

Investigation into the circumstances surrounding the death of a man in March 2011 at outside hospital, following his release on temporary licence from HMP High Down

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

August 2011

This is the report of an investigation into the death of a man who died at outside hospital in March 2011, following his release on temporary licence from HMP High Down. He was 42 years old. He had been diagnosed with a brain tumour in 2004 which, whilst stable for many years, was found to have developed further around six months before he died. I offer my sincere sympathy and condolences to the man's family, and to all who have been affected by his loss.

The investigation was carried out by one of my colleagues. A review of the man's clinical care in prison was conducted by a clinical reviewer on behalf of Surrey Primary Care Trust. I am grateful to her for her assistance. I would also like to thank the Governor and staff of HMP High Down for their co-operation during the course of the investigation.

The man was diagnosed with an aggressive form of cancer and lived longer than might normally be expected for patients with such a tumour. I make three recommendations in this report. Two relate to contact with outside hospitals and a third considers the earlier appointment of a family liaison officer.

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

August 2011

CONTENTS

Summary

The investigation process

HMP High Down

Issues

Conclusion

Recommendations

SUMMARY

1. The man was remanded into custody in April 2001 and was later sentenced to 14 years imprisonment. He had spent much of his adult life in prison and, during a previous spell in custody, had been diagnosed with epilepsy. In June 2004, the man was referred for an x-ray after suffering a number of fits. This and a follow up scan showed that he had an aggressive form of brain tumour. Later that month, part of the tumour was removed by surgery. He had radiotherapy over the following six weeks to treat the part of the tumour that could not be surgically removed.
2. Following his surgery, the man was told that his life expectancy was likely to be months rather than years. However, the tumour did not develop as might have been expected and follow up scans over the next five years showed that it remained stable. In May 2009, a scan found that the man's tumour had grown. As previously, part of the tumour was surgically removed.
3. On 30 September 2010, the man went to hospital for his regular scan. An appointment was made for him to attend a follow up clinic on 7 October. However, he missed the appointment. HMP Coldingley, where the man lived at the time, did not have a record of receiving this appointment. He subsequently attended a revised appointment on 11 November, where he was told that his tumour had again grown.
4. Around this time, the man's memory and reasoning began to decline. It was agreed for him to move to HMP High Down on 19 November, where he could receive 24 hour nursing care that was not available at Coldingley. His cognitive function (meaning his ability to think, reason and remember) continued to decline and, at a clinic with a cancer specialist at outside hospital on 4 January 2011, it was determined that curative treatment was no longer recommended. Instead, the man was referred to the local Macmillan service and a local hospice for supportive care only.
5. On 27 January, the man was admitted to outside hospital, having been found collapsed on the floor of his cell. He was temporarily released from custody on 1 February on account of his ill health. He moved to a hospice on 25 February, where he died the following month.
6. The investigation finds that the man was diagnosed in a timely manner and treated appropriately during his time in custody. I make two recommendations to prison healthcare staff, both with regards to contact with outside hospitals. The first relates to the follow up appointment missed by the man in October 2010. The second recommendation follows comments from his consultant at outside hospital that he might have been referred to their care earlier and that this delay might have had a detrimental effect. I make a third recommendation regarding the earlier appointment of a family liaison officer for prisoners diagnosed with a terminal illness.

THE INVESTIGATION PROCESS

7. The investigation was opened on 7 March 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 as a result.
8. The investigator visited High Down on 11 March. During the visit he met the Governor, the inpatient manager and the prison's family liaison officer. He also visited the inpatient unit and the cell in which the man had lived. The investigator was provided with copies of the man's prison records, including the medical record.
9. On 18 April, the investigator returned to High Down. During the course of the visit he interviewed two members of staff. At the conclusion of the visit, the investigator met the Governor to feed back the initial findings of the investigation. This was subsequently followed up in writing.
10. A review of the man's clinical care in custody was undertaken by the clinical lead at the Macmillan Specialist Palliative Care Service. I am grateful to her for her assistance in this matter.
11. After some difficulty contacting the man's family by telephone, one of the Ombudsman's family liaison officers wrote to the man's brother, as his listed next of kin, to explain the purpose of the investigation and provide an opportunity for the man's family to ask questions or raise any concerns they might have about the care he received in prison. No issues were raised at the outset of my investigation. I hope this report clarifies any issues that remain unclear for the man's family 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?
13. The family liaison officer spoke with the man's brother about receiving the draft version of my report. He said he felt satisfied with the care his brother received and did not feel it necessary to know the detailed findings of the investigation. He further commented that he had been pleased with the help and support he

had received from the prison following his brother's death and there were no issues he wished to raise.

HMP HIGH DOWN

14. High Down opened in 1992 and is located in Sutton, Surrey. It is a local prison for adult males, meaning that it takes prisoners from Croydon and Guildford Crown Courts and surrounding Magistrates' Courts. At the time of the investigation, the capacity of the prison was 1,103.
15. Healthcare services at the prison are commissioned by Surrey NHS and provided by Surrey Community Health. There is a 23 bed inpatient unit, plus a 12 bed "step down" unit (for prisoners requiring a less intensive level of care) which is located on one of the house blocks.
16. High Down was last inspected by Her Majesty's Chief Inspector of Prisons in May 2009. The then Chief Inspector concluded that health services were "good". She went on to say that High Down was performing reasonably well in all four of the Inspectorate's key areas: safety, respect, purposeful activity and resettlement.
17. The Independent Monitoring Board (IMB, a body of local people who independently monitor and report on the prison, ensuring standards of decency and care are maintained) annual report for 2009-10 reported that healthcare at High Down "maintained its high standards throughout the reporting period". They went on to report that prisoners received "at least an equivalent level of care to that which they would receive in the community".
18. The most recent death of a prisoner at High Down, in January 2010, involved a man who was diagnosed with widespread cancer and who also died in a hospice. The clinical lead at the Macmillan Specialist Palliative Care Service also carried out the clinical review alongside this investigation, and found that the care received by the man was comparable with that he might expect to have received in the community.

ISSUES

The diagnosis of the man's terminal illness

19. The man was diagnosed with epilepsy in 1997, during a previous period in prison. He was prescribed the medication carbamazepine, which is taken to control the fits suffered by people with epilepsy. In 2003, he began to suffer more regular fits. An entry in his medical record in April 2004 summarised that he suffered an average of six to ten fits every six months.
20. As a result of his regular fits, the man was referred for an x-ray on 2 June 2004. The results were assessed by a neurologist at outside hospital, who requested his urgent admission the following day. (At the time, the man was living at HMP Full Sutton, near York.) Following a further scan in hospital, he was diagnosed with the most common and aggressive form of brain tumour. During his week long stay in hospital, this was treated by debulking surgery (meaning that part of the tumour is surgically removed, but that this is not possible for the whole tumour).
21. The clinical reviewer notes the National Institute for Clinical Excellence (NICE) guidelines 'Improving Outcomes for People with Brain and other CNS tumours'. This guidance notes that brain tumours, particularly in people of this man's age range, are rare. However, their presentation "can be related to epilepsy".
22. The clinical reviewer notes, however, that this guidance was published in 2006, two years after the man's diagnosis. She concludes as follows:

"I feel that the referral for investigation was made appropriately, and even now very few referrals for these types of tumours are made under the two week rule."

The man's medical appointments and treatment of the prisoner

23. Following his surgery in June 2004, the man undertook a course of cranial radiotherapy over the following six weeks. (This is radiotherapy treatment for the head, to prevent or delay the spread of a brain tumour.) In July, he was told that his cancer could not be cured and that his life expectancy was months rather than years. The clinical reviewer comments that the man's tumour was one that is associated with a poor prognosis, with only 12.5 per cent of those diagnosed surviving for five years.
24. The man returned to hospital every six months for a Magnetic Resonance Imaging scan (MRI, a scan to produce a detailed image of the inside of the body). The purpose of the scan was to monitor the tumour to determine whether it was growing. In the first four years, the man's scans showed that his tumour was stable and the consultant's recommendations were to continue with regular monitoring. During this time, he moved to HMP Pentonville in August 2005, and then to HMP The Mount in September 2006.

25. On 18 May 2009, the man moved to HMP Coldingley. Two weeks later, he was taken to Accident and Emergency at outside hospital having been found collapsed in a toilet at the prison. A scan carried out at the hospital showed that his tumour had grown. In early July, he was admitted to outside hospital for five days. During this stay, he underwent further debulking surgery and had five Gliadel wafers inserted. (Gliadel wafers are small discs which slowly dissolve after they are placed on the brain. They contain a chemotherapy drug which is slowly released and treats tumour cells that could not be removed by surgery.)
26. The man was sent to Accident and Emergency again on 21 July, as nursing staff at Coldingley thought he might have had a stroke. This was on account of him appearing confused and incomprehensible. He discharged himself from hospital against medical advice. However, it was arranged for him to move to High Down from Coldingley so that he could live in their inpatient unit under observation. (Coldingley does not have inpatient facilities.) The man attended hospital in September for his regular scan, which showed that the tumour had not grown since his surgery.
27. In February 2010, the man was well enough to return to Coldingley. Over the summer, he was observed to have slightly slurred speech, although it was noted that this was normal for someone with this man's diagnosis. On 30 September, he went to outside hospital for his regular scan. The hospital made a clinic appointment for 7 October to discuss the results, but he did not attend. The consultant subsequently faxed a letter to Coldingley on 27 October in which she instructed that "it is very important that we see him in the light of recent scan findings." A second appointment was subsequently made for 11 November. The head of healthcare at Coldingley told the investigator that they had no record of the initial appointment.
28. Prior to this second appointment, the man appeared to become more confused and his mobility began to decline. Nursing staff became more concerned on 5 November and called an ambulance to take him to hospital. However, when the ambulance arrived, he refused to go. He also declined an emergency admission four days later, when the prison doctor became concerned about his increasing confusion and disorientation.
29. The man did agree to go to his scheduled clinic on 11 November. He was told that the MRI in late September showed that his tumour had grown and was now inoperable. The consultant recommended him for chemotherapy as an outpatient. On 19 November, he returned to High Down in order to live in their inpatient unit for 24 hour observation and nursing care.
30. Following his transfer, the man attended an appointment at a cancer centre on 20 December. The appointment was for a consultation to determine when his chemotherapy would start. It is not clear what the outcome of the appointment was, although a representative of the hospital telephoned healthcare at High Down to say that they were going to transfer the man's care to outside hospital on account of its proximity to the prison.

31. On 4 January 2011, the man had an appointment at outside hospital. The consultant oncologist (cancer specialist), noted that he had deteriorated further in recent weeks and now had slurred speech and “extremely poor short term memory”. The consultant oncologist now questioned whether the man would gain any benefit from chemotherapy and determined that it should no longer be recommended. He therefore referred him to the local Macmillan service for supportive care only.
32. As I have described above, the man had numerous follow up appointments following his initial diagnosis in 2004. With one exception, all of these appointments were kept and there is clear evidence of ongoing communication with the various hospitals to which the man was referred. The clinical reviewer concludes that all of the man’s treatments followed the recommendations in the NICE guidelines ‘Improving Outcomes for People with Brain and other CNS tumours’.
33. It is unfortunate that the one appointment that the man missed was that of 7 October 2010, to discuss the results of his MRI scan of one week earlier that showed his tumour had grown. He did not see the consultant until the appointment was rearranged for 11 November, over a month later. As I have noted above, the head of healthcare at Coldingley told the investigator that they had no record of this first appointment. She added that they were “very aware” of how ill the man was and would have made every effort to get him to the appointment had they known about it. The investigator subsequently wrote to the consultant at outside hospital to ask her to confirm that an appointment letter was sent and for her view on what impact the month long delay between appointments might have had on the eventual outcome for the man. No reply was received.
34. The investigator wrote to the consultant oncologist to ask his opinion on what impact any delay might have had on the man’s prognosis. He replied that the delay between October and November 2010, on account of the missed appointment, would have had no effect on the final outcome.
35. Nevertheless, there might be occasions in future where such an appointment could have a significant impact on the prospects of the patient.

The head of healthcare at HMP Coldingley should review with outside hospital their procedures for sending and receiving clinic appointments for prisoners.

36. In their response to the draft report, the National Offender Management Service (NOMS) commented as follows:

“The [outside hospital] is not a hospital which prisoners from Coldingley attend on a regular basis and was used only on this occasion to provide continuity of treatment. Therefore it is inappropriate for the head of healthcare to review procedures in general with the [outside hospital] as we are unlikely to have another episode of care there for some considerable time.”

37. I thank NOMS for this response and appreciate their argument. Nevertheless, this does not disguise the fact that the man missed what would have been a significant appointment. In future, should a Coldingley prisoner with a serious condition be receiving treatment at the outside hospital, the head of healthcare might wish to ask her administrative team to ensure that all appointments are received from the hospital.
38. In his letter, the consultant oncologist said he thought that there was a delay before he saw the man for review in January 2011. He considered that this delay was detrimental as it meant that, when he saw the man, chemotherapy was no longer an appropriate option.
39. On 6 December, around two and a half weeks after his move from Coldingley, a nurse at High Down contacted outside hospital to check whether an appointment had been made for him to start treatment. She was told that his care had been transferred to a cancer centre. The man subsequently attended an appointment at the cancer centre on 20 December, after which his care was transferred to outside hospital, on account of its proximity to High Down.
40. It is not clear why the man's care was transferred to the cancer centre from outside hospital when he now lived at High Down, which is very close to the outside hospital, a specialist cancer centre. One possible answer is that staff at the hospital were unaware that the man had moved to a different prison.

The heads of healthcare at HMP Coldingley and HMP High Down should ensure that an urgent referral is made to the appropriate hospital when a prisoner with cancer transfers between the two establishments.

Informing the man about his condition and treatment

41. Following his diagnosis in 2004, the man was told that his tumour could not be cured and that his prognosis was very poor. A prison nurse spoke at length with him on the day he was given this news. He was reportedly depressed and angry in the weeks after being told of his prognosis and there is evidence in his record that healthcare staff spent time with him to offer support. During the weeks that he was undertaking radiotherapy, his cell door was left open so he could associate with and be supported by staff and prisoners.
42. The growth of the man's tumour in autumn 2010 led to a deterioration in his cognitive function (meaning his ability to think, reason and remember). On two occasions in early November, he refused to go to hospital against the advice of prison doctors. On both occasions the man's capacity to make these decisions was considered by a prison doctor, and on both occasions they determined that he had capacity to understand his decision.
43. Shortly after his arrival at High Down on 19 November, the man saw a mental health nurse. The nurse noted that he displayed "clear evidence of cognitive impairment" which affected his short term memory. He advised that healthcare

staff should be mindful of this and that the man would need clear and concise guidance to assist him to process information.

44. Over the following weeks, the man's behaviour became challenging. He was found to have stolen from other prisoners' cells and became more aggressive towards staff. As a result, a decision was made to place him on a separate regime to other prisoners, meaning that he would only be unlocked at times when other prisoners were locked in their cells. The inpatient manager at High Down told the investigator that they considered the impact that the man's illness had on his behaviour:

"He was going into people's cells and I know this was an issue at Coldingley as well, so we felt for his own safety he would be better managed on separate association. The question was whether this was related to his illness or not because he had quite a long history of going into other people's cells before he became unwell, so it wasn't necessarily a change in behaviour ... although the illness probably didn't help in terms of him understanding the consequences. So it was felt by the team that he would be best managed on a separate unlock."

45. The inpatient manager also considered whether the man had understood his diagnosis and prognosis:

"I think in the beginning he did ... but towards the end it all got a bit muddled. It was reinforced to him on a regular basis because he could take information in, he just couldn't retain it."

46. At his consultation at outside hospital on 4 January 2011, the consultant oncologist raised concerns about the man's capacity to make an informed decision about his treatment. It was noted in his medical record that a mental capacity assessment would be carried out by staff at outside hospital. The inpatient manager told the investigator that staff at the hospital made the decision that the man did not have the capacity to make a decision and that it was in his best interests not to proceed with chemotherapy. A prison nurse accompanied him to an appointment with the consultant oncologist to discuss his future treatment plan on 10 January. This was a considerate step and would help the man to understand the consultant's intentions.
47. As a result of the consultant oncologist's decision, the man was referred to the local Macmillan service for palliative care. I will discuss the events following this referral in further detail later in this report.

The man's pain relief and medication

48. Following his diagnosis, the man was prescribed tramadol for pain relief. (Tramadol is used to treat moderate to severe pain.) It is not clear from his record when this was first prescribed, although he took the medication for several years. The man's prescription was to take one 50mg tablet three times a day. In March 2010, the prescription was increased to one 200mg tablet per day. At the same time, he was given paracetamol to take as he required it. Although it is not

explicitly recorded why he was given paracetamol, this medication is often taken by cancer patients for 'breakthrough' pain (meaning pain that comes on suddenly for short periods of time and is not alleviated by the patient's normal medication).

49. The man usually collected his medication on a daily basis to take as it was prescribed. In July 2010, a nurse practitioner (a registered nurse who has completed an advanced nursing education and can prescribe some medication) recommended that the man keep his medication 'in possession' (whereby a prisoner collects a week or several weeks supply of medication at a time to take as prescribed). This was trialled for around three weeks, and was not successful. He was therefore given his medication in a 'dosette box' (an individualised box containing medication organised into compartments by day and time). When he was admitted to High Down inpatients, the man was given his medication on a daily basis, as previously.
50. The clinical reviewer comments that the man's pain was "adequately controlled" and his medication regularly reviewed. She notes that his pain was regularly scored as low on the scale and he did not require controlled drugs (painkillers that are controlled by law based on their harm if misused).

The man's location

51. The man moved to High Down on 19 November 2010, in order to live in their healthcare inpatient unit. Coldingley does not have 24 hour healthcare and was therefore unable to offer the continuous level of nursing which he would need for the stage his terminal illness had reached.
52. In his first few days at High Down, the man was noted to have settled in well. However, within a week he was reported to have stolen property from other prisoners' cells. As a result, he was placed on a separate regime from the other prisoners on the unit. He was still able to talk to other prisoners through their cell doors. His relationship with staff varied. Whilst he often interacted well with staff, he was sometimes reported as being aggressive or ignoring instructions.
53. The clinical reviewer notes that the medical and nursing notes over the period that the man lived at High Down "demonstrate sensitive care planning adapted to his special needs".
54. As I have earlier noted, the consultant oncologist determined in January 2011 that the man would no longer benefit from chemotherapy. He was subsequently referred to the local Macmillan service and to a local hospice. He was visited by staff from the hospice on 18 January, with it being determined that admission to the hospice would be considered when he came to be within the last few days of his life.
55. At around 10.20pm on 27 January, the man was found to have collapsed on the floor and was very unwell. An ambulance was called and he was taken to outside hospital. He did not return to High Down. Once his condition stabilised, there was some discussion as to whether he would return to the prison or move to the local hospice. It was decided that he would be best served by moving to

the hospice. After waiting for a bed to become available for some days, he moved to the hospice on 25 February. I agree that this move was appropriate and that the man's needs were best met at the hospice.

Palliative care plans

56. The man was referred to the local Macmillan service and to the hospice in early January 2011, when the consultant determined that he was no longer suitable for chemotherapy. The clinical reviewer comments that this was the "appropriate time" to refer him to these specialist palliative care services. For the remainder of his time at High Down, he received palliative care only.
57. After initial discussion over the telephone, a specialist in palliative care at the hospice visited the man at High Down on 18 January. She reviewed him and concluded that there was "currently little intervention" required, although she made some recommendations for current or future changes to his medication. She also said that he would be considered for admission to the hospice "when he enters the terminal phase and is in the last few days/week of [his] life".
58. There was continuing contact with the hospice before the man's emergency hospital admission on 27 January. At a case conference on 26 January, arrangements for a hospice move were discussed and it was confirmed that he would be admitted in the last ten to 14 days of his life.
59. On 21 January, the inpatient manager raised the possibility of creating a 'Do Not Attempt to Resuscitate' agreement. This was in response to the NHS Surrey policy on resuscitation, which states that it is not reasonable to attempt to resuscitate a patient who is known to be in the terminal phase of an illness. Over the following week, she discussed this with the specialist in palliative care at the hospice and with the man's brother. The form was completed on 1 February and was signed by a prison doctor.
60. After waiting for a bed to become available, the man moved to the hospice from outside hospital on 25 February. He died at the hospice the following month.
61. The clinical reviewer comments as follows on the man's end of life pathway:

"The end of life care pathway for [the man] was similar to that for anyone with a similar condition living outside of a prison ... During the terminal phase of his illness he was provided with well planned nursing care which was sensitive to his needs. He was appropriately referred to specialist palliative care services and died in a hospice."

Compassionate release

62. A nurse accompanied the man to his appointment at the consultant oncologist's clinic on 10 January 2011. At the clinic, she spoke to the consultant oncologist about the possibility of the man being released 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.

63. 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.”

64. The consultant oncologist agreed to write a letter in support of the application for early release. He sent a letter to High Down on 11 January in which he explained the man's diagnosis and suggested that his prognosis was “very poor, likely to be a maximum of a few weeks to a small number of months”. The following day, the pathways and interventions manager at High Down was appointed to co-ordinate the application.
65. The inpatient manager at High Down spoke to the man's brother on 17 January. She asked whether his brother would be able to live with his family were the application for early release to be successful. The man's brother replied that, unfortunately, there was no one in the family who was in a position to take on this responsibility.
66. On 1 February, a member of staff completed the section of the application for the prison's offender manager. She noted that the man's most recent parole assessment report, completed in July 2010, assessed him as “presenting a high risk of general offending and a high risk of significant harm to the public”. (He was subsequently refused parole by the Parole Board on 30 November 2010.) The member of staff concluded that the man's risk of reoffending remained high “unless he is so unwell that he is incapacitated”.
67. On the same day, release on temporary licence (ROTL) was approved by the Governor of High Down. This is a temporary release from custody, and allows the prisoner to remain in hospital with a reduced security presence. It was approved on account of the deterioration in the man's health. On account of his high risk of reoffending and the recent incidents of theft and indiscipline at High Down, it was determined that one prison officer should remain with him in hospital. He remained on ROTL for the rest of his life. When he moved to the

hospice on 25 February, the accompanying officer was asked to wear civilian clothes.

68. The Governor of High Down completed his section of the application for full early release on 10 February. In the light of the Parole Board's recent judgement and the accompanying reports, he concluded as follows:

"I believe public confidence would be undermined by [the man's] early release, even allowing for his very poor state of health. Arrangements can be made for him to end his life in a dignified way without bringing his sentence to a premature close."

69. Nonetheless, the Governor of High Down asked that the application continue. It was submitted to the Public Protection Casework Section (PPCS) of National Offender Management Services by the pathways and interventions manager at High Down. However, as the man's health had deteriorated since the consultant oncologist's report was completed on 11 January, a revised medical report was required to support the application. On 15 February, the pathways and interventions manager asked the inpatient manager at High Down to contact outside hospital and ask for the relevant update.
70. Over the following two weeks, the inpatient manager and her colleague contacted the hospital regularly to pursue this update. The relevant form was faxed to High Down from outside hospital on 3 March. The consultant gave a prognosis of a "few weeks". The pathways and interventions manager was on leave at the time and the update was not therefore forwarded to PPCS before the man died in March.
71. Given the comments of the Governor and offender manager, it is questionable whether the man's application for early release on compassionate grounds would have succeeded. However, there was a delay of over two weeks in obtaining and submitting the second medical report. The first medical report was requested from outside hospital and was available the day after the request was made. By the time that the update was required, the man was under the care of a further outside hospital. On this occasion, the form was not sent to High Down until two weeks after it was requested. The inpatient manager told the investigator that the hospital might not have realised the importance of the information and the consequences of it not being received in good time. Although I make no recommendation, in future it might be advisable to set out in writing to the hospital the reasons why the form is needed and to give a timescale in which it would be helpful to receive it. It would also be helpful to assign a deputy to the co-ordinator's role so that updates can be sent to PPCS as soon as they are available.

Restraints, security and bedwatch

72. 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.

73. The man was taken to hospital in an emergency admission late on 27 January 2011. A risk assessment completed the following day confirmed that he would be accompanied by two officers and handcuffed to one of these by an escort chain (a chain of 1.8 metre length with a handcuff at each end). The escort chain was removed on 29 January at the approval of the duty governor, as the man had lost consciousness and was very unwell. It was not reapplied when he regained consciousness. Given the man's diagnosis, prognosis and general ill health I consider this to be the right and respectful course of action. I believe this is practice worth highlighting as it underlines the importance of assessing risk based on present circumstances rather than concentrating on the individual's offending history and conduct in prison.
74. As I have previously noted, the escort was reduced to one officer on 1 February when release on temporary licence was approved.

Liaison with the man's family

75. In July 2004, a member of healthcare staff at Full Sutton contacted the man's mother on his behalf. With the man's consent, she told his mother about his diagnosis and poor prognosis.
76. When he was told that his tumour had grown in November 2010, the man again said that he was happy for healthcare staff at Coldingley to contact his family on his behalf. He told staff that he did not have any contact details. However, the prison held a telephone number for the man's mother. A nurse therefore telephoned the man's mother on 16 November to explain the developments and to tell her that it was planned for him to move to a prison with 24 hour healthcare. Shortly afterwards, the man's brother telephoned the nurse and asked that he be the contact point in future, on account of his mother's ill health.
77. On 17 January 2011, the man's brother spoke to the inpatient manager at High Down and asked that he and his family be allowed to visit their relative and that they be kept updated about his condition. The inpatient manager telephoned the man's brother four days later to tell him about the visit from hospice staff on 18 January and to confirm that they were in the process of arranging for a family visit to take place on the inpatient unit. It was later arranged for the man's family to visit him on the inpatient unit on Saturday afternoons, which was their preferred time. This was due to start on 29 January.
78. It is recorded on 26 January that an officer was appointed as the prison's family liaison officer. However, he had no contact with the man's family and the inpatient manager continued to be their unofficial contact point at the prison.
79. The man's family were told of his hospital admission on 28 January, and were able to visit him that afternoon. The following day, the man's brother went to High Down for the arranged visit. He told staff on arrival that he had been told that his brother had returned to the prison. (It is not clear who gave him this

information.) The inpatient manager and the duty governor spoke to the man's brother and told him that he was in fact still in outside hospital. The man's brother was able to visit him in the hospital later that day.

80. The man's family continued to visit him regularly in hospital and following his move to the hospice on 25 February. Their last visits were on 4 March and 5 March. The man died shortly thereafter.
81. The news of the man's death was broken to his family by staff at the hospice. That evening, a prison family liaison officer spoke to the man's brother on behalf of the prison. The following day, a senior officer was appointed as the prison's family liaison officer. He telephoned the hospice and established that the man's brother was due to visit the hospice the following day. The FLO arranged to be there when the man's brother was due to arrive. However, his brother was unable to arrive when he hoped and the FLO therefore left his telephone number at the hospice for them to pass on. The man's brother telephoned the FLO later that day.
82. The man's funeral was arranged by his family and took place on 24 March. At their request, no one from the prison attended. Initially funeral expenses were not offered to the man's family, in contravention of Prison Service Order 2710, which details actions that must be taken following the death of a prisoner. The prison have subsequently written to the man's family to offer a contribution to the expenses. I trust they will do likewise in all future cases.
83. When a prisoner is terminally ill with a poor prognosis, it is good practice to instigate contact with their family at an early stage. There is an indication that an officer was appointed as family liaison officer on 26 January 2011, although he seemingly had no contact with the man's family. However, the inpatient manager had significant contact with the man's brother and it is commendable that she took it upon herself to arrange a family visit in the inpatient unit.
84. Nevertheless, there were some areas whereby family contact might have been done better. I have noted above that there was seemingly a mix up on 29 January that led to the man's brother visiting the prison when his brother was in hospital. In addition, PSO 2710 advises that, for various reasons, the recommended option for breaking the news of a death is for it to be delivered to the family face to face by a prison family liaison officer as soon as possible after the death. In this man's case, he had been living in the hospice for some time before his death and his family had been able to visit him in the hospice. In these circumstances, I think it is reasonable for hospice staff to break the news of the death, as they will have a greater knowledge of the circumstances and might already have a relationship with the family. However, I would expect this to have been agreed by the prison beforehand, and there is no indication that this was the case.
85. In addition, the senior officer was not appointed as family liaison officer until the day after the man's death. I accept that it was unfortunate that he did not see the man's brother at the hospice as he planned. However, I do not consider it good practice that the family's first contact with their family liaison officer was made by

the family themselves. Finally, as I have described above, funeral expenses were not offered to the man's family until some weeks after his death.

86. These difficulties might have been avoided had a dedicated family liaison officer been appointed at an earlier stage. There are benefits to such an appointment for both the prison and the family. A family liaison officer can ensure that the family are informed of any decisions concerning treatment, moves to a hospital or hospice or release on licence. Early appointment also gives both the prison and family the opportunity to determine what will happen should death occur.

The Governor should ensure that a trained family liaison officer is appointed when a prisoner with a terminal illness is nearing the end of life.

CONCLUSION

87. The man was diagnosed with an aggressive form of brain tumour in June 2004. The prognosis for this type of cancer is poor and few people with the diagnosis live for as long as this man did. However, I note the consultant oncologist's concerns that chemotherapy might have been possible later in his life had he been able to review him at an earlier stage. As such, I consider it important that Coldingley and High Down take a more proactive role in future in referring a patient with cancer to outside hospital when they transfer between the two prisons.
88. Once it became clear that palliative care was the only option for the man, he was referred quickly and appropriately to the relevant support services. A move to the hospice was discussed at an early stage and I note the clinical reviewer's comments that the end of life pathway was similar to that which he might expect had he lived in the community.

RECOMMENDATIONS

1. The head of healthcare at HMP Coldingley should review with the outside hospital their procedures for sending and receiving clinic appointments for prisoners.

Partially accepted – [the outside hospital] is not a hospital which prisoners from Coldingley attend on a regular basis and was used only on this occasion to provide continuity of treatment. Therefore it is inappropriate for the head of healthcare to review procedures in general with the [outside hospital] as we are unlikely to have another episode of care there for some considerable time.

There are no concerns with the hospitals that Coldingley regularly refer prisoners to and the processes in place work well.

As a point of note, all of our complex cases are now managed by a 'named nurse'.

2. The heads of healthcare at HMP Coldingley and HMP High Down should ensure that an urgent referral is made to the appropriate hospital when a prisoner with cancer transfers between the two establishments.

Partially accepted – When a patient is under the care of a hospital and the treatment needs to be transferred to another hospital, the hospital will make that referral themselves as heads of healthcare do not have access to all the medical information required.

In this case, the referral was made on 12 November 2010 to outside hospital but they did not immediately respond to the referral and send an appointment.

The head of healthcare at High Down accepts that staff could have contacted the hospital earlier when they did not receive a referral. However, the outside hospital decided to transfer care to a further outside hospital, which resulted in yet another referral which contributed to the delay. For future transfers, staff will contact other providers to follow up appointments within the first 48 hours of transfer.

3. The Governor should ensure that a trained family liaison officer is appointed when a prisoner with a terminal illness is nearing the end of life.

Accepted – This will be actioned at the same time as the case for ROTL or early release is considered.