoking in November 2002 and was successful in achieving this. Other than this, it appears from medical records that he did not attend the healthcare department for any significant health problems until 9 October 2006.

18. A mental health nurse (RMN) who made the entry on 9 October 2006 said that the man attended healthcare complaining of "spitting up blood… seen by the prison doctor advised nothing serious to inform staff if condition worsens". There is no evidence of a referral for further investigation at this stage. My investigator was unable to ask the prison doctor why he did not refer the man for further investigations as the doctor now lives abroad.

19. The man attended an appointment with a second prison doctor on 27 November. He told her that he had been suffering from "flu-like symptoms for the past five weeks, was finding it difficult to walk and described himself as 'feeling like an old man'". The second prison doctor suspected tuberculosis and prescribed paracetamol for his symptoms. Clinical records and the man's wing history sheet show that appropriate procedures were followed for infection control. Healthcare maintained medical confidentiality appropriately. Wing staff were informed that the man was suspected of "having a contagious disease" without disclosing the likely nature of illness. They responded correctly by isolating the man from staff and prisoners and confining him to his cell until test results were known. Test

results received on 3 December said there was no indication that the man had tuberculosis.

20. The man's x-ray results prompted an urgent referral to a chest physician because of a "clear mass on his right lower lung". A letter dated 3 December 2007 from a third doctor at Frankland was sent to the chest physician at University Hospital of North Durham requesting an urgent appointment for the man under the "two week rule". (This is a procedure where patients who are suspected of having cancer are seen by a hospital specialist within 14 days of referral by a doctor.)

21. A note in the man's wing history sheet on 9 December reveals that he was aware that he would be seen by a consultant either in healthcare or in a hospital in the community. He disclosed his fears to staff that he might have cancer. He wished to spend Christmas and the New Year peacefully and said he did not wish to pursue any further investigations at the time. In the meantime, at a medical clinic held at the prison on 12 December, it was noted his symptoms continued and his refusal to be admitted to hospital was acknowledged.

22. In response to the third prison doctor's referral letter, the man attended an appointment on 18 December with the consultant in Thoracic and General Medicine. The consultant wrote to the third prison doctor at Frankland the same day saying "I strongly suspect this man has small cell lung cancer". The hospital arranged a bronchoscopy and a computerised tomography scan (CT) for the following day but the man refused to attend either and signed a disclaimer to that effect.

23. The man refused all further treatment from this point. The prison's attempts to persuade him to accept treatment and their explanations of the consequences are well documented within his clinical records. The man also made it clear that he did not wish to be treated outside the prison healthcare department.

24. On 24 December, the prison telephoned the Macmillan palliative care team in the community. The clinical record says that the Macmillan team had asked that the team be contacted again once a definitive diagnosis had been made and the man had been informed. They would then go to the prison to meet the man.

25. The second prison doctor told the man on 8 January 2008 that it was likely he had small cell cancer of the lung. She explained that the only available treatment was chemotherapy. The clinical records show that the man wanted information about his likely life expectancy and quality of life if he accepted chemotherapy and, similarly, if he did not. My investigator believes that the man was given sufficient and appropriate information regarding his prognosis to empower him to make informed decisions regarding his treatment.

26. My investigator spoke at length with the man's personal officer. The personal officer explained that she been the man's personal officer for 18 months and knew him well. She told my investigator that the man was terrified of cancer and, in her view, refused treatment as he did not want to have his diagnosis

confirmed. She explained that, in addition, he was a private man and did not want to go out to hospital in handcuffs which he would have found undignified.

27. According to his personal officer, the man "panicked" when his medication was not always available. The personal officer explained that this was in part due to a "huge turnover" and shortages of staff in Healthcare. To overcome the difficulty, the man's personal officer arranged for a member of healthcare to visit him every Monday in his cell to dispense his medication. She told my investigator that wing staff approved this as it allowed healthcare staff to make a general observation of the man while dispensing his medication.

28. The man's personal officer impressed my investigator with her commitment to the man's care and this is an example of excellence in personal officer work. She ensured that he received his medication on time and liaised effectively with the healthcare department when his medication was not always available. She told my investigator that she made sure she knew about the palliative care plan. My investigator gained the impression that the plan was difficult to follow at times because the man's personal officer found that he did not always ask for what he needed. She said she thought he felt that if he asked for more equipment or help he would "end up at a hospice".

29. In these circumstances, the man's personal officer said that she made every effort to ensure that his wishes were respected. The man remained in his cell on the wing although it would have been easier for both him and the wing staff if he was moved to healthcare. She managed to obtain an air mattress to reduce the risk of bed sores and increase his comfort. Her motivation was that the man regarded his cell as his home and he wished to die there rather than in healthcare or in a hospice. The personal officer said that she arranged for the man's friend and fellow prisoner to collect the man's medication when he was no longer able to do so. The other prisoner stayed with the man when he took his medication so that he was nearby in case the man experienced any difficulties. The other prisoner told my investigator that he assisted the man telephone his father when he could be moved to a telephone. He did not undertake any personal care tasks as the man was able to do these for himself throughout his illness.

30. My investigator was told that the other prisoner was not trained in the role of carer and neither was he paid for it. The man's personal officer said that the other prisoner asked staff if he could assist his friend and was given the flexibility to do so. The safeguards in this instance were that staff were aware of the other prisoner' role and were flexible around the regime. The man's personal officer said she spoke with the other prisoner often and was vigilant in ensuring that the task the other prisoner had undertaken was not too onerous and emotionally demanding.

31. In her thematic review on older prisoners in 2004, HM Chief Inspector of Prisons Anne Owers makes a recommendation regarding local policy for prisons in using prisoners as special assistance for other less abled prisoners. Her recommendation says that "Prior to a national scheme all prisons should encourage, train support and reward nominated prisoner helpers to assist less

able prisoners." Although the other prisoner had asked to assist the man, his help was not acknowledged by the prison.

32. On 31 March, the medical director wrote to the consultant. In his letter, the medical director writes that he had spoken at length with the man who believed that he has lung cancer and was clear that he did not want any further investigation. The medical director referred to "bony secondaries" and noted that he had referred the man to the Macmillan consultant in Palliative Medicine.

33. The man's care was managed by what I judge to be the effective teamwork of a number of people. They included the wing staff, his personal officer, healthcare staff, his friend and carer, the other prisoner and the Macmillan palliative care team under the leadership of the Macmillan consultant. Clinical records show that following a referral to the Macmillan consultant, the lead nurse of the Macmillan team visited the man on 23 May for an initial assessment. She reviewed his medication and an end of life care plan was discussed. The lead nurse visited the man every week to discuss pain management. She ensured that his medication was effective and adjusted it accordingly when it was not. The man's personal officer recalled that although the man was reluctant to engage with the lead nurse at first, he found her help and advice invaluable and confided in her rather than healthcare staff. She gave him her telephone number and he was able to call her when he needed to. Healthcare staff frequently reminded the man that he could contact them through the wing staff at any time.

34. A multidisciplinary meeting was arranged on 10 June at St Cuthbert's Hospice to discuss the man's future management. Healthcare staff were invited together with the Macmillan consultant. No notes or minutes of the meeting are available.

35. In a letter dated 7 August 2008, the Macmillan consultant wrote to the Governor requesting that the man be considered for early release on compassionate grounds so that he could be cared for at his father's home or in a nearby hospice. The seconded probation officer, informed my investigator that he was not asked to provide a compassionate release medical condition report until around 13 August when he saw the man on the wing. I agree with the seconded probation officer that it would have been helpful if the process had started around the time the man was thought to have terminal cancer. Unfortunately, the process was started too late.

36. Following a visit to the man, the Macmillan consultant wrote to the fourth doctor at Frankland on 11 August. The man's preference to remain on the wing was made clear and his deterioration, as well as his wish not to be resuscitated, was noted.

Events of 22 August

37. Clinical records show that the man was seen by a fifth doctor at 3.40pm at the request of nursing staff. He was noted to be "extremely ill". The man was able to tell nursing staff that he wanted to die in his cell.

38. Later in the afternoon, a Sister telephoned healthcare from the wing to say that she was arranging the man's transfer from the wing to the healthcare department. She contacted the on call doctor, the medical director, at 5.10pm to inform him that the man had deteriorated. The Sister explained to my investigator that this decision was made because it was clear that the man's medication required more intensive management than could safely be given on the wing.

39. The man was moved to the healthcare inpatient unit. Following the medical director's assessment, he was cared for according to the Integrated Care Pathway for the dying. Arrangements were put in place for twilight nursing staff to take over when Macmillan nurses finished. Medication was arranged through a prescription completed by the medical director.

40. The clinical record entry made by the medical director says that the main concern was to keep the man free of pain. This was achieved through a syringe driver which administered Diamorphine with Midazolam, and Hyoscine if required. (Diamorphine is for pain relief, Midazolam is a sedative and Hyoscine helps prevent muscle spasm.)

41. In his statement to the Governor, the principal officer (PO) said he came on duty at 7.00pm and undertook the role of Oscar 1 from another principal officer. (Oscar 1 is the officer with operational control of the prison.) He was told that the man was "extremely poorly" and that healthcare staff had been briefed as to how they should manage him. The principal officer said that the deputy governor had instructed that the man's door was to be left unlocked. My investigator understood this to be the man's wish. The principal officer said the medical director had confirmed to the healthcare staff that the man did not wish to be resuscitated. The principal officer then accompanied the Healthcare Officer (HCO) as he administered treatments to prisoners throughout the establishment.

42. In his statement, the second healthcare officer says, that he arrived for duty at 6.15pm. The Sister told him that the man was now on the Integrated Pathway for the dying and that he was to administer Diamorphine as prescribed by the medical director, with further Diamorphine to be given through the syringe driver if necessary. My investigator noted that as the man complained of further pain, the second Healthcare officer discussed this with the first Healthcare officer and further Diamorphine was given as required to ensure that the man was as pain free as possible. The second Healthcare officer said that, over the next two hours, while he went about other duties in healthcare, the man deteriorated. He told my investigator that although he was aware that staff were in and out of the man's room all evening, he had intended to return to his room to keep him company. Sadly, the man died before he could do so.

43. On or around 12.30am, the second Healthcare officer noticed that the man stopped breathing. The second Healthcare officer tried to find a pulse. When he could not find one, he returned to the office and informed senior prison staff. The second Healthcare officer then contacted the doctor at the out of hours centre. A Doctor from the out of hours centre attended the prison and verified the man's death at 1.05am.

44. The man's father, who lived in the South of England, was informed by telephone. The prison's Family Liaison Officer told my investigator that she spoke with prisons local to where the man's father lived and asked for a Family Liaison Officer to go to his home to tell him the news in person. Regrettably, Frankland's Family Liaison Officer was unable to find a Family Liaison Officer available to undertake this task. She told my investigator that she made a "judgement call" in telephoning the man's father because of the distance involved and the "threat of prisoners telling him" before the prison had the opportunity. The Family Liaison Officer spoke at length with the man's father who was aware of the situation. It is unfortunate that the man was told by telephone but I believe this was understandable and appropriate in the circumstances.

45. My investigator spoke with staff who confirmed that they had received the appropriate support from the prison and that they were aware of support networks if they feel they need it. The other prisoner confirmed to my investigator that he had felt supported during the man's illness and following his death.

ISSUES

Clinical care

46. The clinical review was undertaken on behalf of County Durham Primary Care Trust. The clinical reviewer reviewed all necessary records and spoke with my investigator. He concluded that the management of the man from his initial diagnosis until the end of his life was compassionate and caring. The clinical reviewer is of the view that the man had clearly decided for himself that he had a malignant disease and that he did not want any further investigations or interventions.

47. The clinical reviewer is of the opinion that the consultant and the medical director "went the extra mile" in ensuring that the decisions the man made were informed and that he was aware of the consequences of his actions. I agree.

48. The multidisciplinary working between the healthcare staff and the Macmillan team led by the Macmillan consultant is a very good example of how good care can be given and symptoms effectively managed according to a prisoner's wishes. My investigator found the Sister to be empathic and compassionate in her role as palliative care nurse for Frankland and in the man's case in particular.

    The Governor should write to Healthcare staff to commend them for their excellent care and management of the man's illness throughout.

49. Particular attention is drawn to the man's personal officer whom the clinical reviewer and my investigator feel exemplifies excellence as a personal officer and whom the man thanked for her care in his letter to the Governor. I understand from the deputy governor that the man's personal officer was recognised for her work and was named "Employee of the Month". My investigator spoke with the man's personal officer and she was unaware of this. In the circumstances I would recommend that the man's personal officer be commended for her excellence as a personal officer.

    The Governor should write to the man's personal officer commending her for her excellent work as a personal officer in respect of the man.

Compassionate release

50. My investigator noted that preparations for release from prison on compassionate grounds were not started by the prison until the Macmillan consultant wrote to the Governing Governor on 7 August 2008. It is accepted that the man's decline was rapid and that compassionate release is not appropriate in every case. However, where possible, the process should be started as soon as it is known that a prisoner is terminally ill and has indicated an interest so that procedures are in place for a speedy release. I repeat the recommendation mentioned earlier in this report at paragraph 19 regarding an earlier recommendation in this regard.

The Governor should ensure that where prisoners have indicated they wish to apply for early release on compassionate grounds, the process is started as soon as it is known that a prisoner is terminally ill so that arrangements are in place for a speedy release.

Record keeping

51. My investigator and the clinical reviewer found the standard of record keeping to be poor in the prisons in which the man was held prior to Frankland. The handwritten clinical records were difficult to follow because signatures were often illegible and names are not written in block capitals underneath the signature. Neither was it always clear which prison the man was in at the time the assessment was made.

52. By contrast, record keeping at Frankland was good with clear and detailed entries through the EMIS computerised system. Staff who made entries on the system charted concerns, noted why decisions were made and the medication given.

The man's location

53. Every effort appears to have been made by healthcare staff to ensure that the man's wish to remain on the wing was respected for as long as possible. Healthcare staff demonstrated a caring and compassionate approach and liaison with the community Macmillan team was effective and appropriate resulting in good management of the man's symptoms throughout.

54. I commend the Governor, security and wing staff for their flexibility in accommodating the man's wish to remain on the wing as long as possible while mindful of the security considerations and regime of a category A prison. The man was allowed to leave his cell door open during the day and that permission was extended to the other prisoner who was located opposite to the man and assisted him with his medication. Those who wished to were permitted to keep the man company during the day. It is acknowledged that it would have been easier for staff to have insisted that the man be cared for as an in-patient in healthcare, particularly in the light of risks around the large amount of medication he was prescribed. However, these difficulties were addressed and managed and the man's wish to remain on the wing for as long as was possible was granted.

The Area Manager should write to the Governor and staff on A wing, A3 landing as appropriate to commend them for their flexibility in accommodating the man's wish to die with dignity, in the manner he chose, as far as was possible in the circumstances.

Using prisoners as carers

55. My investigator and clinical reviewer note the valuable contribution the other prisoner made in assisting the man as his health deteriorated. Wing staff ensured that the other prisoner was able to care for the man as necessary by allowing his cell to be opened in the mornings for him to assist the man with his medication. My investigator has seen a letter from the other prisoner addressed to a Senior Officer thanking him and all staff who "helped and shared compassion" to the man during his illness and for giving him the opportunity to be seen as trustworthy to sit with the man during his illness. He thanks staff for "letting me know that he [the man] passed away peacefully in his sleep". The man's personal officer assured my investigator that the other prisoner was cared for during and after the man's death and the other prisoner confirmed this. The man's personal officer informed my investigator that the other prisoner was not paid for his care of the man. She said that he asked staff if he could care for him out of friendship and staff finally agreed. The man's personal officer said that she is aware that the other prisoner finds it difficult to adjust to life without the man and that she keeps a careful watch on him. She told my investigator that the other prisoner was greatly heartened by a recent letter of support from the man's father. My investigator felt that the other prisoner's valuable contribution to the man's care has not been given sufficient acknowledgement by the prison.

56. My investigator has seen a letter from the other prisoner, addressed to the Senior Officer in gratitude for the care and compassion of the staff to the man and to himself, in his role as carer. It is clear that staff were flexible about his regime as they were able to unlock the other prisoner separately from others specifically so he could care for the man. The other prisoner has thanked staff for "letting me know that he passed away peacefully in his sleep".

    The Governor should write to the other prisoner acknowledging his support of the man by providing practical care and emotional support.

CONCLUSION

59. The man's was terminally ill and his death was expected. It was well managed in all the circumstances, particularly considering the constraints within a high security prison. Staff made every effort to ensure that his wish to die in the cell on C wing that he considered his home was respected. His move to healthcare in the final hours of his life so that his medication could be more safely managed was entirely appropriate.

60. Although I make one recommendation relating to earlier consideration being given to compassionate release, the investigation found that the management of the man's care during his illness and at the end of his life demonstrated what is achievable when healthcare, the prison staff and, in this case, a prisoner work together towards a single aim. The result is that the quality of care given to the man equalled and, quite possibly exceeded, that which he would have received in the community.

RECOMMENDATION AND COMMENDATIONS

Recommendation

The Governor should ensure that where prisoners have indicated they wish to apply for early release on compassionate grounds, the process is started as soon as it is known that a prisoner is terminally ill so that arrangements are in place for a speedy release. This recommendation is repeated from an earlier recommendation.

Partnership working is underway with the Prison and PCT to implement a full palliative care policy within the prison. When a prisoner enters the end of life pathway as part of this from a palliative care point of view, the Head of Healthcare will formally write to the Governor. The Governor will then contact other relevant departments to begin work on whether early release on compassionate grounds is possible and if so begin the process. Target date for completion is 30th June 2009.

Commendations

The Area Manager should write to the Governor and staff on A wing, A3 landing as appropriate to commend them for their flexibility in accommodating The man's wish to die with dignity, in the manner he chose, as far as was possible in the circumstances.

Accepted. A letter will be written by the Director in recognition.

The Governor should write to the other prisoner acknowledging his support of the man by providing practical care and emotional support.

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The Governor should write to Healthcare staff to commend them for their excellent care and management of the man's illness throughout.

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