

**Investigation into the circumstances surrounding
the death of a man at a hospice
in February 2012,
while in the custody of HMP Bullingdon**

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

July 2012

The man was 66 years old when he died at a hospice in February 2012. He was a convicted prisoner at the time of his death and in the custody of HMP Bullingdon. I extend my condolences to his relatives.

The man had already been diagnosed with stomach cancer when he was sent to Bullingdon following a trial in November 2011. He had been told that he would not recover. In December, the court imposed a lengthy prison sentence in the knowledge that he was terminally ill. His condition deteriorated in January 2012 and he moved to the hospice at the end of the month, where he died just over a week later. The post mortem report shows that he died from pneumonia, caused by stomach cancer, which had spread to other organs.

The investigation was completed by an investigator. One of my family liaison officers contacted the man's next of kin to discuss the investigation. A review of the clinical treatment which he received in prison was undertaken by a clinical reviewer.

The man was already extremely unwell when he arrived at Bullingdon. I am satisfied, from the evidence of the clinical review, that he received a good standard of care at the prison. The possibility of compassionate or temporary release before his death was considered but discounted not least because this might be seen to undermine the recent decision of the court.

He moved to a hospice at an appropriate time when he came towards the end of his life, but I am concerned that an inadequate and incomplete risk assessment led to him being uncomfortably handcuffed to an officer for a week. Although these restraints were removed before his death, I am not persuaded that they were necessary when he arrived at the hospice. This is disappointing as this office made a recommendation to the Governor of Bullingdon in a similar situation last year and it should not be necessary to repeat the need to learn lessons in such cases.

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.

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SUMMARY

1. On 24 November 2011, the man was convicted of serious sexual offences against family members. He was taken from court to HMP Bullingdon to await sentencing. He had been diagnosed with stomach cancer in the community and his consultant had already indicated that he would not recover. Consequently, he was immediately admitted to the prison's inpatient healthcare unit upon arrival.
2. Healthcare staff began liaising with a palliative care nurse from a local hospice about the man's end of life care. They also consulted Macmillan nurses by telephone. He was taken to outpatient appointments on 21 December 2011 and 13 and 25 January 2012. The palliative care nurse from the hospice visited him on 15 December 2011 and 19 January 2012. A dietician assessed him regularly and drew up a care plan because he had serious problems eating.
3. The man returned to court on 16 and 23 December 2011, when he received a 15 year prison sentence.
4. The prison began to consider the possibility of the man's early release on compassionate grounds (ERCG) or release on temporary licence (ROTL). Ultimately, these options were not pursued because of the risk factors, the lack of a suitable address (he had been convicted of sexually assaulting family members) and because the trial judge had only recently imposed a lengthy custodial sentence in the full knowledge of his prognosis.
5. The man went to the hospice on 30 January accompanied by two prison officers. He was handcuffed to an officer with an escort chain for a week until 6 February, when staff removed restraints because of his deteriorating health. His wife and sons visited him on 3 and 7 February. His sister visited regularly and was present when he died in February.
6. We make one recommendation as a result of the investigation about the need to ensure that all factors are fully considered when assessing a prisoner's risk under escort. The man's escort risk assessment was not properly completed.

THE INVESTIGATION PROCESS

7. The investigator was notified of the man's death on 8 February 2012. Notices were issued to staff and prisoners at HMP Bullingdon outlining the investigation process and inviting them to contact him. No prisoners or staff contacted our office. He visited Bullingdon on 13 February to collect documents relating to the man's time in custody.
8. The local PCT commissioned a review of the clinical treatment the man received while in custody. The purpose of the review was to establish whether the care which he received in prison was comparable with that he could have expected in the community. A clinical reviewer completed the review.
9. On 6 March, the investigator visited Bullingdon to interview three members of staff. He gave verbal feedback about the progress of the investigation to the deputy governor.
10. HM Coroner was informed about the investigation and will be provided with a copy of our report.

The man's family

11. One of our family liaison officers contacted both the man's sister and wife to discuss the investigation and any concerns they had. His wife did not raise any issues but asked to see a copy of our draft report.
12. The man's sister, his nominated next of kin, had several questions. She wanted to know more about her brother's diet and pain management while he was at Bullingdon and asked whether he should have transferred to a hospice sooner. She also wanted to know what had been done either to secure his early release on compassionate grounds (ERCG) or his release on temporary licence (ROTL).
13. She was concerned that her brother was restrained until shortly before his death, even though he was very frail, weighed little more than five stones and could not walk unaided. She said that the heavy escort chain caused sores on his wrists where his skin was very thin and blood could be seen on his bandages as a result. His sister believed that there was too little consideration of her brother's individual circumstances and that the presence of two officers should have been sufficient for security. She felt the use of restraints in these circumstances was indecent and undignified, and caused her brother additional physical pain and discomfort.
14. She complained that the two officers on duty on Monday 6 February had shown her little courtesy and made her feel uncomfortable throughout her visit. She said that the officers sat in the easy chairs, which were not offered to her. One officer was 'lolling around with headphones reading a book', while the other was reading a magazine. They did not ask her for identification when she entered the room and she said that she could easily have attacked

her brother had she wanted to do so. She recalled that it was at least ten minutes before the escort officers made any effort to complete the relevant visitor security form. She thought that these officers showed a lack of compassion, sensitivity and respect.

15. The following day, 7 February, the man's sister was concerned that two escort officers arrived for duty in full prison uniform. She felt that this was inappropriate in a hospice environment.
16. Apart from these concerns, she said that, for the most part, the officers assigned to escort her brother were kind, courteous and professional. Some had gone out of their way to include her and her brother in their conversation and make them feel at ease. She particularly complimented the officer who was on duty when her brother died, who she said showed tremendous compassion and sensitivity and as much concern for her welfare as he did for her brother's. The officer allowed her to spend time alone with her brother before his death, which had meant a great deal to her, and she asked that the officer's professionalism be recognised in the report.
17. The man's sister also spoke very positively about the help and support she had received from the prison family liaison officers, who she described as considerate and compassionate. She received a financial contribution towards the funeral, in accordance with the policy of the National Offender Management Service. She said that her brother's property was returned promptly.
18. 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.
19. The man's sister ultimately declined to receive a copy of our draft report. However, she was pleased to hear from our family liaison officer that we had made a recommendation about escort risk assessments which will affect the treatment of other prisoners in the future.
20. The man's wife received a copy of the draft report. She told our family liaison officer that she did not want to make any comments about the investigation.

HMP BULLINGDON

21. Bullingdon prison is near Bicester in Oxfordshire. The prison holds over 1,000 adult male unconvicted and sentenced prisoners in a mixture of single and shared cells. The prison has 24 hour nursing cover. The inpatient healthcare unit where the man stayed can hold up to 20 prisoners in single cells. A doctor's surgery is held every weekday, and there is an out of hours medical service overnight and at weekends.

The Hospice

22. The hospice is where terminally ill people are cared for in the last few days of their lives.

HM Inspectorate of Prisons (HMIP)

23. Bullingdon was last inspected by HMIP in July 2010. This was a short follow up inspection of a previous full inspection in 2008. A recommendation to increase the number of healthcare staff on duty overnight had been achieved so there was adequate cover for the houseblocks and the inpatient centre. The healthcare environment was described as poor and the regime for inpatients as sparse. The Inspectorate found that there were delays in getting GP and other healthcare appointments. At the time of the full inspection in 2008, the Inspectorate reported that there was a palliative care policy and that healthcare staff had positive experiences of using Macmillan nurses and a local hospice.

Independent Monitoring Board (IMB)

24. Each prison has an Independent Monitoring Board (IMB), whose members are appointed by the Secretary of State for Justice from the local community. Their role is to satisfy themselves that the prisoners are treated humanely and justly. The most recent annual report published by the IMB at Bullingdon covers the period from 1 August 2010 to 31 July 2011. The Board commented extensively and critically on the provision of healthcare and said that, while some progress had been made, the overall standard of service was inadequate and inefficient. The IMB noted that the NHS had served a formal performance notice on the healthcare department requiring improvements to be made.

Previous deaths at Bullingdon

25. Similar to the IMB and HMCIP, some of our previous investigations of deaths at Bullingdon found deficiencies in healthcare delivery at the prison. On this occasion, we found no significant areas of concern and think that received a good standard of care.
26. Following a previous investigation into the death of another Bullingdon prisoner in a local hospital in June 2011, we were critical of the use of restraints during escorts to hospital six months prior to the man's death. We

made a recommendation that the Governor should ensure that escort arrangements were proportionate and took into account the views of health professionals. In their response to the draft version of our report about the man's death, the managers at Bullingdon assured the Ombudsman that the earlier recommendation had been accepted and acted upon.

ISSUES

The diagnosis of the man's terminal illness

27. The man was found guilty on 24 November 2011 of a number of serious sexual offences against family members. He was remanded into custody to await sentencing and taken directly to HMP Bullingdon.
28. The man had already been diagnosed with stomach cancer and had been told by his consultant that he would not recover. He had undergone an operation in the summer, but no further treatment was planned. The escort staff who transferred him to Bullingdon wrote on the Person Escort Record (PER) that he had terminal cancer.
29. When he arrived at Bullingdon, he informed the reception healthcare staff of his terminal diagnosis. He was already very unwell and had lost a lot of weight. He said that he had been given between two and six months to live. One of the GPs working at Bullingdon immediately, and appropriately, admitted him to the inpatient healthcare unit.

Informing the man about his condition and treatment

30. The man already understood his diagnosis when he was admitted to custody. At Bullingdon, he had regular contact with the prison GPs, his consultant at the hospital and a visiting palliative care nurse, who all talked to him about his prognosis as his condition deteriorated.
31. He arrived at Bullingdon with a 'Do Not Resuscitate (DNR)' form. He had already decided that he did not want cardiopulmonary resuscitation (CPR) if he stopped breathing. He completed another DNR form with a GP at Bullingdon on 17 January 2012.
32. We are satisfied that the man was appropriately updated about his condition while he was in custody, including being given information when a scan showed a deterioration in his prognosis.

The man's appointments and treatment

Outpatient appointments

33. The man was escorted to all of his outpatient appointments. When he arrived at Bullingdon, he had an outstanding appointment with his consultant at the hospital on 16 December. The appointment was subsequently moved because of a court appearance booked for the same day. Instead, he was taken to the hospital on 21 December.
34. The consultant contacted the prison healthcare team after this consultation to advise that the man had experienced a significant deterioration in his health. He wrote:

“I reviewed him today. He looked awful and has lost a huge amount of weight from when I last saw him. In these circumstances he is virtually certainly has a metastatic disease [meaning that the cancer had spread to other parts of his body] and I have informed him honestly of this.... Given his appearance today, I suspect sadly his life expectancy is measured in weeks or at best a small number of months.”

35. The man attended a further appointment at the hospital on 13 January 2012. He then went to another outpatient appointment with the consultant at the hospital on 25 January. The consultant told him that his cancer had spread to his upper abdominal area and he was unlikely to live more than a matter of weeks. The consultant informed prison healthcare staff that he should now be referred to a hospice.

The man's diet

36. The man was referred to a dietician. She saw him regularly from 26 November and proactively addressed his dietary needs, which were complex because he was diabetic and his cancer had originated in his stomach. Part of his stomach had been removed during an earlier operation.
37. On 16 December, the dietician contacted a colleague in the catering department because she was concerned that the man and another patient needed extra calories and protein and asked to be informed if there was any reason why this could not be provided. The following day, 17 December, she devised a dietary care plan for the catering department.
38. On 16 January, she telephoned a palliative care nurse at the hospice for advice about the man's diet. The nurse suggested that she telephone the oncologist at the hospital. The next day, a nurse from the oncology department agreed to talk to the consultant about the man's diet. The dietician wrote in the clinical record that she would require advance notice if he were to require artificial nutritional support because staff at Bullingdon would need specialist equipment and training.
39. On 23 January, the dietician drew up another care plan for the man's diet because of his significant problems with nutrition and eating. She also spoke to a doctor about his poor hydration and weight loss.
40. We are satisfied that during his time in prison the dietician appropriately monitored the man's diet and sought advice where necessary.

The clinical reviewer's opinion

41. The clinical reviewer makes the following comments about the man's treatment at Bullingdon:

“Care in the prison medically seemed to be very appropriate with discussion of [his] symptoms, pain and sleep as well as care of

pressure areas. There were also offers of some informal counselling/listeners should the patient require it. There seemed to be good liaison with the oncologist and Macmillan nurses and good attendance by the dietician.”

42. We are therefore satisfied that the man received appropriate medical treatment during his time at Bullingdon.

The man's pain relief and medication

43. The man expressed reluctance to take strong pain relief medication because it made him nauseous. He was prescribed occasional doses of tramadol (a pain killer) from 4 December.
44. On 7 December, staff encountered difficulty when they could not locate his chart. They found his chart by the evening. This meant that his medication was dispensed at night rather than in the day on this occasion.
45. On Christmas Day, the man asked for tramadol but was given oromorph (another pain killer) as an alternative. As his condition deteriorated, he was again given increasing doses of tramadol from 31 December.
46. When the palliative care nurse visited the man on 19 January, she noted that he was still refusing oromorph and recommended an increase in his dose of tramadol. He had been taking regular medication to reduce his blood pressure and cholesterol but the doctor stopped these medications in light of his poor prognosis.
47. The man fell over on 21 January, possibly because the strength of his dose of tramadol had disoriented him. He asked for a reduction in his dose of tramadol, which was implemented until a GP could review the prescription. Two days later, the doctor agreed that the reduction in the dose of tramadol was sensible to prevent further falls. He was also occasionally given zopiclone, a strong sleeping tablet.
48. After the man's outpatient appointment on 25 January, the consultant advised that his pain relief medication should be increased and he should be prescribed oromorph. By 26 January, he was still refusing some of his medication. However, early the next morning he asked for oromorph. From this point onwards, his tramadol prescription ended.
49. From 28 January, the man's medication to control his diabetes was also stopped because of his poor prognosis. A doctor advised the nursing staff that he should be given as much oromorph as necessary. The next day, he asked for more oromorph because his pain had increased.
50. The doctor does not identify any concerns regarding the man's pain relief and we agree with his opinion that this was well managed.

Family liaison

51. It is good practice to begin the family liaison process before a prisoner's death if, like the man, they have a terminal illness and their condition is deteriorating. A trained family liaison officer (FLO) took on this role on 19 January assisted by an officer to cover a week's scheduled leave. The FLO spoke to the man after her appointment and confirmed that he wished his sister to be his named next of kin. She discussed his options with him, including a possible move to a hospice and what this would involve.
52. The close involvement of the family liaison team was important to ensure appropriate arrangements for the man's stay at the hospice because of sensitivities surrounding his offences. Where the victims are family members, there is always the possibility that relatives might direct their anger at the offender. An official from Thames Valley Probation Trust's Victim Liaison Unit (VLU) met members of the man's family on 31 January to inform them that he only had a very short time remaining and had moved to a hospice. His wife and two sons asked to visit him. The same day, the officer obtained his agreement to supervised visits. (As his named next of kin, his sister had already visited the hospice.)
53. The officer and a Detective Constable from the Child Abuse Investigation Unit in Windsor arranged and supervised a visit by the man's wife and sons to the hospice at 10.30am on 3 February. The officer was present to ensure his welfare and the DC attended to support his wife and sons. The usual two escort prison officers were also present.
54. The officer and DC asked the man's family not to discuss his offences with him but to use the time instead to say their farewells. This decision was taken by prison managers to reduce the risk of potential conflict. It was deemed too high risk for the staff present to manage any discussion of his offences at the hospice. Additionally, the meeting was not facilitated by someone trained to properly mediate a "restorative justice" meeting between victims and offender. Although his relatives had many questions to which they wanted answers, they complied with the request and the meeting passed peacefully.
55. The man's wife and sons planned to visit again, but were told by his sister that his death was imminent. The officer arranged for his wife and sons to visit the same day and she attended the hospice to supervise the visit. Once again, the visit passed peacefully. He died the next morning with his sister by his side. She passed the news of his death onto his wife.
56. The prison contributed towards the cost of the funeral, in accordance with the policy of the National Offender Management Service (NOMS). His sister collected his belongings from the prison on 20 February.
57. We commend the manner in which the FLO and the officer dealt with the man's relatives. They showed a great deal of sensitivity in a complicated family situation. They took account of the needs of the hospice staff, the man, family members and the victims of his offences and the arrangements were

an example of effective multi-agency cooperation. The visits were managed safely and the supervision involved was proportionate to any potential risk.

The man's location

58. Because he arrived in Bullingdon with an apparent terminal diagnosis, the man was immediately admitted to a single cell (number 17) in the inpatient healthcare centre. This was an appropriate decision. He remained in the healthcare centre from 24 November until 30 January. Once his condition deteriorated, staff planned for him to be admitted to a hospice. The healthcare team liaised regularly with the palliative care nurse to prepare for his eventual admission.
59. After his consultant confirmed that he should move to a hospice, he was placed on the waiting list for a bed at the hospice. Even for patients in the community, admission to a hospice for end of life care can be difficult to arrange. Alternative arrangements were explored, but on 30 January, a bed became available and he transferred there at 4.00pm that afternoon. Prison staff notified the Probation Trust's Victim Liaison Unit of his move to the hospice.
60. We agree with the clinical reviewer, who considers that the man was moved to the hospice at the appropriate stage of his illness.

Early release on compassionate grounds (ERCG) or release on temporary licence (ROTL)

61. Early release on compassionate grounds (ERCG) involves the permanent release of the prisoner with a terminal illness who is thought to have less than three months to live. Once ERCG is granted, the individual will have nothing more to do with the criminal justice system. A doctor needs to provide a clear and unequivocal diagnosis of the terminal illness. The released prisoner is not subject to licence conditions and returns to the community without restrictions. ERCG requires that the prisoner's release does not put the public at risk. The Governor must assess available evidence about risk before submitting an application to a team at the National Offender Management Service (NOMS) headquarters. Ultimately, any such application is forwarded to a minister for approval. Importantly, the decision to grant ERCG cannot be made on the basis of facts which were already available to the court at the time of sentencing.
62. Release on temporary licence (ROTL) requires a satisfactory risk assessment and the availability of suitable accommodation. The prisoner is not restrained by handcuffs. Escort officers can accompany the prisoner to provide support, manage risk and ensure that visits are managed safely. Prison Service Order (PSO) 6300 concerning ROTL states:

“Any release on temporary licence will only take place once the prisoner has satisfied a stringent risk assessment carried out by a designated ROTL Board at the establishment. Governors have an

overriding duty, when considering any release, to ensure that both public safety and public confidence in the system are maintained. There is no automatic right of entitlement for release on temporary licence to be granted.

“The procedures and policy applying to release on temporary licence are designed to ensure that suitable prisoners are released only for precisely defined and specific activities, which cannot be provided in establishments.

“The Governor must be satisfied that the release of any prisoner on temporary release would not attract reasonable public concern, in that the release would not be likely to undermine public confidence in the administration of justice, having regard to the stage of the custodial period reached.”

63. After the consultant advised the prison doctor on 21 December 2011 of the man’s deteriorating condition, she considered the possibility of early release. However, she wanted to wait for a more specific prognosis. After receiving a letter from the consultant, a doctor recorded on 6 January 2012 that his release should be expedited. On 11 January, a doctor wrote in the clinical record that he wished to die at home but realised that this was unrealistic. He had told her that he was content to die in a hospice.
64. On 15 January, following a request from a doctor, the Governor asked her staff to start preparing the man’s application for ERCG because he had only weeks to live. The plan was for him to move to the hospice when he could no longer care for himself. Prison staff tried to obtain a record of the judge’s sentencing comments as they were critical to the application, but this proved difficult. The Governor’s team confirmed his offences and took information from the pre-sentence report, the main source of information about risk available.
65. The Governor consulted the senior nursing manager, the Deputy Governor, a doctor and the Governor of Bullingdon. The doctor advised that he would die within two or three weeks and that his release should be expedited. He noted that the dietician had recommended intravenous fluids and artificial feeding, neither of which could be provided at Bullingdon.
66. Although staff continued to compile evidence for the man’s application for ERCG, the Governor told the investigator that it became evident that it would be unrealistic to make a case to ministers because of his very recent sentencing for serious offences. Available evidence showed that the judge had known about his terminal diagnosis at the time of sentencing. Staff began a parallel application for compassionate ROTL (also known as special purpose licence) as an alternative.
67. On 23 January, the DC (who had investigated the man’s original offences) gave her views about any potential release. She advised that he should not be released on grounds of ill health because the trial judge had imposed a

custodial sentence in the full knowledge of his prognosis. She stressed that the ordeal the victims had been through required justice to be served. She also highlighted the risk that his relatives might present to him if he was released, because of their anger at his offences.

68. On 25 January, the consultant telephoned the prison with the man's latest prognosis, which informed the ongoing ROTL and ERCG considerations. On 26 January, an officer spoke to him about his possible ROTL to a hospice.
69. On the ROTL form, the officer recorded that the man had complied with his bail conditions for more than a year and a half between his initial arrest and his conviction. However, she also noted that he remained in complete denial about his offences, and had pleaded not guilty, forcing his victims to endure a trial.
70. The officer contacted the local Probation Trust, which supported the application for ROTL provided the man was accompanied by a prison officer at the hospice. She also consulted the local Multi Agency Public Protection Arrangements (MAPPA) coordinator. She recorded that he had been fully compliant in custody and had not attempted to contact his victims. She collated comments from a Governor, the DC and the Probation Trust's Victim Liaison Officer.
71. On 27 January, the officer met the Head of Security and Operations to hold a ROTL board to consider the man's application. Among other issues, they considered possible media attention or public disorder at the hospice. She stressed during interview that the prison had a duty to the members of the public who use the hospice. Based on the evidence she had gathered, the Head of Security decided to recommend that the ROTL application should not be granted.
72. The deputy governor considered the application for ROTL on the same day, 27 January. She turned down the application, on the basis of the risk the man presented to children, the risk of possible reprisals against him from his family, the fact that he was only a month or so into a long prison sentence for very serious offences and the fact that his diagnosis had been known to the trial judge when he was sentenced. Additionally, he remained in denial about his recent serious offences, had not taken responsibility for his actions and could not therefore be said to have reduced his risk.
73. On 30 January, the man moved to a hospice as a serving prisoner under escort. The Governor of Bullingdon assessed his case on 1 February to determine whether a submission for ERCG should be made to ministers. He made his decision without the exact comments the judge had made on 23 December because he was so ill and the decision needed to be made quickly. However, the DC had already confirmed that his sentence was made by the judge in the full knowledge of how ill he was.
74. The Governor was satisfied that the man did not meet the criteria for ERCG because of the risk he presented to the public and the fact that he had only

recently received a custodial sentence from a judge who was aware of his prognosis. He did not therefore submit an ERCG application to NOMS for consideration by a minister. He was however content that further consideration could be given to ROTL if it was deemed appropriate.

75. The man's circumstances were relatively rare, in that he already had a terminal diagnosis when he arrived in custody. The illness progressed rapidly and he was sentenced only weeks before he died. The main obstacle to either ROTL or ERCG was his very recent sentencing. He received a 15 year sentence for very serious sexual offences at Crown Court on 23 December. The judge was aware of his terminal diagnosis when the sentence was made. The judge was also in possession of a pre-sentence report prepared by a probation officer who had contacted the prison healthcare team to discuss his prognosis and his solicitor had spoken to a prison doctor before sentencing to obtain the latest information about his illness. To allow ERCG would effectively have been to undermine the court's decision.
76. Prison Service Order 6000, which sets out the criteria for early release on compassionate grounds, makes it clear that 'a decision to approve release would not normally be made on the basis of facts of which the sentencing or appeal court was aware' and the man's case for ERCG failed on those grounds. We are satisfied that this was a correct decision.
77. Although the prison's assessment of the actual risk the man presented at the time he moved to the hospice is less persuasive, similar considerations applied to his ROTL. To have allowed ROTL could also have been seen to contradict the decision of the sentencing court and undermine public confidence in the system. In refusing ROTL, prison managers took account of public protection issues, the impact on the hospice and the nature of his offences.
78. It would have been inappropriate, even if it were possible, for the man to have returned to a domestic environment without supervision because his victims were family members. Additionally, there was some concern that his relatives might potentially present a risk to him. In the circumstances, the decision to move him to the hospice under escort allowed for supervised family visits that reduced any possible risk for all involved. We are content that the decision not to grant either ROTL or ERCG was justified.

Palliative care plan

79. Healthcare staff rapidly established and maintained contact with the local hospice and palliative care nurses. On 25 November, the day after the man's arrival in Bullingdon, a nurse telephoned the local Macmillan nurses for advice about palliative care. He made referrals to the Macmillan nurses and to local 'end of life' hospice. A Macmillan nurse telephoned the prison on 28 November to acknowledge the referral and confirm that a palliative care nurse would visit him in prison.

80. On 2 December, a prison doctor spoke to a palliative care nurse based at the hospice. She then visited the man on 15 December. She advised the staff to encourage him to accept pain relief, as he was reluctant to do so. He told her that he wanted to die in a hospice.
81. At the start of 2012, staff experienced some trouble arranging for a Macmillan nurse to continue these visits to the man in prison. On 9 January, they recorded that this was an ongoing issue. On 12 January, a prison doctor spoke to a doctor at the hospice about his poor prognosis. The doctor at the hospice agreed that a nurse from the hospice would visit him the following week.
82. The palliative care nurse then visited the man again on 19 January. After his appointment with the consultant on 25 January, it became apparent that he was approaching the end of his life. Prison healthcare staff contacted the palliative care nurses, who agreed that he should be referred to a hospice.
83. The man had an apparently well thought out care plan, and we agree with the clinical reviewer who comments in his review of the man's clinical care that appropriate care plans and end of life pathways were in place.

The use of restraints and the escort at the hospice

84. Because of the seriousness of the man's offences and the fact that he had only very recently been sentenced, the Governor decided that he should be single handcuffed to an officer with an escort chain when he was admitted to the hospice on 30 January. (An escort chain is a piece of chain several feet long with handcuffs on either end. It allows the escort officer to remain at a distance from the prisoner while he receives treatment.)
85. A Senior Officer (SO) completed the first part of the escort risk assessment and recorded that the man presented a medium risk of escape and a medium risk to members of the public. There is no significant explanation included in the documentation to support a medium risk assessment. A member of healthcare staff was supposed to complete the 'Medical information' section of the risk assessment but nobody did so. (This section specifically asks whether there are any medical objections to the use of restraints.) The Governor authorised the risk assessment.
86. Two escort officers remained with the man at the hospice. (The deputy governor told the investigator that this decision was taken not only to manage the prisoner's risk, but also to allow the two officers to support each other.) He was not allowed to use the telephone at the hospice in case he contacted his victims. The duty governor at Bullingdon had to give permission before he received any visitors. The escort officers were told to ensure that he had no contact with any children who might be visiting other patients in the hospice. The escort chain was removed whenever he needed to bathe with the help of hospice staff. He was noted to be always polite and cooperative whilst he stayed at the hospice.

87. At 5.00pm on 6 February, a governor visited the hospice, gave the escort staff permission to remove the escort chain and updated the risk assessment. A doctor then gave the governor a letter for the Governor of Bullingdon in a sealed envelope (which was in fact opened by the deputy governor the following morning):
- “[The man] has deteriorated significantly in his general condition and mobility since his admission on 30 January 2012. With this in mind we do not feel that there is any realistic risk of him attempting to escape from the ward. We would be grateful if you could notify us as soon as possible that his handcuffs can be removed.”
88. Thirty six hours later, at the very end of the man’s life, the escort officers left the room to allow him to be alone with his sister. He died with his sister by his side at 12.20am.
89. The investigator spoke to the governor about the use of restraints. She recalled that she discussed a possible transfer to the hospice with the man after she was appointed as the FLO. She told the investigator that she clearly explained that this move would involve the use of an escort chain as long as he remained mobile because of the risk he presented. She told the investigator that he understood the need for the use of the escort chain and the presence of two escort officers.
90. The investigator spoke to the deputy governor about the use of the escort chain. She fully supported the SO’s and the Governor’s risk assessment. She visited the man at the hospice and checked on the security arrangements. She explained that his room was located on the ground floor and opened out onto the hospice grounds. The door could not be secured. Additionally, he continued to smoke and had to be escorted through the hospice to reach the smoking area. She commented that he could have potentially encountered or spoken to children visiting other patients during these trips. She said that he remained mobile for some days and was still able to walk to the toilet. For all of these reasons, and bearing in mind he continued denial of his offences and risk to children, she endorsed the use of the escort chain until he lost all mobility on 6 February.
91. The deputy governor told the investigator that she spoke to the managers at the hospice when she visited. She discussed the arrangements for his stay and made sure that hospice staff had sufficient information to understand his potential risk to children. She spoke to the hospice managers about the use of the escort chain and they agreed to the use of restraints until his circumstances changed, as they did on 6 February.
92. The man’s sister told our family liaison officer that she was unhappy with the use of the escort chain when her brother was clearly very unwell. She noticed that the weight of the chain had caused her brother’s skin to bleed. The governor visited the hospice and asked for a bandage to be applied to the man’s arm because she noticed that the escort chain was rubbing it.

93. The managers at Bullingdon considered that the man presented a medium risk of escape. They considered that his risk was exacerbated because of his recent conviction and because he continued to deny his offences. They therefore required restraints to be applied. However, we have seen little evidence that they fully considered his physical capacity at the time and the effect this would have had on his risk. This is one of the main reasons for a risk assessment in such circumstances. He was a very frail and sick man and had lost a great deal of weight. Realistically, we think that his risk should have been able to be managed adequately by the presence of two escort officers without the use of restraints.
94. The decision about the level of restraint required appears to have been made in advance. Additionally, the healthcare section of the escort risk assessment had not been completed. Had it been completed, it is possible that the man would have been assessed as low risk. It is particularly concerning that the healthcare assessment was not completed in the light of the information from his sister and from the governor that the escort chain was causing significant discomfort.
95. We are disappointed that one of our previous recommendations to Bullingdon, made after an investigation of the death of a prisoner in June 2011, does not appear to have affected the way the man's escort was handled. In that case, we recommended that the Governor remind all security staff undertaking risk assessments of the need to ensure that escort arrangements are proportionate and take into consideration the opinions of health professionals. We therefore share some of his sister's concerns about the use of restraints and make the following recommendation:

The Governor should ensure that all relevant sections of an escort risk assessment are properly completed. The risk assessment should fully take into account the medical condition of the prisoner and his physical capacity at the time.

96. After they read our draft report, managers at Bullingdon provided the following response to our comments in paragraphs 93 to 95:

'Bullingdon accept that some of the paperwork was not correct however, they dispute that managers did not consider the man's physical capability. This is one of the main risks that was looked at on the management visit by the deputy Governor and other governors during his time in the hospice. The managers asked [whether] he was moving and he had been walking to the toilet. He was frail but was able to support himself and be mobile. He was also located in a ground floor room with a patio door which gave easy access to the outside areas which he was, at times, capable of walking into. During a visit from the deputy governor, there was talk about whether the move to the hospice had taken place too early and consideration was being given to his return to Bullingdon.'

The bedwatch officers

97. Escort officers mostly avoided wearing their prison uniforms so as not to upset visitors to the hospice and to avoid attracting attention to the man. However, his sister said she was upset that on one occasion both escort officers wore prison uniforms. It is unfortunate that this happened and in general we regard it as considerate of the prison to allow the officers not to wear uniforms.
98. The man's sister was also unhappy with the conduct of two escort officers who did not check her identity when she arrived on 6 February and who she found discourteous. This brief lapse in security and family support is disappointing. It was inconsistent with the stated intention of prison managers to monitor any potential risk to him from family members. We draw the Governor's attention to her comments in the 'Investigation process' section of the report. After he has addressed the incident with the staff involved, we think that it would be appropriate for him to write to her explaining the outcome.
99. This incident aside, we note that the man's sister generally praised the support and treatment she received from other escort officers, singling out for particular praise the officer who was with her when her brother died. We hope that the Governor passes on her positive comments to the officer concerned.

CONCLUSION

100. The man died only two and a half months after arriving in prison and only six weeks after being sentenced. When he arrived at Bullingdon, staff immediately moved him to the prison's healthcare centre and later transferred him to a local hospice when his health further deteriorated. He regularly saw prison doctors and attended all of his outpatient appointments. We are satisfied that that he received appropriate medical care during his time at Bullingdon. Consideration was given to ROTL and ERCG, but ultimately neither was granted. Prison staff recorded their reasons for not pursuing these options, which followed Prison Service guidance. He was restrained for a week at the hospice. Regrettably the escort risk assessment was not completed properly and we consider the decision to use restraints did not fully take into account his physical condition.

RECOMMENDATIONS

1. The Governor should ensure that all relevant sections of an escort risk assessment are properly completed. The risk assessment should fully take into account the medical condition of the prisoner and his physical capacity at the time.

The Governor accepted the recommendation and provided the following response:

'The establishment will work with the healthcare provider to ensure the risk assessments take into account fully the medical condition of the prisoner.'