

**Investigation into the circumstances surrounding the
death of a man in January 2011
at HMP Long Lartin.**

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

September 2011

This is the report of an investigation into the death of a man. He died at HMP Long Lartin in January 2011. He was 62 years old. The cause of his death was metastatic prostate cancer (cancer of the prostate that has spread to other parts of the body), which had been diagnosed around six months before he died. I offer my sincere sympathy and condolences to his friends and family and to all who have been affected by his loss.

The investigation was carried out by my colleague. A review of the man's clinical care in prison was carried out by a clinical reviewer on behalf of the local Primary Care Trust. I am grateful to him for his assistance.

I would also like to thank the Governors and staff of HMPs Long Lartin and Wakefield for their co-operation during the course of the investigation.

This report reflects well on staff at Long Lartin for the care they provided the man following his move to the prison in December 2010. Prior to this move, he lived at HMP Wakefield, where he had been diagnosed with cancer the previous summer. I have highlighted some areas of practice which might be improved at Wakefield and make a total of six recommendations for the prison to address. Most significantly, there was a delay of several weeks before he was told of his diagnosis.

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.

Thea Walton
Acting Deputy Ombudsman

September 2011

CONTENTS

Summary

The investigation process

HMP Long Lartin

HMP Wakefield

Issues

Conclusion

Recommendations

SUMMARY

1. The man was sentenced to 12 years imprisonment in December 2005, and moved to HMP Wakefield three months later. At Wakefield, he experienced occasional chest pain and took medication for high cholesterol and high blood pressure. In late March 2010, he reported pain in his rectum to a prison doctor. A blood test taken around three weeks later found a high prostate specific antigen (PSA, an indicator of prostate disease). The prison doctor subsequently made an urgent referral to the local hospital for further investigation. The clinical reviewer comments that he would have made this referral under the 'two week rule' for suspected cancer (whereby persons with suspected cancer are seen by a specialist within two weeks of referral).
2. A hospital appointment was arranged for 17 May, at which a biopsy (a medical test involving the removal of tissue for examination) of the man's prostate was taken. The results were not made available to prison healthcare for some time. On 15 July, a letter from the hospital was received at Wakefield confirming that he had prostate cancer. Although the letter was scanned into the electronic medical record on the same day and was therefore available to all clinicians, the news of his diagnosis was not broken to him until his next hospital appointment on 11 August. The clinical reviewer describes this delay as "unacceptable".
3. At his appointment on 11 August, he was told that he might live for two to three years. He began a treatment plan involving medication and injections to block the production of testosterone, a hormone which increases the growth of prostate cancer. At Wakefield he was placed on the Gold Standards Palliative Care Framework, a means of optimising the care for patients nearing the end of life.
4. Following his diagnosis, he strongly requested that he either be released early on compassionate grounds or transferred to a prison closer to his home area. Early release was considered at Wakefield, but he did not meet a number of the criteria that must be satisfied. It was agreed, however, that he could move to HMP Long Lartin, the nearest high security prison to his home area. He subsequently moved on 15 December, arriving the following day having stayed overnight in HMP Birmingham.
5. On arrival at Long Lartin, he moved into a cell on the inpatient unit. At Long Lartin, his care was planned using the Liverpool Care Pathway. The care plans developed were comprehensive and applied meticulously at Long Lartin. I share the clinical reviewer's view that the care he received at this establishment was excellent. Consideration was given to admitting him to a local hospice, and it was agreed that he could go when medical staff deemed it appropriate. However, he deteriorated quickly and died on 25 January before a move to a hospice could be facilitated.
6. It is concerning that he was not told of his diagnosis for some weeks after Wakefield were made aware. I recommend that the healthcare manager ensure that news of a significant diagnosis is, in future, broken at the earliest opportunity by an appropriate member of staff. I make a further five recommendations to

Wakefield. These include ensuring that referrals for suspected cancer are made appropriately. Significantly, the clinical reviewer concludes that the cancer was highly aggressive and any delays that occurred are unlikely to have affected his prognosis.

THE INVESTIGATION PROCESS

7. The investigation was opened on 27 January 2011, when the investigator issued notices announcing the investigation to staff and prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known to the investigator. No one came forward at Long Lartin. One prisoner at Wakefield wrote to the investigator.
8. The investigator visited Long Lartin on 31 January. During the visit he met the deputy governor and the inpatient manager. He also visited the inpatient unit and the cell in which the man had lived. The investigator was provided with copies of the prison records, including the medical record.
9. On 16 May and 31 May, the investigator visited Wakefield, where the man lived before his move to Long Lartin. During the course of these visits he interviewed four members of staff.
10. A review of the man's clinical care in custody was undertaken by a clinical reviewer, on behalf of the local Primary Care Trust. I am grateful to him for his assistance in this matter.
11. One of the Ombudsman's family liaison officers wrote to the man's friend, his nominated next of kin, and his daughter on 17 February. She explained the purpose of the investigation and provided the opportunity for them to ask questions or raise any concerns they might have. No reply was received. I hope this report clarifies any issues that may remain unclear for his family and friends and helps them better understand what happened in the time leading to his death.
12. My investigation assesses the following aspects of the man's care and treatment:
 - Whether his diagnosis was made in a timely fashion
 - Whether he was told about his condition and the treatment which followed
 - Whether he was treated properly and attended hospital appointments as necessary
 - Whether the liaison with his family was appropriate
 - Whether he was accommodated in the most appropriate part of the prison
 - Whether consideration was given to compassionate release from prison
 - Whether appropriate palliative care was provided

HMP LONG LARTIN

13. HMP Long Lartin is a high security establishment, one of eight high security prisons in England and Wales. It accommodates prisoners with a sentence of over four years including those serving a life sentence. It also accommodates high security remand prisoners. The prison has recently increased its maximum capacity from 454 prisoners to 622.
14. All prisons in England and Wales have an Independent Monitoring Board (IMB), which is staffed by volunteers from the local community. They ensure that standards of decency and care are maintained. The IMB has access to every area of the prison, including attending meetings, adjudications and segregation reviews. Members also answer prisoners' queries and investigate complaints. The IMB also publishes an annual report. Their latest report, for 2009-10, comments that the healthcare department delivered a "high standard of treatment and care" to prisoners during the reporting year.
15. An announced inspection of Long Lartin was held in July 2008 by the then Chief Inspector of Prisons. Her report following the inspection praised Long Lartin for successfully managing the increase in the population.
16. The report described the primary healthcare services as good with a broad range of nurse led clinics and visiting consultants. The recent increase in the population had not been matched with an increase in healthcare staff although a nurse had been appointed as an elderly care specialist. The inspection team noted that there were no delays in prisoner access to secondary health services.
17. Two prisoners died at Long Lartin in 2010, one of which was due to natural causes. The investigation into this death found that the man received a very high standard of healthcare. The report recommended that compassionate release be considered when a prisoner is terminally ill. I am pleased to note in this instance that staff at Long Lartin carefully considered whether compassionate release was appropriate for the man and clearly recorded their conclusions.

HMP WAKEFIELD

18. HMP Wakefield is a high security prison for men and has a centre for life sentenced prisoners. The prison can accommodate approximately 700 prisoners, including a maximum of 100 category A prisoners (prisoners who would be highly dangerous to the public, police or national security if they were to escape) and ten high risk category A prisoners.
19. There are four accommodation wings, A, B, C and D, all built on four levels. All cells are single occupancy, each wing has shower and cooking facilities for the prisoners and there are snooker and pool tables for recreation. D wing has 183 cells over the four levels. Each landing has three officers during the day and each wing has one officer during the night time.
20. Healthcare services are commissioned by the local Primary Care Trust. There is a new primary care centre in the main residential block, consisting of the prison doctor's consulting room and a treatment hatch (where prisoners' collect their medication). The main healthcare centre has a 19 bed inpatient unit.
21. The prison's Independent Monitoring Board's report for 2009-2010 notes that "the Health Care Unit provides a comprehensive service that meets the needs of the prison population".
22. HM Chief Inspector of Prisons carried out an announced inspection of Wakefield in 2008. The then Chief Inspector commented that prisoners had to wait too long to see the prison doctor. She also observed that too many outside hospital appointments were cancelled with little monitoring of the reasons.
23. Ten Wakefield prisoners have died in custody since January 2010, eight of which were due to natural causes. Those investigations in which I have issued a report carry no significant similarities to the death of the man.

ISSUES

The diagnosis of the man's terminal illness

24. On 29 March 2010, the man had an appointment with Prison Doctor A, at which he complained of experiencing rectal pain. This was the first time that he had reported such symptoms. In previous years he had reported chest pain, and subsequently took medication for high cholesterol and high blood pressure.
25. The doctor explained that he examined the man's rectum during the consultation on 29 March, and found nothing abnormal. He prescribed him a course of suppositories (medication that is inserted into the rectum, often to resolve problems local to that area) for the pain, and asked that he return in a month if the pain had not improved. A blood test was taken, with the results considered by Prison Doctor B, on 21 April. The results showed a high prostate specific antigen (PSA, an indicator of prostate disease). He was asked to return to see Prison Doctor A, and an appointment was made for 27 April.
26. When he saw the doctor on 27 April, he said that his pain was better since he began using the suppositories. On the same day, the doctor wrote a referral letter to the hospital on account of his previous pain and the high PSA. The doctor did not make the referral under the 'two week rule' for suspected cancer (whereby persons with suspected cancer are seen by a specialist within two weeks of referral) but asked that he be seen "urgently, to rule out any serious pathology in his prostate".
27. The clinical reviewer comments and recommends as follows:

"Despite suspicion of cancer and a raised PSA the initial referral was not on the two week rule. In my locality, our proforma states that raised PSA would necessitate a two week referral."

The healthcare manager at HMP Wakefield should ensure that the appropriate proformas are used when a referral for suspected cancer is made.

28. As a result of the referral, the man saw a consultant at hospital on 17 May 2010, where he had a biopsy of his prostate. A follow up letter, dated 19 May, told the healthcare department at Wakefield that he would be reviewed when the biopsy result was available.
29. Over the following month, his pain continued and doctors at the prison prescribed him a series of increasingly strong pain killers, finishing up with dihydrocodeine (opiate based pain relief). On 21 June, the hospital contacted Wakefield and asked them to repeat some blood tests for him, as a matter of urgency, and to follow that up with an urgent request from the prison doctors for him to have an MRI scan. (Magnetic Resonance Imaging uses powerful magnetic fields to provide an image of what is going on inside a person's body.) A blood test was initially booked for the following day, but he did not attend the healthcare department. He eventually had his blood tests on 25 June, although

it is not clear from the records what the results were. There is no indication that an MRI scan took place.

30. He continued to experience pain over the following days. A note in his medical record indicated that the results of the biopsy were still not available. After complaining of pain in the lower back, rectal area and abdomen on 14 July, he had an ECG (electrocardiograph, an electrical tracing of the heart). Doctors at the prison and the hospital considered that there was nothing abnormal in the results. (His ECG was sent via a telemedicine link to the hospital for doctors there to review the reading).
31. A letter from the hospital written on 15 July was received at Wakefield on the same day. The letter indicated that the man's case had been discussed in a meeting at the hospital the previous day. His diagnosis was confirmed as prostate cancer which had spread to the bone. The letter was scanned onto his medical record the same day and a brief entry noting "metastasis to bone" was made by a clerical worker in his ongoing electronic medical record.

Informing the man about his condition and treatment

32. The man saw Prison Doctor A on 20 July, for a review, as he was experiencing nausea and some abdominal pain. Despite the information received five days earlier, the doctor noted in the medical record that the results of the biopsy were still not available. At interview, he told the investigator that he checked for the results that day but was unable to find them. In relation to his new symptoms, the doctor diagnosed a urinary tract infection and prescribed a course of antibiotics.
33. Over the following two weeks, the man saw prison doctors and nurses on a number of occasions. At no point was his cancer diagnosis raised or discussed. An appointment was made for him at hospital on 4 August, but he was unable to attend on account of a problem with the taxi booked. He was still not told of his diagnosis by anyone at the prison.
34. A revised appointment was made for 11 August, which he was able to attend. The consultant told him about his diagnosis and what treatment options were available. He was told that his cancer could not be cured but, with treatment, he might live for two to three years. On his return to Wakefield, he was noted to have taken the news "quite well".
35. There appear to have been significant failings in communication between prison healthcare and the hospital, and subsequently with the man. The clinical reviewer describes it as "unacceptable" that the man was not told of his diagnosis until 11 August, despite initial investigations taking place in May. There are two reasons for this failure. Firstly, that the results of his biopsy of 17 May were never formally communicated to the prison and the appointment for review of these results was not chased by healthcare staff. Secondly, and more significantly, at no point did any member of healthcare staff discuss with him the contents of the letter of 15 July, which specified that he had advanced cancer. I would expect a prison doctor to have told him about his condition.

The healthcare manager at HMP Wakefield should ensure that the results of clinical investigations in cases of suspected cancer are urgently followed up should they not be received within a reasonable time frame.

The healthcare manager at HMP Wakefield should review the procedure for reviewing letters and results of clinical investigations that arrive at the prison. He should ensure that the news of any new diagnosis, especially for a terminal condition, is broken to the prisoner by a suitable member of staff at the earliest opportunity.

36. I note the clinical reviewer's comment that the man's cancer was highly aggressive and that any delays are unlikely to have affected his prognosis.

The man's medical appointments and treatment

37. The man had a scheduled appointment at hospital on 4 August 2010. However, he was unable to attend on account of a problem with the transport arranged. The healthcare manager told the investigator that a taxi was not initially available and when it arrived he had missed his appointment slot. As I have noted above, this meant that a further week went by before he was told of his diagnosis and treatment options. As I have previously noted, staff at Wakefield ought to have been more aware of the seriousness of his condition. They would therefore have better understood the importance of attending this appointment.

The Governor of HMP Wakefield should review arrangements for transporting prisoners to outside hospital appointments and ensure that those who have been diagnosed with a serious condition are given the appropriate priority.

38. At his appointment with the consultant urologist on 11 August, the man's treatment plan was set out to him. He was prescribed a course of Casodex (a medication known as an 'anti-androgen' which is used to block testosterone, a hormone that increases the growth of prostate cancer). The consultant asked him to return for an MRI scan and for an injection of the drug Prostag (medication used to stop the pituitary gland releasing the hormone that is used to produce testosterone). The purpose of these medicines was to slow the progress of the cancer and therefore allow him to live for longer.
39. He subsequently returned to hospital on 6 September for his scheduled MRI scan. This showed "widespread bony metastases in the spine and significant liver metastases" (meaning that the cancer had spread to his spine and liver). It was noted that this meant that he had a poor prognosis. On 15 September, he visited hospital again for his first Prostag injection. The next injection was due in 12 weeks and the prison was asked to facilitate this. The consultant asked that he return in six months time for a review.
40. On 14 October, it is recorded in his medical notes that he was now on the Gold Standards Framework (a model of care for looking after terminally ill cancer patients). He continued to be seen on a regular basis for medication reviews

and adjustments, particularly if he experienced vomiting or pain. He also started to use a wheelchair to relieve some of the pain that he was feeling in his lower back.

41. He was visited by the urology nurse specialist on 7 December. The nurse reviewed the treatment he had been receiving and also gave him his second Prostag injection.

The man's pain relief and medication

42. When he first reported rectal pain on 29 March 2010, he was given suppositories to use as pain relief. At his review with Prison Doctor A on 27 April, he said that his pain was better with this medication. On 25 May, he was prescribed diclofenac tablets by the doctor, to use for pain relief instead of the suppositories. However, this medication had little effect on his pain and he was subsequently prescribed dihydrocodeine on 8 June. A month later, he was given a course of paracetamol to take as he required it in addition to the dihydrocodeine. Over the course of the following month he complained of pain in his lower back and rectum.
43. The clinical reviewer comments on the man's pain control as follows:

“Following his initial presentation, he had numerous recorded consultations for pain. He was assessed regularly and treated with various analgesics [pain relief] with variable effect. Unfortunately it appears that he was in considerable pain for several weeks before being aware of his diagnosis. His initial treatments would seem to be reactive and in the absence of a diagnosis this could be seen as appropriate ... He appeared to be in unnecessary pain during the delay in communicating his diagnosis.”
44. He continued to complain of pain in his back in August. However, in September he did not take his dihydrocodeine on several days and told healthcare staff that he did not think he needed it. In October, he was placed on the Gold Standards Palliative Care Framework.
45. On 22 October, Nurse A was called to see him in his cell. He said he was unable to get out of bed on account of his pain. An appointment was made for him to see Prison Doctor B, although this did not take place for five days. The doctor increased his dihydrocodeine prescription to the maximum dose. He noted that he now used a wheelchair to cover long distances in the prison on account of the pain that walking caused. At a review on 2 November, he told the doctor that his pain had now reduced significantly.
46. Two weeks later, he began to experience further pain. At a review with Prison Doctor B on 15 November, he was prescribed fentanyl patches to use alongside dihydrocodeine. (Fentanyl patches are used to relieve severe pain and are worn for three days at a time for continuous pain relief.) He was also prescribed oromorph (a morphine based painkiller used to treat severe pain) to take as required. In line with Wakefield's policy, he could not keep oromorph in his cell (as he was able to for his other medications) on account of its potential for

misuse. He therefore had to ask for it to be administered when he felt he needed a dose. An entry in his notes on 23 November indicates that he was, at the time, unaware that he could ask for oromorph. The following day, the doctor doubled the strength of his fentanyl patches as he said he was finding it difficult to move on account of the pain.

47. At a review on 9 December, he said that the pain in his back tended to fluctuate. He told Nurse B that he did not always take his prescribed medication as he did not think it helped him sufficiently. He was advised to take his medication regularly, as prescribed, in order to obtain the full benefit.
48. The clinical reviewer comments and recommends as follows:

“There was improvement in [the man’s] pain assessment and management after his diagnosis and reference to the Gold Standards Framework, although he did appear to remain in pain with sub-optimal control.”

The healthcare manager at HMP Wakefield should consider providing training for staff in palliative care pain management.

49. Following his move to Long Lartin on 15 December, his pain levels were reviewed regularly. He experienced some breakthrough pain, and was given oromorph or paracetamol to counter this as he required. The clinical reviewer concludes that the care he received following his move was “excellent”.

Palliative care plans

50. In October 2010, the man was placed on the Gold Standard Palliative Care Framework. This is a means of optimising the care for patients nearing the end of life, and is aimed specifically at generalist medical staff. Prison Doctor B told the investigator that his care was reviewed at monthly meetings of the Gold Standard team (including himself, another doctor and visiting nurses). However, there is little indication in the man’s notes of the findings or outcome of these meetings.
51. Following his arrival at Long Lartin, his care was formally planned using the Liverpool Care Pathway. This is used to plan the care of a terminally ill person so as to achieve the best quality of care. There is ample evidence within his medical notes to show that staff at Long Lartin adhered to the care plan developed for him. The electronic medical notes show that nurses and healthcare assistants used the care plan to guide them in their assistance with his daily activities, including washing and dressing him as required.
52. The pathway is a robust guide that includes all aspects of care that might be required for someone who is terminally ill. One of the important features of the plan is monitoring someone’s pain, and again there is good evidence to show that almost at every encounter healthcare staff had with him, they asked if he needed any additional pain relief.

53. He was referred to a hospice for their advice. A Macmillan nurse (a specialist in cancer and palliative care) from the hospice subsequently visited him on 12 January 2011 to assess him. They discussed the criteria for hospice admission and the nurse reiterated that his treatment would be palliative only. It was noted that he had unrealistic expectations about his future. A second visit was planned for 26 January.
54. Another of the key aspects of Liverpool Care Pathway is the issue of resuscitation at the end of someone's life. It is clear that this issue was something that exercised staff at Long Lartin in the final few weeks of his life. He told Nurse C on 18 January that he wished to be resuscitated in the event that this was needed.
55. The position regarding his wishes to be revived if he were to collapse was further discussed on 19 January with the Macmillan nurse from the hospice. She told staff at the prison that any doctor could override his wishes "if it is not considered to be in the patient's best interests". Prison Doctor C advised that at this stage he should still be resuscitated if necessary.
56. When the man's friend, his nominated next of kin, visited on 20 January, further discussion took place. Prison Doctor D noted the view of healthcare staff and the friend that the decision he had taken was not now in his best interests. However he also noted his view that the man had the capacity to make such a decision and, at this point, they did not feel that they could override his decision.
57. A further meeting took place on 25 January between prison doctors and nursing staff. On account of a deterioration in his condition, they now took the view that "to attempt resuscitation would be futile and would not have a positive result".
58. At around 8.55pm that night, Officer A observed that he did not appear to be breathing. He was now on an 'open door policy', meaning that his cell was not locked overnight and that healthcare staff could have access to his cell at any time of the day and night. The officer alerted two nurses. They checked for a pulse and for breathing but could detect no signs of life. As agreed, no attempt was made to resuscitate him.
59. The clinical reviewer comments as follows:

"The man's care after transfer to Long Lartin appeared to be excellent and in my opinion not only equitable but on occasion superior to community provision ... His care plans were robust and comprehensive with appropriate and excellent application. He was treated with dignity and respect and was fully involved with and informed of his care at all times."

The man's location

60. In the weeks after he learnt of his diagnosis, he became adamant that he should be transferred to HMP Exeter, or a nearby prison, so that his friends could visit him more easily. He had requested transfer to the south west on a number of occasions in previous years. These requests were refused (other than a brief

stay at Exeter on the accumulated visits scheme) as he was required to carry out courses to reduce his risk of re-offending that were available at Wakefield. As he had not participated in these courses, on account of denying his guilt, it was deemed that the risk he presented should be managed in a high security prison and that Wakefield was most suitable on account of the courses available at the establishment. (Exeter is a local prison, meaning that it mostly takes new prisoners from courts in the surrounding area. It does not run the courses that he was required to complete.)

61. Following his diagnosis, he wrote to his local MP in his home area to press his case for a transfer closer to home. A reply was sent in October 2010 on behalf of the Chief Executive Officer of the National Offender Management Service (NOMS). The Chief Executive replied that the Governor of Wakefield remained of the view that he should continue to live in a high security prison for the time being. However, as a result of his recent diagnosis, it was agreed that he could move to Long Lartin, the nearest high security establishment to the south west.
62. This move also required NHS hospitals in the Worcester area to accept him, and therefore took some time to arrange. Eventually it was agreed and arranged and he moved to Long Lartin, via HMP Birmingham overnight, on 15 December (arriving at Long Lartin on 16 December).
63. Prior to his move, Nurse D was asked to telephone Long Lartin to discuss his condition. She recalled that she spoke about his diagnosis, treatment and how he was coping with his terminal illness. She also faxed a copy of his medical notes. She recalled that it was not certain at this time that he would make the move, on account of the hospital local to Long Lartin not having yet accepted him. Once the move was confirmed, there is no evidence of any further discussion between the prisons. Staff at Long Lartin told the investigator that he was more unwell on his arrival than they had expected. They also expressed the view that he was not well enough to move in a cellular vehicle and would have benefited from completing his move in a non-emergency ambulance.
64. Prison Service Order (PSO) 3050 sets out guidance that should be followed when a prisoner with significant health issues is transferred between establishments. It notes that the sending establishment (in this case HMP Wakefield) should be “responsible for ensuring standards of continuity of care” and lists various information that should be provided. This includes a summary of practical health needs and an assessment of his future care needs. It also suggests that a multidisciplinary case conference may be appropriate. In this case, this might have included a prison doctor and nurse who made up the Gold Standards Palliative Care Team.

The healthcare manager at HMP Wakefield should ensure that appropriate information is provided to the receiving establishment ahead of the transfer of a prisoner with a terminal illness, in line with PSO 3050.

65. Following his arrival at Long Lartin, the man was allocated a cell in the healthcare inpatients unit. He was still keen to move to Exeter, and some discussion was held with that establishment with regards to a possible transfer.

The deputy governor considered various options for him in a memo of 18 January 2011. He noted that a response was still outstanding from Exeter with regards to whether they would be able to take him, but that he did not now consider such a move to be appropriate on account of a deterioration in his health.

66. Consideration was also given to whether he might move to a hospice. On 31 December 2010, he told Prison Doctor E, that he would like to move to a hospice in Devon, his home area. The doctor explained to him that his condition did not presently necessitate hospice admission, but that this would be monitored and discussed when appropriate. This was reiterated to him when the Macmillan nurse visited on 12 January 2011.
67. In his memo of 18 January, the deputy governor also gave consideration to a move to a hospice either in the man's home area or locally to Long Lartin. After seeking advice from the head of healthcare, he determined that he was not yet in need of hospice care. However, he noted that a move to a hospice local to the prison would be arranged as soon as it was recommended by the doctor. He subsequently deteriorated very quickly and died before such a move could be arranged.

Compassionate release

68. Shortly after he was told of his diagnosis, he asked that he be released from prison early on compassionate grounds. This is a permanent release on licence, usually on medical grounds, and any decision to grant early release can only be made by the Minister responsible. The criteria for early release are set out in Prison Service Order (PSO) 6000:
- the prisoner is suffering from a terminal illness and death is likely to occur soon; or the prisoner is bedridden or similarly incapacitated; and
 - the risk of re-offending is past; and
 - there are adequate arrangements for the prisoner's care and treatment outside prison; and
 - early release will bring some significant benefit to the prisoner or his/her family.
69. Paragraph 12.4.1 of PSO 6000 provides the following guidance to applicants:
- “Early release may be considered where a prisoner is suffering from a terminal illness and death is likely to occur soon. There are no set time limits, but three months may be considered to be an appropriate period. It is therefore essential to try to obtain a clear medical opinion on the likely life expectancy.”
70. The Head of Reducing Re-offending at Wakefield wrote to him on 14 September 2010 with regard to his request. He explained to him that they would not be

taking his request further at that stage as his prognosis, whilst poor, was not sufficiently short to meet the criteria of PSO 6000. I also note that he denied his offences and had not therefore completed any offending behaviour work to reduce his risk of re-offending. As such, I agree with decision made.

71. He continued to press for early release on compassionate grounds. He instructed his solicitor to write to Wakefield to state his case (a letter was subsequently sent on 12 November) and he personally wrote to Inside Time, a national newspaper for prisoners. His letter was published in the December edition of Inside Time.
72. An undated reply was sent to his solicitor, explaining that his prognosis did not meet the criteria for early release at this stage. It was also noted that there remained significant concerns about his risk of re-offending. The conclusion was that he did not presently qualify for early release, but that a submission would be considered should he deteriorate to the extent that the criteria applied.
73. As I have previously discussed, he moved to Long Lartin on 16 December. During his time at Long Lartin, the possibility of releasing him early on compassionate grounds was thoroughly and comprehensively considered. Reports were prepared by the security department, offender management unit and his external offender manager to consider the risk that he would pose were he to be released from custody. Various options were considered alongside compassionate release, including a move to a hospice. In a memo written on 18 January 2011, the deputy governor concluded that, whilst he was very ill, the risk he posed was still too great to make early release a viable option.
74. By this stage, his prognosis had deteriorated significantly. Although I have seen no formal report, indications are that he was now expected to live for only a few weeks. Nevertheless, I accept the deputy governor's conclusions and note that he consulted various sources before reaching his decision. However, in future it might also be worth contacting the Public Protection Casework Section (PPCS, the unit within NOMS that manage such applications) to seek their view on whether an application should go ahead.

Restraints, security and bed watch

75. The Prison Service has a duty to protect the public and hence restraints and escort staff are routinely used when prisoners are taken out of the prison for any reason. An individual risk assessment is completed on each occasion and regular management checks are made. The assessment will consider the offences and the risk of further offending, as well as the prisoner's health and mobility.
76. Restraints were used when the man attended outpatient appointments at hospital. These appointments lasted around two hours from leaving the prison to returning. He was a category B prisoner (a category B prisoner is one for whom the highest security conditions are not necessary but for whom escape must be made very difficult) who had been convicted of serious offences. He denied his offences and had not therefore completed any offending behaviour

work to reduce his risk of re-offending. I acknowledge that he was in pain when his symptoms were being investigated, which affected his mobility, and that, later, he was diagnosed with a terminal illness with a poor prognosis. However, on balance, I am satisfied that the use of restraints was appropriate in the short periods of time that he spent at the hospital.

Liaison with the man's family

77. The man had not had any contact with his family since he was sent to prison in 2005. He was keen on remaining in contact with friends, however, and moved to HMP Exeter for a month in February 2009 on the accumulated visits scheme.
78. Following his cancer diagnosis, he was clear that he did not want his family to be told. He asked that a friend be appointed next of kin. Following his move to Long Lartin on 16 December 2010, his friend was able to visit him at the prison. During a visit on 20 January 2011, staff at Long Lartin consulted his friend over whether he should be resuscitated towards the end of his life. His friend was also contacted by telephone by staff at Long Lartin during his illness.
79. The news of his death was broken to his friend over the telephone by a family liaison officer at Long Lartin. His friend had indicated beforehand that he was content to be contacted in this manner. Long Lartin contributed funeral expenses and prison staff assisted with the funeral arrangements.

CONCLUSION

80. The man was diagnosed with prostate cancer in July 2010, whilst living at Wakefield. He was initially given two to three years to live, but died around six months later. There were some delays in obtaining his test results and revealing his diagnosis. However, I note the clinical reviewer's comments that his cancer was highly aggressive and that any delays are unlikely to have affected his prognosis.
81. Throughout his time at Wakefield, he had campaigned to move to a prison in the south west, his home area. He became more determined when his diagnosis was confirmed, and it was agreed that he could move to Long Lartin, the closest high security prison to the south west. Following his move, he received excellent care at Long Lartin and this report reflects well on staff at the establishment.

RECOMMENDATIONS

1. The healthcare manager at HMP Wakefield should ensure that the appropriate proformas are used when a referral for suspected cancer is made.

Accepted - Enquiries will be made with the local acute trust in order to establish a correct system and to obtain the current local policy. Once the correct proforma is obtained this will then be saved on SystmOne for GP / clinician use and appropriate training will be given to ensure that the form is completed whenever there is a reason to suspect cancer.

2. The healthcare manager at HMP Wakefield should ensure that the results of clinical investigations in cases of suspected cancer are urgently followed up should they not be received within a reasonable time frame.

Accepted - The recording and reading of pathology results has greatly improved since 2010 this is partly due to the SystmOne trainer that attends the prison regularly. At the time of treating this prisoner pathology links were not available on SystmOne. In light of the recommendation it has been agreed that a small audit will be undertaken to ensure that this is being completed correctly.

3. The healthcare manager at HMP Wakefield should review the procedure for reviewing letters and results of clinical investigations that arrive at the prison. He should ensure that the news of any new diagnosis, especially for a terminal condition, is broken to the prisoner by a suitable member of staff at the earliest opportunity.

Accepted - A system is now in place which ensures that all hospital letters are looked at within one week of being received from the local acute trust. One GP session is allocated per week to review letters and relevant investigations. If on review of any letters cancer or any other diagnosis is received then the GP would book the prisoner into the next available session to ensure that they were told as soon as possible.

4. The Governor of HMP Wakefield should review arrangements for transporting prisoners to outside hospital appointments and ensure that those who have been diagnosed with a serious condition are given the appropriate priority.

Accepted - An Escorts and Bedwatches Officer prioritises all escorts to outside hospital giving priority to those with serious health conditions. Procedures have been reviewed for transporting prisoners to outside hospital and if there are any operational pressures then prisoners who have a serious medical condition would be given priority to attend.

5. The healthcare manager at HMP Wakefield should consider providing training for staff in palliative care pain management.

Accepted - A dedicated palliative care team now exists, including a GP, hospital consultant, prison nurse and community palliative care team. Gold Standards Framework procedures on SystmOne have been reviewed to ensure that an

equitable service is being offered to those prisoners with cancer. Monthly meetings also take place in the Primary Care Centre for all those staff involved in treating palliative care patients.

6. The healthcare manager at HMP Wakefield should ensure that appropriate information is provided to the receiving establishment ahead of the transfer of a prisoner with a terminal illness, in line with PSO 3050.

Accepted - In this case all healthcare information was sent to the receiving establishment prior to transfer however measures have been put into place to facilitate case conferences with a relevant member of the palliative care team.