



**Investigation into the circumstances surrounding the
death of a man in January 2012,
while in the care of HMP Long Lartin**

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

August 2012

This is the investigation report into the death of a man at HMP Long Lartin in January 2012. He was 48 years old. A post-mortem examination concluded that he died from heart and brain cancer that caused bleeding in the brain. I offer my condolences to his family and friends.

The investigation was carried out by an investigator. The local Primary Care Trust (PCT) appointed a clinical reviewer to review the man's clinical care. Long Lartin cooperated fully with the investigation.

The man had no significant medical conditions when he entered prison in February 1998. In August 2011, he was diagnosed with terminal cancer, with a very short life expectancy. He received very good palliative care at Long Lartin. Overall, the clinical reviewer concluded that the standard of care received by him before and after diagnosis was equal to that which he could have expected in the community.

Notwithstanding this commendable healthcare, the investigation does identify some learning from the man's case. His condition was considered terminal six months before he died, but a family liaison officer was only appointed the day before his death. Next of kin should be offered a single point of contact at a much earlier stage and I recommend that the Governor appoints a family liaison officer much sooner in future, in accordance with national instructions. Similarly, while recognising that he was a category A prisoner, I am not satisfied that his medical condition was always given sufficient weight when staff assessed the level of restraints required. This resulted in him being restrained while in a medically induced coma. A recommendation is made for daily reviews of escort risk assessments to take into account a prisoner's physical condition.

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

August 2012

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SUMMARY

1. The man first entered custody in 1998, and received a life sentence in August 1999. He was assessed as a category A prisoner (those who present the highest risk to the public in the event of an escape) and placed in the high security prison estate. After moving around the high security estate, he was eventually transferred to Long Lartin in September 2009.
2. He first complained of feeling unwell in May 2011, although blood tests were all normal. In June, he went to the prison doctor again and was treated for a nasal infection. His symptoms worsened (swelling in his neck) and he was referred for a routine appointment with an ear, nose and throat specialist (ENT) because staff were worried he had mumps. Initially his symptoms improved with antibiotics, although he began to experience headaches and told staff that he had coughed up blood. He was eventually referred under the 'two week rule' in July (for those suspected of having cancer) to an ENT specialist at hospital.
3. Following examination on 22 July at hospital, the man was referred for a computerised tomography scan (CT - a special type of x-ray using a scanner and computer equipment to take pictures of the brain or spine). He returned to Long Lartin but was readmitted to Worcestershire Hospital on 29 July and had a CT scan. He was assessed as high risk and escorted by three officers who used double cuffs to restrain him.
4. The next day he was transferred to hospital and, on 1 August, it was established that he had untreatable cancer. His prognosis was poor. As his condition deteriorated, his restraints were reduced to an escort chain, which remained in place even when he was put into a coma for medical reasons.
5. The man was referred for palliative care (used to relieve and prevent the suffering of terminally ill patients) and discharged back to the healthcare centre at Long Lartin on 10 August. Consideration was given to Early Release on Compassionate Grounds, but he was not assessed as suitable for release and he did not want to be discharged to a hospice. The application for early release and the decision not to release him to a hospice were reviewed regularly. He was a resident in the healthcare centre for the next five months, where he was monitored and his pain was managed.
6. On the 28 January 2012, the man's condition worsened and a family liaison officer was appointed. During the early hours his condition deteriorated and he was pronounced dead at 3.45am.
7. The clinical reviewer does not make any recommendations and concludes that the clinical treatment the man received before and after diagnosis was appropriate and equal to that he could have expected in the community. We are concerned about the level of restraints used on him and the late appointment of a family liaison officer and have made recommendations accordingly.

THE INVESTIGATION PROCESS

8. The investigation was opened on 6 February when the investigator visited HMP Long Lartin and was given the man's documentation. During this visit, she met the Primary Care Manager and spoke to two prisoners who knew the man well. Notices were issued in advance of her visit announcing the investigation to staff and prisoners. No-one responded to these notices.
9. The local Primary Care Trust (PCT) appointed a clinical reviewer to review the man's clinical care. He was provided with the medical records to assist the clinical review, which was received on 4 May 2012.
10. The investigator contacted Her Majesty's Coroner for Worcestershire to inform him of the nature and scope of the investigation and request a copy of the post-mortem report. The investigation report will be sent to the Coroner to assist his enquiries.
11. One of the Ombudsman's family liaison officers contacted the man's sister on 6 March, to inform the family about the investigation and to invite them to ask questions about his care while he was at Long Lartin. The family, via their legal representative, asked the following questions:
 - Why was the medical report written by a doctor used to determine his suitability for release on compassionate grounds, when she says she did not have the competency to make the required risk assessment?
 - Why was he not reassessed by a psychologist at Long Lartin?
 - Why were the daily updates provided via the Treasury Solicitor on his condition not congruent with the entries in the patient medical records?
 - Following the deterioration in his health, the family have asked why the application was referred to the Parole Board for consultation when there was insufficient time and the decision not taken by the Secretary of State.
 - Why did the PPO request documents from the family, when they should have been provided by Long Lartin?

It is hoped that this investigation report answers these questions.

12. The investigation has assessed the main issues involved in the man's care including his diagnosis and treatment, liaison with his family, his location and security arrangements, whether compassionate release was considered and whether appropriate palliative care was provided.
13. The family received a copy of the draft version of the report as part of the consultation period. We are grateful to them for the time they have taken to consider the report. Having considered the investigation findings they raised further issues, via their legal representative on 13 August and the investigator reviewed the findings of the investigation. Any concerns not covered in the finalised report are addressed in separate correspondence to them.

HMP LONG LARTIN

14. HMP Long Lartin is part of the high security prison estate. It holds up to 622 category A and B adult men who have been sentenced to at least four years imprisonment. The man was classified as a category A prisoner; highly dangerous to the public, police or national security if he were to escape.
15. Healthcare services are provided by the local PCT and operate like a community general practice. In addition, there is a small acute admissions unit for prisoners needing more intensive care.

HM Inspectorate of Prisons

16. HM Chief Inspector of Prisons last conducted an unannounced full follow-up inspection of the prison between 17 and 26 August 2011. The Chief Inspector noted that:

“There were good inpatient facilities for very ill patients and the quality of palliative care had recently been commended following an independent clinical investigation.”

Previous deaths at Long Lartin

17. There was one death at Long Lartin in the year before the man died, which was due to natural causes. There have been seven previous deaths in total since the Ombudsman was given responsibility for investigating deaths in custody in England and Wales in April 2004, three due to natural causes, three self-inflicted and one unclassified. The investigator reviewed the Ombudsman’s report into the most recent natural cause deaths and she found no direct similarities between these deaths and that of the man. However, a recommendation was made in one investigation report regarding the timely review of those subject to health care plans. It is pleasing to see that this recommendation is reflected in the care he received.

ISSUES

18. On 11 December 1998, the man appeared at the court and he was sentenced to life imprisonment with a tariff of seven years (the minimum that must be served prior to being considered for release) for violent and sexual offences. On 23 August 1999, he was sentenced for further similar offences and received a concurrent life sentence with a tariff of eight years. Following his arrest for these offences in February 1998, he was initially taken to HMP Belmarsh and transferred to HMP High Down on 15 September 1998. He eventually went to HMP Long Lartin on 29 September 2009.
19. Following a violent assault by another prisoner in May 2005, the man was blinded in his left eye and he had sight difficulties in his right eye. He was regularly reviewed by an ophthalmologist (a medical expert in eye care) and received medication to manage glaucoma (pressure in the eye). He was also regularly prescribed omeprazole for excess stomach acid.

The diagnosis of the man's terminal illness

20. On 10 March 2010, a nurse recorded that the man experienced chest pains. He was admitted to hospital and following extensive tests was discharged back to Long Lartin on 15 March with a diagnosis of muscular pain.
21. He again suffered from chest pains on 9 October 2010 and had an ECG (electrocardiogram - measures the electrical activity of the heart to help with diagnosis) which was within normal limits. A prison doctor examined him on 8 November 2010 as he was still suffering from chest pain, and he was referred for further tests. He had an ECG on 13 November at Long Lartin, and a chest x-ray on 6 December, but there were no significant findings.
22. The man was examined by a doctor on 31 May 2011, as he had been experiencing headaches and pressure in his head. The doctor requested blood tests, which were all within normal range. The man declined pain killers. He told a nurse on 17 June that he was still experiencing pressure in his head, above his eyes. His blood pressure and pulse were both normal and he was referred to the prison doctor. The doctor reviewed him on 20 June and he was prescribed antibiotics for sinusitis (a nasal infection).
23. Six days later, he was examined by a nurse for a swelling to the right side of his jaw. He told her that the antibiotics prescribed for sinusitis improved his symptoms by "90 per cent". She consulted the on call prison doctor, who examined him later the same day. He diagnosed him with possible mumps (a viral infection causing a painful swelling of the salivary glands). The doctor examined him the following day and queried the diagnosis of mumps. He prescribed co amoxiclav antibiotics (used to treat infections) and asked for more blood tests.
24. On 28 June, the doctor examined the man and recorded that the swelling in his jaw was reducing. He did not go for his blood tests on 29 June, and there is no explanation for his absence. A doctor reviewed him on 5 July and noted

that the swelling had reduced further. He prescribed a further course of antibiotics and planned that he would be reviewed in one week.

25. A doctor reviewed the man on 12 July and recorded:

“neck slowly settling, still swollen but non tender. for referral to ent [ear nose throat specialist] non urgent”.

However, two days later a nurse examined him, and found that his face was swollen and he said that his throat “felt tight”. He was observed overnight, but there were no recorded problems.

26. The next day, on 15 July, a nurse examined the man, who told her that he had been experiencing headaches and had a cough, often with blood. A nurse made an urgent referral to the ENT specialist, and suggested that he should have an ultrasound on his neck and more blood tests. A doctor examined him a short time later and also referred him for a chest x-ray and prescribed an antibiotic.

27. The ultrasound was completed on 18 July at Long Lartin. The ultrasound practitioner found two lumps on the left side of the man’s neck in addition to a “tubular” structure which was separate from his carotid (the artery that supplies the head and neck with oxygenated blood) and concluded that a specialist opinion was necessary. The doctor reviewed the results of the scan and made a referral to the ENT specialist under the two week rule (for those suspected to have cancer). He was referred to hospital and on the referral form it was recorded that he had been told about the possibility he had cancer.

28. A doctor examined the man on 21 July, recorded that there was a large mass below his jaw and admitted him to the healthcare centre for closer observation every four hours. He attended the ENT clinic at hospital on 22 July for a chest x-ray. In his report after the x-ray, the doctor concluded:

“compared with the previous examination (26.11.10) there is now the impression of fullness in at the right hilum [part of the lung], the heart is enlarged and this may be due to vascular shadows [an opaque image on an x-ray] but a possibility of more sinister pathology [the diagnosis of a disease] at the right hilum cannot be entirely excluded in this examination. I would recommend requesting a more penetrated PA [an enhanced x-ray] and right lateral view in the first instance, if any doubt persists, and with the history of haemoptysis [coughing up blood], then a CT scan will be required”

29. A specialist registrar ENT examined the man the same day. She recorded that a full diagnosis would be made following the CT scan. Initially, the hospital told the prison that the earliest they could complete the CT scan was 15 August. Two prison doctors were so concerned regarding the length of time he had to wait, that they contacted the consultant oncologist (a specialist

in treating and managing patients with cancer) on 28 July to request an earlier appointment.

30. On 29 July, the man's arms and legs began to swell and he complained of being breathless. A prison doctor authorised he to be escorted to outside hospital. He was admitted to the medical assessment unit (MAU) at hospital and had a CT scan the same day. He was transferred to another hospital on 30 July and was assessed by a specialist registrar oncology. A multidisciplinary team (MDT – where all those involved in decision making regarding treatment attend) discussed the diagnosis of malignant mesotheliona (a terminal cancer of the lung). The MDT concluded that he was not suitable for chemotherapy and that he should be referred for palliative care.
31. Further tests, on 1 August, confirmed that he also had multiple blood clots in his heart. He remained at hospital until he was discharged back to Long Lartin on 10 August.
32. In his consideration of the diagnosis, the clinical reviewer notes:

“In view of the fluctuating nature of the man's early symptoms and presentation, I felt that the initial consultations, subsequent suspicion of cancer and resulting referral within the two week rule were appropriate and equitable to the care and procedures he would have expected to have received in the community.

“On review of correspondence between his appointed legal team and the Healthcare providers, I can see that there was a request that he had an assessment on an exercise treadmill. In addition, shortly before his death, a query was made as to whether he should have a head or brain scan. I would like to reassure the family that in my opinion I would concur with the Healthcare team that neither of these investigations were likely to have resulted in any clinical benefit or change in treatment for him. Also in this correspondence was a statement that the solicitor was considering referring the Healthcare team to the Care Quality Commission. This may have raised anxieties amongst family members regarding the care that he was receiving. In my opinion, from reviewing the records, I can see no clinical reason for this consideration and I feel that the care he received was excellent”.
33. In light of the clinical reviewer's comments, we conclude that the diagnosis of the man's terminal illness was timely and appropriately handled.

Informing the man about his condition and treatment

34. The man underwent a number of diagnostic tests in the weeks before the consultant oncologist confirmed that he had cancer. On 18 July, when he was urgently referred to an ENT specialist recorded that he spoke to him about the possibility he had cancer.

35. Following admission to hospital on 29 July, the man was informed of his diagnosis by a hospital consultant. The consultant confirmed that there was no treatment and that the prognosis was poor, and he had a life expectancy of “weeks”. On 3 August, the Clinical Team Manager from Long Lartin visited him in hospital. During this visit she met him and the hospital staff treating him and discussed his care plan.
36. On 11 August, following his return to Long Lartin, the man met with a mental health nurse. During this meeting, he said he understood his condition and that he was to receive palliative care. The next day the Clinical Team Manager discussed his condition with him and contact with his family. Later the same day, a psychiatric nurse discussed the palliative care plan with him, told him that he would be allowed out of his cell as much as possible and that he would be able to contact his family and receive visits as often as possible.
37. On 26 August, he met a consultant in palliative medicine and confirmed he understood his condition and the prognosis. The consultant explained to him that his symptoms would be managed and reassured him that he would receive medication to ensure that he was pain free.
38. In his report, the clinical reviewer comments as follows:

“I felt that the man was given full information on the reasons for his referral... he was advised regarding the nature of his malignancy [cancer] and of the prognosis...there is documented evidence which details the information given to him regarding his condition and treatment, and his involvement in this as his illness progressed.”
39. According to his medical records, hospital and healthcare staff at Long Lartin ensured that he was fully informed at all times about his condition, from the initial diagnosis and subsequent palliative care. He was supported by mental health staff to come to terms with his prognosis. We are satisfied that he was appropriately informed about his condition and prognosis.

The man’s medical appointments and treatment

Appointments

40. The man was regularly reviewed at Long Lartin as an in-patient in the healthcare centre. He was not required to attend appointments at outside hospital regularly, as he was receiving the appropriate palliative care in the prison.

Treatment

41. An oncologist held an MDT meeting on 9 August at the hospital, and it was agreed that there was no treatment available to cure the man and that palliative care would be provided. A referral was made to a Palliative Care Consultant at a hospice for ongoing advice.

42. When he got back to Long Lartin, a doctor explained to him that he was at risk of cardiopulmonary arrest (a heart attack) due to his illness and resuscitation was not likely to be successful. He had already discussed this with a consultant in hospital and signed a Do Not Attempt Resuscitation (DNAR) form on 10 August. This was endorsed on 11 August by another prison doctor.
43. He was prescribed dexamethasone (a steroid used to reduce the swelling in his heart) which caused him to develop diabetes which he was able to manage with daily insulin injections.
44. The clinical reviewer writes:

“Hospital specialists discuss all cancer diagnoses at multidisciplinary team case conferences to plan the appropriate treatment. They concluded that he had an incurable cancer for which there was no active treatment available.”
45. The man’s treatment options were limited to managing his symptoms, rather than curing the underlying illness. We agree with the clinical reviewer that his treatment was appropriate to his condition.

The man’s pain relief and medication

46. The man was prescribed all the medications as directed by the hospital consultant and palliative care team. At the time of his death, he was prescribed the following medication:
 - MST continus (morphine – for severe pain relief)
 - Hyoscine butylbromide (for relief of abdominal pain)
 - Cyclizine (to treat nausea and dizziness)
 - Humalog (insulin to treat diabetes)
47. Healthcare staff regularly reviewed the palliative care plan and he was provided with specialist equipment to help alleviate his pain (an adjustable bed and a pressure mattress). When considering his pain relief and medication, the clinical reviewer says:

“His symptoms were regularly reviewed, analgesia (painkillers) in the form of morphine was readily available and he was involved in discussion regarding analgesia control and management. There is good evidence of his involvement in this aspect of his care.”
48. In light of the clinical reviewer’s comments, we conclude that the management of the man’s medication and pain relief was appropriate to meet the needs of his condition.

Palliative care plans

49. Palliative care is defined by the National Institute for Clinical Excellence (NICE) and the National Council for Palliative Care (NCPC) as:
- “ ... the active holistic care of patients with advanced progressive illness. Management of pain and other symptoms and provision of psychological, social and spiritual support is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families. Many aspects of palliative care are also applicable earlier in the course of the illness in conjunction with other treatments.”
50. The man was subject to a palliative care plan when he was discharged back to Long Lartin in August 2011. Consideration was given to placing him on the Liverpool Care Pathway (a means of optimising care for patients nearing the end of their life, and is aimed specifically to manage symptoms), although ultimately this was not considered necessary as his condition was regularly reviewed and managed. A Consultant in Palliative Medicine visited him on 26 August, along with a prison doctor and a nurse and they reviewed the care plan with him present.
51. His care was reviewed almost daily by healthcare staff, all recorded in the electronic medical notes. Specialist palliative care nurses from the hospice continued to have input into his care plan and visited him at Long Lartin when required. The care plan was formally reviewed each month and adjusted as necessary.
52. In addition to his physical care, there is evidence that the man's emotional and spiritual needs were also well considered, evidenced by the number of daily interactions with healthcare staff and staff's facilitation of contact with his family and the prison Imam (Islamic religious leader). Further, his friend was allowed to visit him in the healthcare centre and he was allowed to associate with other prisoners located on the unit.
53. The clinical reviewer notes:
- “In my opinion there was excellent communication between prison Healthcare and all outside providers involved in his care...the care plan appeared holistic, robust and complete and the comprehensive nature of the care plan was commented on and complimented by the consultant in palliative care who supported and reviewed his care”
54. In summary, prison healthcare staff provided a high standard of palliative care with attention to both the man's physical and emotional needs.

The man's location

55. The man was transferred to HMP Long Lartin on 29 September 2009. As soon as he was diagnosed with a terminal illness, a referral was made to the hospice on 10 August for advice and support with his palliative care plan. He

told prison staff on a number of occasions that he did not want to be discharged to a hospice, and this was respected.

56. On 12 August, the man asked healthcare staff if he could be transferred to a prison in London (HMP Belmarsh) to be closer to his family. However, he was concerned that he would not receive the same level of care at a different prison, so decided that he preferred to stay at Long Lartin. He was located in a single cell in healthcare and the clinical reviewer notes:

“There was considerable discussion regarding alternative accommodation, he [the man] was offered a larger cell in the Healthcare department but he preferred to stay in his current cell due to its proximity to the Healthcare office.”

57. Long Lartin ensured staff were able to enter his cell easily if they needed to. On 13 January, he was examined at Long Lartin by the consultant in palliative medicine, who concluded that he was not immediately dying, did not have complex medical needs and that hospice care was not appropriate at that time. An open door policy was implemented on 17 January, so that staff could get into his cell without delay. At a multi-disciplinary meeting on 24 January, attended by the man, the possibility of a transfer to a hospice was discussed again. He repeated that he did not want to go to a hospice and the clinical reviewer said:

“Transfer to a hospice was discussed... however, he [the man] was adamant latterly that he did not want to go to a hospice.”

58. We agree with the clinical reviewer that the man was located appropriately and the prison respected his wishes to be cared for at Long Lartin.

Compassionate release

59. Prisoners who are suffering from a terminal illness with a short life expectancy qualify for Early Release on Compassionate Grounds (ERCG). A release plan is necessary, including a suitable release address assessed as appropriate to manage any ongoing risk. The man provided his mother's address, which was assessed as not suitable. His mother was unaware of the exact nature of her son's sexual offending and was deemed unlikely to be able to provide protection to any children visiting the address.
60. Arrangements for prisoners, such as the man serving an indeterminate (life) sentence, are set out in PSI 29/2010. Before exercising the power to release a prisoner on compassionate grounds, the Parole Board has to be consulted unless the circumstances make this impracticable. Each case is considered on its own individual merits. For life sentenced prisoners decisions for release have to be approved personally by a Minister and such decisions are not delegated to officials. The criteria for compassionate release on medical grounds for all indeterminate sentence prisoners (ISP) are as follows: -

“The prisoner is suffering from a terminal illness and death is likely to occur very shortly (although there are no set time limits, three months may be considered to be an appropriate period for an application to be made to Public Protection Casework Section [PPCS]), or the ISP is bedridden or similarly incapacitated, for example, those paralysed or suffering from a severe stroke; and the risk of re-offending (particularly of a sexual or violent nature) is minimal and further imprisonment would reduce the prisoner’s life expectancy; 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.”

61. An application for ERCG was started following the man’s diagnosis on 11 August and was received by the PPCS for consideration on 19 August. There were reports from his offender manager, offender supervisor and the Governor about his level of risk and likelihood of re-offending. A medical report completed on 16 August by a prison doctor confirmed that his life expectancy was “weeks”. The application was considered on 22 August by PPCS, and refused on the grounds that he still posed a high risk of harm to the public and had the capacity to re-offend. A letter on behalf of the Secretary of State refusing ERCG was issued to him the following day which stated:

“None of the report writers are in support of your early release on compassionate grounds at this stage, and deem the potential for re-offending remains ... However I have asked the Governor [Long Lartin] to keep your case under review and apply again if your circumstances change.”

62. The Clinical Director for Offender Health submitted two subsequent reports on 25 November and 12 December, having reassessed the man. These reports detailed some deterioration in his condition, although these were not assessed as significant and the conclusion was that he still had the capacity to re-offend and posed a risk of serious harm.
63. In January 2012, the man’s legal representative arranged for a Registered Forensic Psychologist to provide an independent assessment on his capacity to re-offend, risk of serious harm and his application for compassionate release. She met with him on 15 January and submitted a report on 20 January concluding that she had assessed his risk of harm and re-offending as minimal. In addition, the Consultant in Palliative Care assessed him on 13 January, and concluded that there had been a significant deterioration in his condition.
64. The Clinical Director re-assessed the man on 19 January and in her report concluded that “[the man’s] current mental and physical condition make it unlikely that he now has the capacity to offend to a level where there is a risk to life or limb”. Long Lartin re-referred the application for ERCG and PPCS received it the following day, Friday 20 January. PPCS referred the application on Tuesday 24 January to the Parole Board panel for

consideration. A panel date was set for 3 February to consider the submission; however he died before his case was considered.

65. In addition to the application for ERCG, the man submitted a request and complaint form to the Governor, requesting a meeting regarding an application for Release on Temporary Licence (ROTL - in certain circumstances, a prisoner may be allowed to leave prison on a temporary licence. ROTL is designed to ensure that suitable prisoners are released for precisely defined and specific activities). The Governor of Long Lartin, met with him on 13 September, and told him that, in line with the criteria set out in PSO 6300 Release on Temporary Licence, that he was not eligible for consideration due to his category A status.
66. The investigation found that there was a timely application for ERCG after his diagnosis. There is evidence that the case was regularly reviewed by medical staff and communicated to PPCS without delay.
67. The man's risk of serious harm and capacity to re-offend was only assessed as having reduced in the last week of his life. He was not able to provide a suitable release address where it was considered the identified risks could be adequately managed and monitored. We are satisfied that his case was constantly under review and that communication with PPCS was within reasonable timescales.

Liaison with the man's family

Visits

68. The man had not received visits during his time in custody, but his family visited him while he was in hospital. Following his return to Long Lartin, arrangements were made for his family to visit him in the healthcare centre, without the need for a visiting order. (When a prisoner is convicted, they must send a visiting order to their family or friends. For category A prisoners, visitors need to be pre-approved.) The Governor authorised that his family could visit (with proof of identification), while checks were taking place and they were granted permission to visit him on 11 August.
69. Throughout the remainder of his time in Long Lartin, the man received telephone calls and visits from his family. Healthcare staff, with his permission, ensured that his family were updated regarding his condition. He was also allowed to contact his brother, who is a prisoner at another establishment, via video link.
70. We are satisfied that Long Lartin ensured that his family were able to support the man, despite the restrictions of a high security prison.

Family Liaison Officer

71. The Acting Head of Residence was appointed to be the family liaison officer on the 28 January, as the man's condition worsened. His family were with him that day and asked to be contacted by telephone if he died.
72. As requested, the Head of CPIU - Crime Prevention and Investigation Unit telephoned the man's mother at 5.30am to break the news of her son's death, and the family liaison officer spoke to his sister at 7.30am. The prison FLO maintained contact with the family and offered funeral expenses on behalf of the prison, as well as help to arrange the funeral. The man's relatives visited Long Lartin on 9 February. The funeral was held on 16 February, and was attended by representatives from Long Lartin, with the family's consent. On 20 February, the man's mother and daughter visited Long Lartin again and went to his cell. They sorted his belongings and were told that additional property was not at the prison, but would be forwarded to them. The family liaison officer spoke to the family on 23 April to apologise for the delay in returning his remaining property caused by her absence, but assured them it would be sent to them. It is surprising that no-one was appointed to cover her. She kept a record of contact she had with the family and we consider that she undertook this role satisfactorily.
73. The new Prison Service Instruction 64/2011 Safer Custody (PSI – prison guidelines containing mandatory instructions which are written in italics) was implemented on 1 April 2012 (subsequent to the man's death) and continues to require the early appointment of a family liaison officer:

“Prisons must ensure that arrangements are in place for an appropriate member of staff to engage with the next of kin or nominated person of prisoners who are either terminally or seriously ill.”

A FLO was only appointed the day before the man died. While the family regularly visited him at Long Lartin, and were supported by prison and healthcare staff, a single point of contact should have been appointed when he was diagnosed with a terminal illness.

The Governor of Long Lartin should ensure that a family liaison officer is appointed when a prisoner is assessed as terminally or seriously ill.

Restraints, security and bed watch

74. The Prison Service has a duty to protect the public and prevent escape so restraints and escort staff are used when prisoners are taken out of the prison for any reason. An individual risk assessment should be completed on each occasion and regular management checks made. On 29 July, the man was subject to double cuff restraints (when two sets of handcuffs are used; one set is applied to the prisoner's wrists and one cuff of the second set is attached to the prisoner and the other to one of the escorting officers) and escorted by a senior prison officer and three prison officers when outside of prison. In reaching this judgement, Long Lartin considered the risk posed by him to the

public, his security category (A), and his medical condition which was under constant review.

75. This escort risk assessment was reviewed following the man's admission to hospital on 29 July. The next day authority was given for the use of an escort chain when he was on the ward and double cuffing (with an escort chain) when he was moving around the hospital. Authority for removing the restraints was given when he underwent a diagnostic procedure on 4 August, but the restraints were reapplied immediately. Following this procedure, he was placed in a medically induced coma until 8 August. The restraints were not removed during the period he was unconscious. The bed watch records described an escort chain 'with padding', although on 7 August the restraint is described as a 'ratchet with padding' but the following day, it is again described as an escort chain. Long Lartin have confirmed a ratchet handcuff is an escort chain.
76. Prisons have a primary responsibility to protect the public but must also ensure dignified treatment of prisoners. There is no evidence that the removal of restraints was considered when the man was in a medically induced coma. There is no evidence that a medical opinion about his condition was considered as part of a dynamic risk assessment. It is possible that, due to the nature of his offences and ongoing security concerns, he should have been subject to restraints at various points while in hospital. However, it is difficult not to conclude that the prison failed to properly assess his risk when he was in coma.

The Governor of Long Lartin should ensure that all relevant sections of the escort risk assessment are completed each day a prisoner is in hospital so that full account is taken of a prisoner's health and physical condition and the impact this has on his actual risk while outside of the prison.

Family concerns

Prison doctor

77. The man's family asked why the medical report written by the Clinical Director was used to determine his suitability for release on compassionate grounds, when she did not have the competency to make the required risk assessment. Their legal representative highlighted that the Clinical Director says in one report that she was not in a position or 'competent' to make such a risk assessment. The clinical reviewer says:

"In my opinion, a General Practitioner, making an assessment based on examination with feedback from other medical and nursing colleagues who are involved in a patient's day to day care and management, would be in a position to provide information and to give an opinion on the ability to perform certain physical tasks, taking into account all aspects of the individual's health."

The reports focus on his health and mobility and whether or not he was rendered incapable of offending. In light of the clinical reviewer's findings, we are satisfied that the Clinical Director was qualified to complete the risk assessments.

Psychology assessment

78. The man's family asked why he was not re-assessed by a psychologist at Long Lartin. There is no requirement for a prisoner to be risk assessed by a psychologist as part of an application for ERCG. The independent assessment and report were completed at the request of the man's legal representative and was submitted to PPCS. He did not have a suitable release address, and until the last few weeks of his life was still able to move around so he did not meet the criteria for release.

Updates on medical condition

79. The Treasury Solicitor was instructed to represent PPCS and act as the liaison between that unit, Long Lartin and the man's family. The family's legal representative asked why the updates provided by the Treasury Solicitor about his condition were not congruent with the entries in the patient medical records. The investigator contacted PPCS who provided the following statement:

"This issue was raised by the man's solicitors at the time, particularly in letters dated 25 and 26 January 2012. The Treasury Solicitor replied to these concerns in some detail by letter dated 27 January 2012 ... I should perhaps clarify that the Treasury Solicitor did not receive or have sight of the patient medical records which the health care centre agreed to provide to the solicitors on a weekly basis. The daily updates via the Treasury Solicitor were to ensure that the solicitors had notice of any *significant*

change in his condition which had bearing upon the application for early release on compassionate grounds.”

80. There was not a requirement to advise the man’s solicitors of all entries contained in the medical records regarding his health. We are satisfied that significant changes in his health were communicated to PPCS. This prompted a re-referral for ERCG which was processed expediently, given the need to review his risk assessment and provide a further medical report.

Referral to Parole Board

81. Following the deterioration in the man’s health in January, the family asked why the application was referred to the Parole Board for consultation and not sent directly to the Secretary of State, given there was insufficient time for a decision to be made.
82. The details of how the ERCG application progressed are outlined from paragraph 58. If a prisoner’s life expectancy is likely to be more than two weeks, there is a requirement that the Parole Board is consulted. While there had been a deterioration in the man’s health, he was not assessed as being in the terminal phase. PPCS were notified at 4.20pm on Friday 27 January that there had been a further deterioration in his health. PPCS were advised on Monday 30 January that he had died while the application was still being processed.

Documentation

83. The man’s family’s legal representative asked why documentation was requested by the investigator directly from his family, rather than being provided by Long Lartin. No evidence was brought to the attention of the investigator by the family that had not already been received from the prison. Long Lartin co-operated fully with the investigation.

CONCLUSION

84. During his time at Long Lartin, the man had well documented and regular interactions from doctors and other healthcare staff. There was good liaison between healthcare staff and hospital specialists to ensure that he received appropriate treatment and medication, and we agree with the clinical reviewer that the care was at least equal to that he could have expected in the community. However, family liaison officers should be appointed as soon as a prisoner is diagnosed with a terminal illness and improved risk assessments for prisoners in hospital are needed to demonstrate that security arrangements are proportionate and take into consideration the prisoner's physical condition at the time of the assessment.

RECOMMENDATIONS

1. The Governor of Long Lartin should ensure that a family liaison officer is appointed when a prisoner is assessed as terminally or seriously ill.

ACCEPTED: *A FLO and deputy will be appointed in times where a prisoner is assessed as terminally or seriously ill. This will be completed by the designated Head of Safer Custody. Target: Completed.*

1. The Governor of Long Lartin should ensure that all relevant sections of the escort risk assessment are completed each day a prisoner is in hospital so that full account is taken of a prisoner's health and physical condition and the impact this has on his actual risk while outside of the prison.

ACCEPTED: *The Head of Security will ensure that a Risk Assessment and relevant sections are completed on a daily basis by the Security Department to take into account any new or emerging issues.*

This will then be issued to the outgoing staff as part of their pre shift briefing.

Target: July 31st 2012.