PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Full Sutton in September 2012

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 a man. He died in September 2012 at HMP Full Sutton. He was 55 years old. He died of metastatic carcinoma (cancer) of the lung with pulmonary embolism (a blood clot in the artery that transports blood from the heart to the lungs). I offer my condolences to his family.

The investigation was carried out by an investigator. A review of the man's clinical care in custody was carried out by a clinical reviewer on behalf of the local Primary Care Trust (PCT). Full Sutton cooperated fully with the investigation.

After spending nearly two decades in prison, the man was diagnosed with cancer of the right lung in July 2012. The clinical review concludes that this was diagnosed in a timely manner and that he received very good care and support from healthcare staff at Full Sutton. I am satisfied that overall he received good treatment at the prison. However, there is a need for Full Sutton to review its risk assessment procedures for terminally ill men receiving hospital treatment and to ensure that payments towards funeral costs are in line with national guidance.

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 **April 2013**

CONTENTS

Summary

The investigation process

HMP Full Sutton

Issues

Recommendations

SUMMARY

1. The man was sentenced to life imprisonment in 1993 and, six years later, transferred to HMP Full Sutton. In June 2012, he saw a prison doctor and said that he had had a persistent cough for around a year. The doctor referred him for a chest X-ray, the results of which led him to make an urgent referral to a hospital with suspected cancer. He had a scan at the hospital on 10 July, which showed he had cancer of the right lung. The news of this diagnosis was broken to him by the consultant at the hospital. The clinical reviewer concludes that medical staff at Full Sutton made the appropriate investigations and referrals that led to his diagnosis.

2. Over the following month, the man expressed reluctance to undergo the recommended investigations and treatment. Several members of healthcare staff spoke to him about his options, and a prison nurse accompanied him to an appointment with the consultant to discuss this further. He agreed to have chemotherapy, and a preliminary appointment was made for 29 August. At the appointment, the consultant determined that chemotherapy was no longer the best option. He referred the man for radiotherapy instead. This was due to start on 19 September.

3. In September, after a night in which he had vomited several times, the man moved to a cell on the healthcare inpatient's unit at Full Sutton. His health deteriorated further several days later and he died.

4. Overall we judge that the man received appropriate treatment following his diagnosis, in line with what he could expect to receive in the community. His pain management was appropriate, but the clinical reviewer suggests in future the prescription of anticipatory painkilling drugs for quick access towards the end of life.

5. We believe there are additional lessons to be learnt. Contrary to national guidance, a family liaison officer was not appointed until after the man's death, and his family were not offered the expected contribution to the cost of his funeral. We also consider that restraints were sometimes unnecessarily used when he underwent intrusive investigations following his diagnosis and when he had been given only a short time left to live.

THE INVESTIGATION PROCESS

6. On 17 September 2012, notices were issued announcing the investigation to staff and prisoners, inviting anyone who had relevant information to contact the investigator. One prisoner wrote to the Ombudsman as a result.

7. The investigator visited Full Sutton on 9 November. During the visit he interviewed four members of staff. He also visited C wing, where the man lived, and spoke to a prisoner who knew him. The investigator met the Governor to provide feedback on the investigation, and followed this up in writing.

8. A review of the man's clinical care at the prison was undertaken by a clinical reviewer on behalf of the local Primary Care Trust (PCT). She is a senior commissioning manager for cancer and palliative care.

9. One of the Ombudsman's family liaison officers telephoned the man's sister, his nominated next of kin, on 17 October, to explain the investigation. His sister asked that the investigation address whether his cancer could have been diagnosed at an earlier stage and whether there were delays in treatment. She asked what caused the mark that she observed on his face. She also wanted to know whether the level of restraints when he was in hospital was appropriate and whether he could have been released early from his sentence or transferred to a prison closer to his home.

10. The investigation has assessed the main issues involved in the man's care, including his diagnosis and treatment, liaison with his family, his location, whether compassionate release was considered and whether appropriate palliative care was provided.

11. As part of the consultation process the man's sister received a copy of the draft report. She commented on various aspects of the care he received in prison, the inappropriate use of handcuffs while at hospital and the support received following his death. We have considered the issues raised and have addressed these outside of this report in separate correspondence to her. The report was also sent in draft to the Prison Service. Their response to the recommendations is included at the end of the report.

HMP FULL SUTTON

12. Full Sutton opened in 1987 as a purpose-built maximum security prison. It holds up to 608 category A and B prisoners serving a minimum of four years. Healthcare services are commissioned through the local PCT. There are registered general and mental health nurses, as well as a nurse prescriber (a nurse who is qualified to prescribe medication) and daily GP cover. There is an inpatient unit with six beds and 24 hour nursing cover.

HM Inspectorate of Prisons (HMIP)

13. HMIP conducted an unannounced full follow up inspection of Full Sutton in October 2010. The Inspectorate found that the healthcare nursing team was well qualified with a good skill mix. Their survey found that prisoners were dissatisfied with access to and the care provided by prison doctors, although the Inspectorate themselves concluded that GP provision was excellent. The Inspectorate also found that a palliative care policy had been developed and there were excellent links with local cancer organisations, including Macmillan nurses.

Independent Monitoring Board (IMB)

14. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. The IMB annual report for 2010-11 commended healthcare staff for the care and compassion they provided to terminally ill prisoners.

Previous deaths at HMP Full Sutton

15. The man was the eighth prisoner to die at Full Sutton since February 2011. There has subsequently been one further death. Five of the previous seven deaths were also due to apparent natural causes. One of these previous deaths involved a man diagnosed with terminal cancer. We found that he received clinical care at Full Sutton at least equivalent to what he could expect to receive in the community. However, we also found that the application for early release on compassionate grounds placed too much emphasis on historical risk factors rather than fully considering the man’s physical condition and the effect this had on his risk. As in this case, our other most recent investigation found that Full Sutton did not contribute to the cost of the funeral in line with national guidance.

ISSUES

The diagnosis of the man's terminal illness

16. The man was born in 1957 and served a number of prison sentences in the 1970s and 1980s. He was remanded in custody to HMP Cardiff in March 1993 and, later that year, sentenced to life imprisonment with a tariff (the minimum time to be served before release on licence can be considered) of 12 years. He transferred to Wakefield in 1994 and to Full Sutton in 1999, where he lived for the remainder of his life.

17. In October 2010, the man arranged an appointment with a prison doctor, at which he said he had had a cough for around a month. The doctor prescribed an antibiotic. The man was advised to arrange another appointment if his cough persisted. He did not do so. In September 2011, he again complained of a cough. The doctor diagnosed a chest infection and, again, prescribed a course of antibiotics. As previously, he did not submit an application for a follow up appointment. The clinical reviewer comments that there was nothing identified to suggest that this chest infection had a malignant (cancerous) cause.

18. The man had no further recorded contact with healthcare staff until he began a smoking cessation course on 30 May 2012. Around a week later, on 7 June, he applied for an appointment with a doctor saying he had had a cough for around one year. An appointment was made with a doctor for 14 June. After examining him, the doctor concluded that he might have chronic obstructive pulmonary disease (COPD, a term that encompasses a number of lung disease including chronic bronchitis and emphysema). He prescribed a course of antibiotics and gave the man an inhaler to use when he felt he needed it. The doctor also asked that a chest X-ray be carried out.

19. The X-ray was done at the prison on 18 June and sent to the radiology department of a local hospital for analysis. No specific disease was identified on the scan, and the radiologist noted that he could not rule out the presence of a mass (possibly of cancer cells). As a result, the doctor made an urgent two week referral (an NHS target for patients with suspected cancer to be seen by a consultant within two weeks) to the hospital on 22 June. An appointment was made by the hospital for 10 July, just over the two week target. There is no suggestion that his status as a prisoner had any bearing on the date of this appointment.

20. The man went to hospital on 10 July for his scheduled appointment. A CT scan was performed, the results of which showed that he had cancer of the right lung. An appointment was made for a biopsy to determine the specific nature of the tumour and what the treatment options were.

21. The clinical reviewer comments that the correct investigations were carried out when the man reported a long term persistent cough in June 2012. These investigations led to an appropriate urgent suspected cancer referral. As noted, he was not seen at hospital within the nationally specified two week target. The clinical reviewer comments that national performance standards require a

The man's medical appointments and treatment

22. The man's biopsy was arranged for 19 July, at hospital. After considering the results, the respiratory consultant (chest specialist) wrote to a prison doctor on 25 July to explain that the man's tumour was inoperable. The consultant explained that he had referred the man to an oncologist (cancer specialist) to consider whether chemotherapy was an appropriate option. An appointment was made with the oncologist for 1 August.

23. At the man's request, a prison nurse accompanied him to this appointment to help him understand the discussion and his treatment options. The consultant oncologist explained that the cancer was inoperable but they could offer chemotherapy with a view to controlling the spread of the disease and prolonging his life. The oncologist also explained to the man that that without treatment he was likely to die within three months. With treatment, he could live for an additional three months. The decision on whether to have chemotherapy was left with the man to consider.

24. Around a week later, the man decided that he would have chemotherapy. An appointment for a preliminary assessment was made at the oncology clinic for 29 August. At this appointment, the oncologist noted that he had recently experienced increased breathlessness and had coughed blood (a common effect of lung cancer). Because of these symptoms, the oncologist now had doubts about whether chemotherapy was appropriate. He also noted that the man was still a little unsure about chemotherapy, partly on account of a long standing phobia of needles. The oncologist suggested that radiotherapy might now be a more suitable alternative.

25. On 3 September, the man returned to hospital to see a different oncologist in order to discuss radiotherapy as a treatment option. The main aim of radiotherapy would be to help control his coughing of blood and it was also hoped it would have some effect on his breathlessness. He agreed to have radiotherapy. An appointment was made for a preliminary CT scan on 14 September, which he attended, with a view to starting radiotherapy on 19 September.

26. The man became more unwell in the days following this appointment. One morning in September he vomited blood and was struggling for breath. He was given oxygen but his breathing slowed and stopped. He was pronounced dead by a doctor at 8.40am.

27. The clinical reviewer notes that there is a national target for 85 per cent of patients referred with urgent suspected cancer to have their first treatment within 62 days of receipt of the referral. This target date for the man was 23 August. Not unreasonably, he took a week to consider his options before ultimately deciding that he wanted to pursue chemotherapy. It was a further three weeks

28. We are satisfied that the man received appropriate treatment after his diagnosis and was able to attend all appointments. Although treatment was due to start outside the national 62 day target, we are satisfied about the reasons. There was evidence of good communication between healthcare and hospital staff and we agree with the clinical reviewer that he received care comparable to that he could have expected to receive in the community.

Informing the man about his condition and treatment

29. A doctor discussed the man's symptoms and the potential causes with him when he made the two week referral for suspected cancer on 22 June. Over the next two weeks, he showed some reluctance to attend hospital but was persuaded by a doctor on 5 July, after further discussion of the possible implications of his X-ray result.

30. The CT scan on 10 July confirmed a diagnosis of lung cancer. The news of this diagnosis was broken to the man by the consultant at the clinic. The man discussed the findings further with a doctor the next morning.

31. The man expressed further reluctance to return to hospital for his biopsy. He told healthcare staff that this was because he had been embarrassed to be handcuffed when he was in hospital. (This issue is explored further in the section on restraints, security and bedwatch.) Several members of staff, including a doctor and a member of the prison's mental health in-reach team, spoke to him about his options and their implications. As a result, and following discussions with his family, the man decided to continue with his investigations and treatment.

32. At his request, a prison nurse accompanied the man to his clinic on 1 August. The results of his biopsy and subsequent treatment options were discussed at this appointment. The oncologist recorded that the man understood his cancer was not curable and his prognosis had been explained.

33. In the next week, the man spoke to a doctor and several nurses about his treatment options, and decided that he would like to have chemotherapy. The clinical reviewer comments that he was provided with good support by prison healthcare staff to help him make this decision. As we have noted, due to a change in his symptoms the man later agreed to radiotherapy as a more beneficial option.

34. It is apparent that the man was informed of his diagnosis by the consultant at the first opportunity. When he returned to Full Sutton he was able to discuss the diagnosis further with a doctor. Over the following two months, the man had many discussions with healthcare staff about his diagnosis and treatment options. It is commendable that a number of different members of healthcare

The man's pain relief and medication

35. The man did not complain of any pain in the lead up to his diagnosis. He first reported experiencing significant chest pain on 20 July, and was prescribed co-codamol by a doctor. (Co-codamol is a combination of codeine and paracetamol and is prescribed for mild to moderate pain.)

36. A week later, on 27 July, the man told a doctor that he was continuing to experience chest pain but was not keen to take co-codamol which he had declined to take on a couple of occasions. The doctor encouraged him to take the prescribed dose in order to receive the full benefits of the medication.

37. On 8 August, the man's painkiller was changed from co-codamol to tramadol. Tramadol is a stronger painkiller prescribed for moderate to severe pain. A doctor told the investigator that the man was experiencing increased pain at the time, which was the reason for the change in medication.

38. The man told a doctor on 9 August that his pain was well controlled. However, the next day, his dose of tramadol was increased. There is no record in the notes of an assessment or of him complaining of increased pain.

39. On 21 August, the man told a nurse that he was experiencing increasing pain. A doctor spoke to him about increasing his dose of tramadol, but he said he did not want to increase the dose at that time.

40. A week later, on 28 August, the man said he was in a lot of pain but was reluctant to ask for support. He said he was experiencing some blurred vision as a side effect of tramadol. That afternoon a multi-disciplinary meeting was held, with attendees including a prison nurse, pharmacist and a Macmillan nurse. Changes were recommended to his medication, and he was now prescribed morphine sulphate as pain relief. (Morphine is a strong painkiller used for prolonged relief of severe pain.) The next day, the man told a doctor that he could not tolerate the stronger painkiller and he was prescribed tramadol again but at a higher dose.

41. Over the next week, the man experienced some intermittent pain in his chest, but told healthcare staff that it was manageable. The dose of tramadol was increased again on 13 September, when he said that the dose he was on was no longer adequate to control his pain.

42. The clinical reviewer comments that the man was provided with appropriate pain relief. She adds that his symptoms, particularly pain, were managed in a timely and appropriate manner. While they were not needed in his case, she notes anticipatory drugs, such as subcutaneous analgesia (pain relief injected into the fatty tissue under the skin where it can be absorbed more slowly), were not prescribed so they were available if required.

The Head of Healthcare should ensure that anticipatory prescriptions are used to enable quick access to appropriate analgesia and sedation for end of life symptom control.

Palliative care plans

43. On 23 July, a doctor made a referral to the local Macmillan service, including with this details of the man's medical history and recent diagnosis. The next day a community Macmillan nurse visited and met the man at a multi-disciplinary team meeting along with a doctor and a prison nurse. A nurse later told the investigator that all prisoners who have been diagnosed with cancer are seen at least monthly by the Macmillan nurse.

44. The Macmillan nurse visited the man for a second time on 28 August, and saw him at a multi-disciplinary team meeting along with the nurse, a pharmacist and a physiotherapist. The Macmillan nurse gave advice on his medication.

45. Healthcare staff held several discussions with the man about his wishes for future care. As we have noted, they provided good support when he was having doubts about continuing with his treatment. His wish to live on his wing for as long as possible was respected and, as we will describe later, nursing staff produced a management plan to help wing staff support the man.

46. The nurse told the investigator that the Liverpool Care Pathway[1] is used at Full Sutton. The pathway is opened when a multi-disciplinary team agree that a change in the patient's condition means that they are now dying. This is usually in the last days or hours of the patient's life. The nurse explained that the man's sudden deterioration and death came very unexpectedly and he did not meet the criteria to open the Liverpool Care Pathway before his death.

47. The clinical reviewer comments that there was timely liaison with specialist palliative care services. She commends the joint working between healthcare staff and specialist services and concludes that the man received a good level of person centred care.

Liaison with the man's family

48. On 12 July, the man told a prison nurse that he had spoken to his family about his diagnosis (which had been confirmed two days earlier). At the time, he was having doubts about continuing with treatment and he told the nurse that his family had encouraged him to do so. Around a week later, the man told another nurse that he had spoken to his family again about diagnosis and treatment.

49. The man's sister visited him at Full Sutton on 10 August. He asked that a prison nurse accompany him to the visit in case he needed help explaining his illness to

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[1] The Liverpool Care Pathway is intended to provide the best quality of care possible for dying patients in the last hours or days of life, tailored to an individual's needs and in line with their wishes.

his sister. A nurse went with him and explained the benefits of chemotherapy to him and his sister together.

50. After the man's death in September, a prison chaplain and an officer visited his sister to break the news to her. She lives in Wales, a significant distance from Full Sutton. A trained family liaison officer was appointed on 18 September and contacted her on the same day.

51. Prison Service Instruction (PSI) 64/2011 provides guidance on the management of prisoners who are terminally or seriously ill. It provides the following instruction (the italics signify that a particular action is mandatory):

    "*Prisons must ensure that arrangements are in place for an appropriate member of staff to engage with the next of kin or a nominated person of prisoners who are either terminally or seriously ill* … With the prisoner's agreement, the family should be kept informed and updated on the prisoner's condition particularly if there is a deterioration in their condition."

52. The family liaison officer told the investigator that he spoke to the man after his diagnosis about contacting his family, to which he replied "let's wait until it's done". However, the family liaison officer described this as an informal approach conducted very briefly and in passing. Managers did not consider formally appointing a family liaison officer after the man's diagnosis.

53. While it appears there were some positive examples of positive family contact, such as the nurse speaking to the man's sister about his condition, good practice would be to appoint a family liaison officer at an early stage when a prisoner is diagnosed with a terminal illness, in line with PSI 64/2011. This is beneficial for the family as they have a point of contact should they have any concerns about their relative they wish to discuss. Another important aspect of the role might be, at an appropriate moment, to discuss with the family how they would prefer the news of a death to be broken to them, and to prepare them for the procedures that must be followed in the event of a death in custody. It would also benefit the prison to have established a relationship should they need to contact the family in the event of a sudden deterioration or death. If there is any doubt about whether a terminally ill prisoner wishes a family liaison officer to contact their family, this can be fully discussed with the prisoner and their decision recorded.

54. The Governor has responded to the investigator's initial feedback to say that he will ensure that, in future, a family liaison officer is appointed when a prisoner is diagnosed with a terminal illness. We welcome this approach.

    The Governor should appoint a family liaison officer when a prisoner is diagnosed with a terminal illness.

55. PSI 64/2011 also provides the following instruction with regard to funeral costs:

    "*Prisons must offer to pay a contribution towards reasonable funeral expenses of up to £3,000.*"

56. The PSI goes on to provide examples of which costs and services might be reasonable for a prison to contribute towards, and which might not. The man's funeral cost a total of £4,088, towards which Full Sutton made a contribution of £2,350. Although not all items in the total cost met the criteria of PSI 64/2011, a significant proportion of the sum does meet this criteria and this is clearly greater than the contribution offered by the prison.

57. Following the investigator's visit to Full Sutton, the Governor wrote to provide details of how the contribution was reached. While some of his views on what costs might be considered unreasonable are in line with PSI 64/2011, others are not. For instance, he suggested that the sum of money given to the man's sister from that left in his private prison account was taken into consideration. A cheque for £651.05 for outstanding monies in his account was given to his sister, which included a total of £74.00 collected by prisoners on his wing. PSI 64/2011 explicitly states that "*a deceased prisoner's monies must not be used to meet the costs of their funeral*".

58. We have also raised the issue of funeral expenses in another recent investigation at Full Sutton, in relation to a death in July 2012. We make a similar recommendation here.

    The Governor should ensure that, in line with Prison Service guidance, an appropriate contribution is made to the man's family to cover the reasonable costs of his funeral, up to £3,000, and that the prison abides by the guidance in future.

59. This recommendation was not accepted by Full Sutton who, in their response, said that their contribution of £2,350 was "in accordance with Prison Service guidelines". We do not agree with this statement. PSI 64/2011 is explicit in its description of which costs of a funeral might be considered reasonable for a prison to meet. As we have noted above, a significant proportion of the total cost of the man's funeral meets this description of reasonable costs and this sum is greater than that offered by the Governor. It is disappointing that he does not agree, and reflects badly on the prison.

The man's location

60. The man lived on C wing at Full Sutton. At the time of his diagnosis he was offered admission to the healthcare centre's inpatient unit for monitoring and support, but preferred to stay on C wing with the support of friends. He was offered admission to the inpatient unit a number of times over the following two months. He agreed to 24 hour admissions on 27 July, when he experienced pain and nausea, and on 29 August, when he felt unwell after a hospital clinic.

61. A management plan was written by a nurse on 8 August, to guide wing staff in their supervision of the man. This included advice on the diet the kitchen would provide him, approval for use of a wheelchair to get to healthcare should he need it, and a request that his door remain unlocked during the core day. The plan also confirmed that a bed was available for him in the inpatient unit at any time he wanted it.

62. The man vomited several times in the week of 11 September. When this increased in frequency on the night of 14 September, he asked to move to the inpatient unit where he remained until he died. We are satisfied that his wish to remain on the wing with his friends was respected for as long as was realistically possible. Consideration was also given to the man moving to a hospice at the appropriate stage, but he deteriorated very quickly and died before a move could be arranged.

63. Shortly after his diagnosis, the man asked to transfer to HMP Cardiff so he could be in a prison closer to his family. His sister told our family liaison officer that this would have enabled her to visit him more often.

64. The population manager at Full Sutton contacted Cardiff in early August to ask them to consider a transfer. It was agreed that an application for early release on compassionate grounds would be considered first, with further discussion on a transfer if that were unsuccessful. This was initially considered, and rejected, by managers at Full Sutton later in the month. (This process is discussed further in the following section.)

65. The Head of Offender Management at Full Sutton contacted the lifer manager at Cardiff on 29 August to tell her that early release on compassionate grounds would not proceed and asked that Cardiff now consider a transfer. The lifer manager told the investigator that she passed this request onto her line manager, who would lead on the decision and the application was still under consideration when the man died a little over two weeks later. It is unfortunate that no progress was made on this transfer but we accept that at that stage it was not anticipated that he would die so soon afterwards.

Compassionate release

66. Early release on compassionate grounds (ECR) is a means by which prisoners who are seriously ill can be permanently released from custody before their sentence has expired. The criteria for early release for indeterminate sentenced prisoners are set out in Prison Service Order (PSO) 4700 and prisoners are usually expected to have less than three months to live. The criteria include that the risk of re-offending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) within the National Offender Management Service (NOMS).

67. Managers at Full Sutton first considered the possibility of early release on compassionate grounds in August 2012, but the application was not pursued at the time as the man was due to undergo chemotherapy, with the aim of prolonging his life. His prognosis could not therefore be known with any certainty and it was thought he might have a life expectancy of more than three months. We agree that this was a reasonable decision at that stage.

68. When, on 30 August, the consultant oncologist determined that the man was no longer suitable for chemotherapy, the possibility of an application was reconsidered. The population manager asked the relevant people to complete their sections of the application form.

69. A doctor was responsible for completing the medical section of the form and needed written confirmation of the man's prognosis from his consultant. On 31 August, he asked the consultant oncologist to write a letter to support the application. The doctor recorded that the consultant's verbal comments were that he would "deteriorate rapidly" regardless of whether he had further treatment and was unlikely to live longer than three months. Two weeks later, on 13 September, the doctor spoke to the consultant's secretary as the required letter had not yet been received. The consultant's letter was not received until 18 September, the day after the man's death. The population manager told the investigator that this was the main reason for the delay with the ERC application. In his letter, the consultant estimated that the prognosis was likely to be "in the order of a few weeks to short months".

70. We do not know whether the man would have met all the criteria for compassionate release and given the speed of the deterioration in his health it possible that the outcome would not have been determined before his death. Nevertheless, it is important that reports in support of compassionate release are collated quickly. We accept that letters from consultants are outside the control of the prison but it might be helpful to ensure that the local hospital understands the need for urgency in these cases.

    The Head of Healthcare should liaise with the hospital to help ensure that prognosis letters for applications for early release on compassionate grounds are given appropriate priority.

Restraints, security and bedwatch

71. 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 and which also takes into account factors such as the prisoner's health and mobility. 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. It deemed that handcuffing a prisoner receiving chemotherapy (and, by implication, other life saving treatment) was degrading and that such restraint would be likely also to be regarded as inhumane unless justified by other relevant considerations.

CT scan on 10 July 2012

72. Following the two week cancer referral submitted by a doctor, an appointment was made for the man at hospital for a consultation and CT scan of his chest on 10 July. A risk assessment was completed before the appointment, which was authorised by the Governor. The man was assessed as a medium risk to the public (on a scale of low, medium, high) because of his offence. He was assessed as a low risk to escort and hospital staff, and a low risk of escape. A governor concluded that three officers should escort him to hospital, double cuffs[2] should be used on the journey to and from hospital, and an escort chain[3] should be used during the scan. The deputy Head of Security at Full Sutton explained that these are standard arrangements when a category B prisoner has a CT scan at hospital.

73. Although he was unwell at the time, having complained of a persistent cough and shortness of breath, the man had not yet been diagnosed with cancer and was an active man. It is surprising that such a level of escort and security was judged necessary when he had been assessed as a low risk of escape, but in the circumstances, we accept that the prison did not consider there was a compelling reason to diverge from the standard security arrangements for a Category B prisoner.

Biopsy on 19 July 2012

74. When the results of the CT scan revealed that the man had lung cancer, a biopsy was arranged for 19 July to determine the specific nature of the cancer and what the treatment options were. His circumstances had now changed in that he had been diagnosed with a terminal illness. In addition, this was a more intrusive procedure and involved, under sedation, inserting a long, flexible tube (a bronchoscope) into his nose and threading it to his lungs.

75. An escort risk assessment was completed and as previously, he was assessed as a medium risk to the public because of his offending history. The assessor recorded that the man had a "history of violence but nothing while in prison" (he had been in prison for 18 years at the time). The healthcare contribution indicated just that there was no medical objection to the use of restraints rather than whether or how his condition impacted on his risk. Again, the man was assessed as a low risk to escort and hospital staff and of low escape potential. It was determined that two officers would accompany him and an escort chain would be used for the bronchoscopy.

76. British Medical Association guidance is that there should be a presumption that prisoners are examined and treated without restraints, unless there is a high risk of escape or the prisoner represents a threat to himself, the health team, or others. We acknowledge that public protection is paramount, but security measures must be proportionate to a prisoner's individual circumstances. The

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[2] Double cuffs means that two pairs of handcuffs are used; one to cuff the prisoner's wrists together and one to cuff one of his wrists to that of an officer.

[3] An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.

man had been assessed as a low risk of escape and a medium risk should he do so. Although he was still relatively active, he had been diagnosed with a terminal illness and was due to undergo a particularly intrusive procedure. We do not consider the risk he presented warranted the use of an escort chain during this procedure. If additional security measures were considered necessary then a third officer could have been added to the escort.

CT scan on 14 September 2012

77. The man had another CT scan on 14 September, in preparation for the radiotherapy due to start five days later. This was not such an intrusive procedure as the bronchoscopy, but he now had a short life expectancy of around three months. While he was still relatively active – a doctor told the investigator that his mobility was not affected when he last saw him, on 13 September – he had been more unwell that week and had vomited several times.

78. The man's risk was assessed to the same levels as those described previously and the same arrangements were recommended as for the previous CT scan. On the morning of the scan, the escort staff contacted the duty governor, who permitted them to remove the double handcuff (meaning the handcuff between him and one of the officers). The officers left the scanning room and stood outside, although his wrists remained handcuffed in front of him.

79. We agree that it was appropriate that the man was not handcuffed to an officer during this procedure. However, we do not consider it was necessary for him to have had his wrists handcuffed together when he was not regarded as a risk of escape or to hospital staff. If officers considered his risk was such that they could leave the room then he should not have been handcuffed during the scan.

The Governor should ensure that the risk assessment undertaken before a prisoner visits hospital for an invasive clinical investigation gives thorough consideration to the type of procedure and the individual circumstances of the prisoner, including their general health. Prisoners diagnosed with a terminal illness and assessed as low risk to escort and hospital staff and a low risk of escape should not routinely be restrained during such procedures.

RECOMMENDATIONS

To the Governor

1. The Governor should appoint a family liaison officer when a prisoner is diagnosed with a terminal illness.

   Accepted

   In line with PSI 64/2011, HMP Full Sutton will appoint a FLO as per the mandatory action below:

   "Where prisoners have a terminal illness or suffer an unpredicted and/or rapid deterioration in their physical health, they must be encouraged to engage with their families or nominated person where it is appropriate to do so."

2. The Governor should ensure that, in line with Prison Service guidance, an appropriate contribution is made to the man's family to cover the reasonable costs of his funeral, up to £3,000, and that the prison abides by the guidance in future.

   Not accepted

   The prison contributed £2,350 to cover reasonable funeral costs in accordance with prison service guidelines.

3. The Governor should ensure that the risk assessment undertaken before a prisoner visits hospital for an invasive clinical investigation gives thorough consideration to the type of procedure and the individual circumstances of the prisoner, including their general health. Prisoners diagnosed with a terminal illness and assessed as low risk to escort and hospital staff and a low risk of escape should not routinely be restrained during such procedures.

   Accepted

   HMP Full Sutton will ensure that the risk assessment undertaken before a prisoner visits hospital for an invasive clinical investigation. We will ensure that the assessment gives thorough consideration to the type of procedure and the individual circumstances of the prisoner, including their general health.

   The man had a history of sexual offences dating back to the 70's. Although the risk he posed to escape was managed through cuffing and staffing arrangements. To mitigate the risk of removal of cuffs there would have needed to be an increase in staffing which would have proven prohibitive. When he attended his out patient appointment he was sufficiently fit to pose a risk to the public. However, as in other cases the replacement of cuffs with escort chains or total removal is always considered dependent on the well being of the individual.

To the Head of Healthcare

4. The Head of Healthcare should ensure that anticipatory prescriptions are used to enable quick access to appropriate analgesia and sedation for end of life symptom control.

   Not accepted

   The prescribing and treatment pathways for patients approaching their end of life are completed in consultation with the patient and the MDT with the professional guidance provided by the Community McMillan Nurse.

   We are happy to consider as part of MDT, but this has to be an assessment by the Independent Community Nurse, which reflects community practice.

5. The Head of Healthcare should liaise with the hospital to help ensure that prognosis letters for applications for early release on compassionate grounds are given appropriate priority.

   Accepted

   This will be raised at the Partnership Meeting with the request that the Acute Trust accept this recommendation and act upon it. However, we recognised that the HOHC has no direct authority to manage this recommendation and priority of clinical interventions and reports sits with Consultants within the Acute Trust.