PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent investigations

Investigation into the circumstances surrounding the death of a man, at hospital in November 2011, whilst in the care of HMP Leeds

Report by the Prisons and Probation Ombudsman for England and Wales

June 2012

This is the investigation report into the death of a man who was in the care of HMP Leeds when he died in November 2011. He was 76 years old. A post mortem examination concluded that he died from a pulmonary embolism (a blockage of the main artery of the lung), right deep calf thrombosis (a blood clot in the calf) and carcinotatosis (widespread cancer). I offer my condolences to his family and friends.

The investigation was carried out by an investigator. I would like to thank the Governor of HMP Leeds, and his staff, for their co-operation during the course of our enquiries. I am also grateful to the local Primary Care Trust (PCT) for appointing a clinical reviewer to review the man's clinical care. As he died from natural causes, the findings of the clinical review were essential to my own conclusions.

The man had a history of lung cancer when he entered prison. In September 2010, it was diagnosed that the cancer had recurred and was terminal. He received palliative treatment and the clinical reviewer has concluded that the standard of care he received was very good and at least equitable to that which he could have expected in the community.

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 **June 2012**

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SUMMARY

1. The man was sentenced to 8 years imprisonment on 29 April 2010 at Crown Court for violent offences and taken to HMP Leeds. (This sentence was subsequently varied on 28 September 2010 to 7 years following an appeal.) He disclosed that he had previously suffered a heart attack, had a history of lung cancer and had hearing difficulties. He was a smoker, but wanted to stop.

2. In September 2010, the man was diagnosed with a recurrence of his lung cancer, and was placed under the care of a consultant oncologist (cancer specialist) at hospital.

3. The man was referred for palliative care (the form of healthcare that focuses on relieving and preventing the suffering of terminally ill patients). He was able to undergo chemotherapy to extend his life expectancy, and radiotherapy treatment to help manage his pain and spread of cancer. He was moved to the in-patient unit at Leeds, as he did not meet the criteria for release on compassionate grounds or discharge to a hospice. One evening in November, he became very unwell. He was taken to hospital but was pronounced dead at 9.18pm.

4. The clinical reviewer did not make any recommendations and concluded:

> "I think the overall medical care given to the man was very good and of a high standard. I was impressed with the palliative and personalised care that he received. I have no issues with any of the treatment that he received and in my opinion he is unlikely to have received better care if he had been at liberty in the community. I hope that fact that he received good quality care from the professionals who dealt with him is of some comfort to his family."

5. We make one recommendation as a result of this investigation concerning Release on Temporary Licence (ROTL) applications.

THE INVESTIGATION PROCESS

6. The investigation was opened on 18 November, when the Ombudsman's investigator visited HMP Leeds and was provided with all documentation relating to the man. Notices were issued announcing the investigation to staff and prisoners. No staff or prisoners came forward in response to these notices.

7. The local Primary Care Trust (PCT) asked a clinical reviewer to review the man's clinical care on their behalf. He was provided with the medical records to assist this review.

8. The investigator contacted Her Majesty's Coroner for West Yorkshire Eastern District to inform him of the nature and scope of the investigation and request a copy of the post mortem report. Upon completion, the investigation report will be sent to the Coroner to assist his enquiries into the man's death.

9. One of the Ombudsman's family liaison officers contacted the man's granddaughter on 7 December, and his son, who lives in Botswana, on 13 December, to inform them about the investigation and to invite the family to ask questions or raise concerns about the care of his whilst he was at Leeds. The family asked the following question:

    - Was he ever assessed for physiotherapy following a number of falls approximately one month before he died?

10. The 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?

11. The investigator has sought to address the issue raised by the man's family in the report. The family received a copy of the draft report as part of the consultation process. Having considered the investigation findings, they commented they had found the report informative and helpful, and had been happy with the care in general provided. However, they remained concerned with the speediness of his diagnosis of cancer and will raise these concerns at the inquest hearing.

12. The man's family in Botswana provided some further written concerns and remained unhappy with the level of communication from Leeds regarding his medical condition and the decision not to grant early release. The investigator has sought to address these. Any concerns not covered in the final report are addressed in separate correspondence to the family.

HMP LEEDS

13. HMP Leeds is a category B local prison holding up to 1,120 men. The prison serves Magistrates' and Crown Courts in the West Yorkshire area taking adult male prisoners on remand until trial and for short periods after sentence. Prisoners are held on six wings and in the healthcare centre.

14. Healthcare staff are available in Leeds 24 hours a day. By day, there is a doctor in the prison; at night cover is provided by nursing staff. At the time of the man's death, there was a nineteen bed inpatient unit which is located directly above the main healthcare department, staffed by prison and clinical healthcare staff. Primary healthcare staff at Leeds prison are commissioned and provided by Leeds Community Primary Care Trust (PCT).

HM Inspectorate of Prisons

15. HM Chief Inspector of Prisons last conducted an unannounced full follow-up inspection of the prison between 3-12 March 2010. The Chief Inspector at the time noted that since the last full inspection in 2007:

> "Overall, this is an encouraging report on a prison that has had to grapple with some serious underlying problems. Improvements were evident in all three of the areas about which we had concerns last time: respect, safety and activity. It was particularly pleasing that relationships between staff and prisoners, a major concern at the last two inspections, had improved markedly, though a minority of staff continued to cause concern. It is a credit to managers and staff that progress has continued, in spite of the obvious limitations in a large, old prison with a transient population and insufficient activity places.
>
> There was a 20-bed inpatient unit above the main health services department. It was clean and tidy, but not an ideal environment. It was staffed by hospital officers and discipline staff, all of whom worked well together to provide patient care. A member of the primary mental health and well being team was allocated to the unit daily."

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) whose members are appointed by the Secretary of State for Justice from the community. Their role is to satisfy themselves that the prisoners are treated humanely and justly and that there are adequate programmes for preparing prisoners for release. The IMB report directly to the Secretary of State for Justice if they have any concerns. They also submit annual reports about how the prison has met the standards and requirements placed on it. Members of the IMB have access to every prisoner, every part of the prison and every prison record.

17. In their most recent published annual report for 2010 the IMB made the following comments in respect to the provision of the healthcare centre:

> ”The team is very well led and there is a clear aspiration to matching levels of care with those expected outside of the prison. There has been considerable change and restructuring in recent months and healthcare staff have adapted well. The Healthcare Team have done excellent work this year with their involvement of prisoners in the delivery of health services. … The Board is concerned about the quality of the facilities in which healthcare is delivered – particularly for inpatients. The cells in the healthcare unit on H3 are of a very poor, dilapidated standard and are not conducive to the provision of quality healthcare. It is understood that capital funding of £100,000 has been set aside to improve these facilities and that approximately half the cells will be undergoing refurbishment in the near future.”

Previous deaths at Leeds

18. There was one previous death at Leeds in the past year, which was self-inflected. There have been 43 previous deaths in total since the Ombudsman was given responsibility for investigating deaths in custody in England and Wales in April 2004:19 due to natural causes (the most recent being in July 2010), 20 self-inflicted, two due to an illicit drugs overdose, one murder and one unclassified. The investigator reviewed the Ombudsman’s reports into the most recent natural cause deaths and she found no direct similarities between the earlier deaths and that of the man.

Person Escort Record (PER)

19. This is a form that accompanies prisoners on all journeys from and between prisons, police and hospital. It serves as a communication tool about risks a prisoner poses on escort or transfer. It also provides a chronological record of events during the journey, such as the times of meals and when the vehicle reached the destination.

Restraints

20. On each occasion that a prisoner is escorted outside the prison to hospital, a risk assessment considers the risk to the public, potential for escape and likelihood of outside assistance. The assessment informs the decision about the number of escorting officers and the type of restraint to be used (single cuffs, double cuffs or two metre long escort (closet) chain with a cuff at either end). It also determines the circumstances and the authority required for the restraints to be removed. The risk assessment is reviewed by prison managers each day that a prisoner is in hospital and amended where necessary.

Categorisation

21. Prisoners are risk assessed when they come into prison and given a category based on their offence and the risk that they pose to the public should they escape. There are four levels of category: A, B, C and D, with category A prisoners the most dangerous. The man was a category C prisoner, which are

prisoners who cannot be trusted in open conditions, but who do not have the resources and will to make a determined escape attempt. He returned to Leeds from Wealstun, a category C prison, due to his medical condition.

Prison Service Orders (PSO)

22. Prison Service Orders were long-term instructions intended to last for an indefinite period. They were introduced to replace Standing Orders, Advice to Governors and Instructions to Governors and were updated by the issue of Prison Service Instructions (PSIs). Guidelines written in italics within the PSO are mandatory instructions

ISSUES

The diagnosis of the man's terminal illness

23. The man entered custody on 29 April 2010 with a number of ongoing medical problems, including cataracts and some deafness. Following an initial healthscreen, he advised healthcare staff that he was worried about his health and disclosed that he had previously suffered from lung cancer. He said that, in July 2009, he had been diagnosed with papillary adenocarcinoma (lung cancer), had a resection of his right lower lobe (surgical removal of a part of the lung) and had undergone three cycles of chemotherapy (the use of anti-cancer (cytotoxic) drugs to destroy cancer cells. The drugs go into the bloodstream and travel throughout the body to treat the cancer cells wherever they are) between September and November 2009 under the care of a doctor at hospital.

24. The man was examined by a prison doctor the day he arrived at Leeds. A prison doctor examined him on 5 May, when he routinely reviewed his medications. He told the doctor that he had been "chesty since Jan 2010". Following this consultation, he was referred for a chest x-ray. He had this x-ray on 11 May and the results were received at Leeds on 14 May. A prison doctor noted that his x-ray was described as "essentially clear" and an ECG (electrocardiogram test- measures the electrical activity of the heart to help with diagnosis) completed on 24 May was normal.

25. Following his transfer to HMP Wealstun on 2 June, the man was regularly reviewed by healthcare staff. On 23 August, he requested to see a doctor as he had a cough and pains in his chest and was concerned that his cancer had recurred. He was examined the same day by a prison doctor, who noted that "chest few scattered creps [a sign of fluid or infection in the lungs]" and he was prescribed antibiotics for an infection. Later the same day, the doctor was urgently called to G wing as he complained of chest pain. The entry in the medical record, made by a nurse refers to the earlier examination by the doctor, but does not detail what occurred during this contact.

26. On 26 August, the man was reviewed by a nurse practitioner, as his symptoms had not improved and he felt increasingly unwell, with an ache in his right chest and abdominal pain. He was referred for an appointment the following day to the prison doctor and was examined by a doctor. She noted that, despite the course of antibiotics, he was still short of breath and he had not been reviewed by a specialist since April (although a routine follow-up appointment had been arranged with the hospital for 2 September). She requested blood tests and noted that effusion had started (effusion is excess fluid that accumulates between the two pleural layers, the fluid-filled space that surrounds the lungs). She also recorded the scheduled appointment with the speciallist.

27. The man was examined by a consultant in respiratory medicine at hospital on 2 September. He diagnosed that the man had a large right sided pleural

effusion and that “this is highly likely to represent a recurrence of his adenocarcinoma”.

28. In his consideration of the diagnosis, the clinical reviewer notes:

> “He [the man] attended his hospital appointment with the consultant in respiratory medicine on the 2nd September 2010. He noted his chest pain, weight loss and shortness of breath. He confirmed the presence, both clinically and radiologically, of a large right sided pleural effusion. He immediately concluded that this was likely to represent recurrence of the lung cancer. This was discussed with him [the man].”

29. When the man was suspected of having a recurrence of his cancer he was referred appropriately. In light of the clinical reviewer’s comments, and the fact that he was told in a timely manner, we conclude that the diagnosis of his terminal illness was appropriately handled.

Informing the man about his condition and treatment

30. According to his medical records, hospital and healthcare staff both at Wealstun and Leeds ensured that he was fully informed at all times about his condition, from the initial diagnosis and including the potential treatment options.

31. During his appointment with the consultant in respiratory medicine on 2 September, he raised the possibility that his cancer had recurred and the consultant confirmed this. In a follow up letter to the prison doctor, the consultant stated “If this is confirmed as malignant recurrence his [the man’s] life expectancy is likely to be in the order of months. I have not communicated that estimate with the patient”.

32. On his return to Wealstun on 2 September, the man was assessed by a staff nurse, who recorded that she had a one-to-one discussion with him about his diagnosis, when he reflected that he needed the support of his family.

33. On 5 October, the nurse accompanied the man to an outpatient’s appointment with a consultant at the hospital. He was advised by the consultant that his life expectancy could be between 3-6 months but, with treatment, it could be prolonged and recommended chemotherapy to try to achieve this. He was referred to a hospice’s palliative care team and he requested that his family were told of his condition, which Wealstun healthcare agreed to do.

34. In his report, the clinical reviewer comments as follows:

> “He [the man] appears to have been rather stoical at times and did not always want to bother the staff with his ongoing problems. This was understood by staff who I can see asked regularly after his needs and feelings. It is apparent that he was able to talk fairly

> openly and frankly to a variety of staff members with regard to his future and so was helped to make arrangements about his funeral and what to do about his possessions both inside and outside prison. He did have several significant problems though throughout the latter part of his life and in my opinion each one was dealt with competently and appropriately by the nursing, medical and prison officer staff who looked after him."

35. The man was informed of his diagnosis by a hospital doctor. On his return to prison, he had a conversation with a nurse about it, where he shared his concerns. Furthermore, a prison nurse accompanied him where he was informed of his prognosis. Given these interactions, we are satisfied that he was appropriately made aware of his condition and prognosis.

The man's medical appointments and treatment

Appointments

36. In total, the man attended seven outside hospital appointments and no appointments were cancelled by the prison. However, he was due to be routinely reviewed in July 2010, prior to his diagnosis, but this did not happen. The clinical reviewer notes:

> "The man was transferred to HMP Wealstun on the 1st June 2010. At the time of this transfer healthcare staff had been told by the hospital staff that he [the man] had missed his last hospital appointment in mid April [prior to entering custody] and that he was on a waiting list for a follow up appointment in July 2010. This message was followed up by HMP Wealstun healthcare staff two days later and they were told that he had not got an appointment yet for his routine check-up."

37. Following his appointment with the doctor at Wealstun on 26 August, he had already been sent his routine follow-up appointment for 2 September. The clinical reviewer comments:

> "He [the man] was seen at the end of August by two of the attending medical officers and the consultations were within four days of each other. At the second consultation it was apparent to the examining doctor that there were new chest symptoms and signs suggesting a possible pleural effusion. This was the first time medical staff had found chest signs that raised the suspicion of a further chest problem that could be serious. The hospital follow up appointment was just six days away so this came at exactly the right time and there was no delay in getting a specialist opinion.
>
> "When he was taken into custody he may have just recently missed a routine follow up appointment at the hospital but he had been placed on a waiting list for another one. It is unlikely that this had any major impact on his care."

38. Although the man missed a routine review appointment prior to entering custody, this was unlikely to have been significant. Following sentence, the prison ensured that he attended all appointments and we are satisfied that attendance was prioritised, ensuring that he received appropriate care.

Treatment

39. The man told a nurse on 2 September 2010 that he was in "terrible" pain, and she advised the healthcare manager. The consultant in respiratory medicine made an urgent referral for the pleural drains to be fitted (a tube that is inserted into the chest wall which is attached to a drainage pot that allows excess fluid to be removed from the pleural area relieving the pressure in the chest) and he was admitted to hospital on 10 September where the drain was fitted. There is a letter from the consultant confirming that he was admitted to hospital for this procedure, but no record of this in his electronic medical record.

40. On 5 October 2010, a consultant met the man at hospital. The possible treatment options were discussed, and he was made aware that palliative chemotherapy (the form of healthcare that focusses on relieving and preventing the suffering of terminally ill patients) would be offered. This treatment was not a cure, and he was made aware that it might extend his life expectancy by approximately 10 weeks. He signed a consent form and two cycles of chemotherapy were administered, the first commenced on 13 October and the second on 3 November. In addtiion, he underwent two cycles of radiotherapy (the use of high energy rasy to destroy cancer cells) in 2011 in an attempt to stop his tumour spreading and as a means to help manage his pain.

41. The clinical reviewer writes:

> "It is clear from the regular and clear communication from hospital that his [the man's] recurrent cancer was not going to be curable and all further treatment would be about palliation of symptoms and perhaps adding a month or two onto his short life expectancy."

42. The clinical reviewer adds:

> "By the end of June 2011 he [the man] was complaining of a rash around the exit site of his Pleurx drain…He was reviewed by a consultant on the 12th July it was clear that this was metastatic cancer that had spread to this place. The consultant asked the radiotherapists therefore to organise two sessions of radiotherapy to try and stop these tumour deposits growing any further and also reduce the pain from them … The two sessions of radiotherapy took place at the end of July and early August 2011."

43. By the time of the man's diagnosis, his treatment options were limited to managing his symptoms, rather than curing the underlying illness. He

underwent chemotherapy and radiotherapy and we agree with the clinical reviewer that his treatment was appropriate to his needs.

The man's pain relief and medication

44. The man was prescribed all the medications directed by the hospital consultant and palliative care nurse. At the time of his death, he was prescribed the following medication:

- Fentanyl (for severe pain relief)
- Prochlorperazine (to treat dizziness and problems with balance, and for nausea and vomiting)
- Pregabalin (for pain relief)
- Salbutamol (to aid breathing).

45. When considering the man's pain relief and medication, the clinical reviewer says:

> "A plan for increased pain relief, a referral to palliative care nursing and a chemotherapy regime was drawn up and this is well documented. During December 2010 there are occasional entries in the medical notes to suggest that he [the man] was feeling less well with some breakthrough pain. He was offered top up morphine on several occasions and this appears to have been effective."

46. 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.

Liaison with the man's family

47. He was made aware of his diagnosis on 2 September 2010. He was in regular contact with his family and he was able to advise them of his condition. Following his attendance at hospital on 5 October, he asked the nurse if she could arrange a telephone call to his son in Botswana so he could tell his son of his prognosis. She made several attempts to speak with his son but was unable to make contact. On 6 October, he told healthcare staff that he felt depressed as he was thinking about his children and found it difficult to speak to his wife in Zimbabwe about his health issues. This was because his international phone card only allowed for two minutes of conversation.

48. The nurse made several attempts over the following days to contact the man's son in Botswana, without success. She contacted another family member on 9 October and was provided with a different telephone number, but no contact was made.

49. Following his transfer back to Leeds on 15 October, a Healthcare Officer (HCO) was appointed as the prison's family liaison officer (FLO). The HCO had regular contact with various members of the man's family. On 16

October, a governor gave permission for him to receive telephone calls from his family, which enabled him to speak to them more regularly and he was able to make contact with his son in Botswana.

Visits

50. The man had been regularly visited by his extended family throughout his time in custody. On 20 October, 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, if they wish friends or family to visit them, they must send a visiting order which the visitor uses to book a visit. Orders are usually valid for 28 days. The form requires that the names and addresses of all visitors to be given and visitors must bring proof of identification before they are allowed in.) On 18 January, he was visited by his son who lived in Botswana. Throughout the remainder of his time in Leeds, he continued to receive telephone calls and visits from his family.

51. The HCO assisted the man's family following his death. He ensured that the man's property was returned to his nominated next of kin and offered funeral expenses on behalf of the prison. He kept a detailed record of contact he had with the family and we consider that he undertook this role with good effect.

52. The provision of the telephone calls from the family and the arrangement of family visits without visiting orders shows that the liaison with them was good, and we consider that they were well supported by Leeds.

The man's location

53. The man was transferred to HMP Wealstun on 2 June 2010. His terminal illness was diagnosed in September 2010 and it was decided to return him to Leeds, as they were able to provide full time health care. A referral was made to a hospice in Leeds on 7 October. In a letter dated 14 October 2011 the Macmillan Nurse Specialist, wrote:

> "Place of care – Whilst there has been some discussion around desire to transfer him [the man] to hospice care, on this assessment it did not appear that he was at a point where he completely fitted the criteria for hospice admission i.e. within the last short weeks of his life or with very difficult to manage symptoms. I did offer to refer him with all the information available to myself to allow another hospice in Leeds to clarify this decision themselves, however he preferred to return to his normal place of residence"

54. The man returned to Leeds on 15 October 2010. In an interview with the investigator a prison doctor said in response to how he presented when he returned to Leeds:

> "When he went out I had to really bend down to put my ear right next to his mouth to hear what he was trying to say. And when he came

> back he was sat on the bed having a chat with me. He was dramatically better."

55. The doctor told the investigator during interview that the man's condition had not deteriorated to the point where he would have met the criteria for transfer to a hospice and that his symptoms could be satisfactorily managed at Leeds. He remained an inpatient in the healthcare facility at Leeds, apart for his admissions to hospital. The HCO confirmed that, after his return to Leeds from Wealstun, there was an open door policy, whereby his cell door was left open to ensure that healthcare staff had easy access to assist him if necessary.

56. The clinical reviewer concludes:

> "The need for terminal care in a hospice did appear to be a distinct possibility on several occasions so a request for a ROTL was submitted in mid August. In the end the medical teams both at hospital and the healthcare unit at HMP Leeds did not request a hospice place. This was because on at least two occasions he [the man] rallied and was able to return again to the healthcare unit."

57. Given the conclusion of the clinical reviewer, we are satisfied that the man was located correctly. Leeds acted appropriately by ensuring that staff were able to enter his cell easily if they needed to.

Compassionate release

58. Prisoners suffering from a terminal illness and for whom death is thought likely to be imminent (generally a life expectancy of three months or less) can be considered for release from prison on compassionate grounds. An application must be sent to the Public Protection Unit (PPU) in the National Offender Management Service (NOMS) headquarters. The application form includes sections to be completed by the Governor, a prison doctor and an offender manager (responsible for assessing risk, managing the sentence plan objectives and authorising any release accommodation). A full prognosis must also be provided. Once the form is submitted, caseworkers in the Public Protection Casework Section (PPCS) determine whether the application meets the criteria set out in Prison Service Order (PSO) 6000 (the instruction that deals with the release and recall of prisoners). When making the decision, the caseworkers consult with the Parole Board (an independent body which considers each case focussing on the risk of re-offending and on re-integration into the community) and specialist medical advisors in the Department of Health. PSO 6000 states:

> "The criteria applied in medical and tragic family circumstances cases are as follows:

Medical

- 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."

59. An application for early release on compassionate grounds (ERCG) was made on behalf of the man by a prison doctor on 10 March 2011. The application included details of his medical condition and gave his life expectancy as between 6 and 12 months. The Governor of Leeds considered this application on 25 March but, as the man had only been sentenced in April 2010 and the assessed level of risk he posed was still present, he was deemed ineligible for ERCG.

60. He made an application for ROTL (Release on Temporary Licence) for special purpose leave on 17 August to visit his niece in Leeds. Further information was requested by the ROTL clerk on 25 August (a memo was sent to the man asking him to clarify details of his application) but there is no evidence available as to whether he responded to this request. The investigator was unable to establish if this application had been fully processed.

61. During an interview with the investigator, the manager of the ROTL clerk said he initially thought that this application referred to a request to be released to a hospice. He recalled that he made numerous telephone calls to various prison departments and the hospital regarding the man, but was not able to provide any evidence to support this. Documents relating to a ROTL application in respect to a hospice placement were not provided to the investigator. Although the investigator did not consider that this was a deliberate attempt to avoid providing the information requested, it indicated that the recording of the ROTL application process needed to be improved. He commented during interview that he and his colleagues were extremely busy, did not have time to keep a record of all such contacts and the IT facilities did not support such work. He stated:

> " … the channels of communication were very blurred. And this seems to be a feature of this particular function in fact, the ROTL process, which I'm trying desperately to get made a bit better. At the time we didn't have any, had so many structures in place, as we do at the moment, and we were given the form and then that normally sets in train a set process of dealing with administration on these things."

62. The clinical reviewer comments:

> "So in my opinion I do not think that any confusion and poor communication regarding certain aspects of the ROTL process led to any negative consequence for him [the man]. I think if he had become more slowly symptomatic and extremely frail a hospice place would have been secured easily and quickly enough for him to have been transferred there in his final few days."

63. PSO 6300 (Release on Temporary Licence) states:

> "*The Governor must develop a written protocol outlining how PSO 6300 – release on temporary licence will be locally administered*."

64. The investigator was provided with a copy of Leeds' local protocol, dated July 2011. In the section relating to the administration of an eligible application, it states:

> "The processing AO [administrative officer] will be responsible for generating and administering the process and should aim to complete the paperwork within 5 working days from the date of the original application. To help this process and where possible electronic documentation should be used in preference to paper copies.
>
> "The responsible AO will maintain a spread sheet tracking system that will indicate the progress of each application and ensure paperwork is returned in a timely fashion within the 5 working day cycle"

65. Despite the fact that there was some confusion by the prison regarding the nature of the ROTL application, there is no evidence that this directly affected the man, or influenced any decision to transfer him to a hospice. However, in a wider context there was evidence that the management of ROTL applications could be improved. It is unclear if there was ever an application for release to a hospice, so the investigator is unable to conclude if any documents had gone missing. There should be a more robust recording system to ensure that any communication regarding a ROTL application, particularly concerning a terminally ill prisoner, is better evidenced so each stage is managed in a timely manner and the prison are able to provide a clear audit trail.

The Governor should ensure the recording process for ROTL applications is managed in line with Leeds' local ROTL policy.

Palliative care plans

66. 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."

67. The man was placed on the Gold Standard Palliative Care Framework. This is a means of optimising care for patients nearing the end of their life, and is aimed specifically at medical staff. His care was reviewed at monthly meetings of the Gold Standard team (attended by a prison doctor, healthcare staff and the palliative care nurse), the details of which were recorded in the electronic medical notes. An end of life care pathway was established, which is a robust guide that includes all aspects of care that might be required for someone who is terminally ill. One of the important features of the plan is monitoring someone's pain, and there is evidence that at almost every encounter healthcare staff had with him they asked if he needed any additional pain relief.

68. On 14 October 2010, at a specialist palliative care team meeting, the Macmillan nurse (a specialist cancer nurse) met with the man during a visit to Leeds. The Macmillan nurses continued to have input into his care plan and were willing to visit him at Leeds when required.

69. In addition to his physical care, there is evidence that his emotional needs were also well considered, evidenced by the number of daily interactions with healthcare staff and staff's facilitation of contact with his family.

70. The clinical reviewer notes:

> "The healthcare unit at HMP Leeds used the Gold Standards Framework in palliative care when assessing and then managing his needs over the next 12 months of his life until his death. There is evidence of good and high quality medical care in following these guidelines. It was good to see the occasions of joint working with palliative care Macmillan nurses and also excellent facilitation in getting him [the man] to his appointments and treatment and also in arranging for him to receive visits, phone-calls and personal care when required."

71. In summary, prison healthcare staff provided a high standard of palliative care with attention to both the man's physical and emotional needs, which is an example of best practice.

Restraints, security and bed watch

72. On each occasion when a prisoner is escorted outside the prison to hospital, a risk assessment is undertaken to consider the risk to the public, potential for escape and likelihood of outside assistance. The assessment informs the decision about the number of escorting officers and the type of restraint to be used (single cuffs, double cuffs or two metre long escort (closet) chain with a

cuff at either end). It also determines the circumstances and the authority required for the restraints to be removed. The risk assessment is reviewed by prison managers each day that a prisoner is in hospital and amended where necessary.

73. Leeds considered the risk posed by the man to the public, his security category (C) and assessed that he should be subject to a single cuff and escorted by two officers when outside of prison. On each occasion, he attended outside hospital or was admitted to hospital, this assessment was reviewed. Authority was given to remove restraints if requested to do so by medical staff for examination or when he underwent any diagnostic procedure, and the use of an escort chain was authorised during admissions.

74. The risk assessment procedures were appropriately followed, regularly reviewed, and we consider them reasonable in the circumstances.

Family concern

75. On 25 September 2011 at 8.46am, a nurse has recorded that “He [the man] has fallen out of bed twice no injuries seen”. Due to his deteriorating health, including low oxygen levels and dehydration, he was transferred to hospital later that day. In a subsequent entry made by the nurse on 8 October, she recorded, in respect to the above incident; “He did not fall from the bed to the ground but that his lower extremities i.e. legs were dropped off the side of the bed as though he was trying to get out of the bed but got stuck”. This is the only recorded incident of him falling in the months preceding his death.

76. The man’s family asked if physiotherapy was considered following this fall. The investigator did not see any specific evidence that physiotherapy was considered. However, he was receiving significant support and care from healthcare staff. In addition, the Macmillan nurses regularly reviewed his palliative care plan which covered every aspect of his care and well-being and we are satisfied that, if physiotherapy had been appropriate, he would have been considered.

CONCLUSION

73. During his time at Leeds, the man had well documented and regular interventions 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 equivalent to that available in the community.

RECOMMENDATIONS

1. The Governor should ensure the recording process for ROTL applications is managed in line with Leeds' local ROTL policy.

   Partially accepted - *HMP Leeds local ROTL policy will be withdrawn and we will produce a local protocol as outlined within PSO 6300 which will include clear management arrangements regarding ROTL applications. Target date for completion 30 April 2012.*