PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the death of a man at Leicester and Rutland Hospice in April 2012 while in the custody of HMP Onley

Report by the Prisons and Probation Ombudsman for England and Wales

September 2012

This is the report of the investigation into the death of a prisoner at HMP Onley. The man died at Leicester and Rutland hospice in April 2012 of small cell carcinoma of the lung. I offer my condolences to his family and friends.

The investigation was carried out by one of my investigators with the full cooperation of Onley. A clinical reviewer was commissioned to conduct a review of the clinical care the man received at Onley.

In April 2011 the man was sentenced to four years imprisonment at Leicester Crown Court. Seven months after he arrived at Onley he began to feel unwell. Tests were undertaken and in January 2012, a diagnosis of cancer was confirmed.

The man received active treatment for his cancer and was regularly admitted to hospital for chemotherapy. Appropriate arrangements, including 24 hour nursing care, were made to help him continue to live on his residential unit in the prison, among his friends. On 10 April, his health deteriorated significantly and he was transferred to hospital. Soon after he moved to Leicester and Rutland hospice where he remained until he died.

The investigation indicates that the use of restraints when the man was admitted to hospital was not fully justified by a fully balanced risk assessment, but overall I agree with the clinical review that he received a very high standard of care from prison and healthcare staff at Onley. The man's family and friends were also treated with commendable sensitivity.

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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Prisons and Probation Ombudsman **September 2012**

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SUMMARY

1. In April 2012, the man was sentenced at Leicester Crown Court to four years imprisonment. He was sent to HMP Onley. During a routine health screen when he arrived, he said that he had no concerns about his health. He had no further contact with healthcare until 24 November, when he reported a consistent cough and headache.

2. On 7 December, after his symptoms got worse the man was diagnosed as having pneumonia and was prescribed antibiotics. He had a chest X-ray at hospital on 12 December, which showed he had fluid on his lung. He remained in hospital and a scan showed swelling of the lymph glands in his neck and chest cavity. Samples were taken and tested, and a diagnosis of cancer was made.

3. As the symptoms were unclear the hospital was not at first able to diagnose the type of cancer. On 9 January, the man was told he had either germ cell cancer (a cancer of cells formed during development as an embryo) or lung cancer. The man was told that germ cell cancer could be curable, whereas lung cancer would not.

4. Tests continued and hospital staff believed that a diagnosis would be clearer after a course of chemotherapy. The man had four cycles of chemotherapy, but these were not successful. In between hospital treatment he remained living on his wing at Onley with suitable adaptations to care for him. On 10 April, the man's condition deteriorated and he was admitted to hospital. A scan on 11 April, showed the cancer had spread. The consultant in charge of the man's care confirmed that he had lung cancer and the man was told he had no longer than three months to live.

5. The consultant concluded that further treatment was unlikely to be effective and the man was to be treated palliatively. On 18 April, the man moved to Leicester and Rutland Hospice where he was cared for until he died.

6. In the days that followed the prison family liaison officer maintained contact with the man's family and offered appropriate support.

THE INVESTIGATION PROCESS

7. The Ombudsman's office was notified of the man's death on the day of his death. Notices were issued to staff and prisoners at HMP Onley to inform them of the investigation process and asking anyone who had information relevant to the investigation to contact the investigator. Four prisoners were interviewed as a result.

8. A clinical reviewer was commissioned to conduct a review of the clinical care the man received in custody. The clinical reviewer received copies of all relevant medical and prison documentation.

9. The investigator visited Onley on Tuesday,1 May 2012. She met the prison's family liaison officer, the Head of Healthcare, an Independent Monitoring Board (IMB) representative and a Prisoners Officers Association (POA) representative. The investigator received all of the documentation relating to the man's time in custody including his medical record.

10. The investigator and the clinical reviewer interviewed staff on Thursday 5 July.

11. HM Coroner for Northamptonshire was informed of the investigation and a copy of the post mortem was requested. A copy of the investigation report will be sent to the Coroner to assist with her enquiries.

12. One of the Ombudsman's family liaison officers (FLO), contacted the man's sister shortly after his death. She explained the investigation process and invited his sister to ask any questions or raise any concerns about the man's care. The man's sister did not raise any specific questions, but said that his family would like to find out a bit more about what happened and whether the man had received appropriate care. His sister was positive about the support she had received from a manager at the prison and the chaplain.

13. 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.

HMP ONLEY

14. HMP Onley is an adult male category C prison, near Rugby. It can hold up to 710 prisoners, over 12 wings. Northamptonshire PCT provides the healthcare services. There are daily weekday clinics in the healthcare centre and out of hours services are provided by the same service as in the community.

HM Inspectorate of Prisons (HMIP)

15. HMIP last conducted an inspection of Onley in November 2010. Inspectors noted that the healthcare centre was clean and well managed. Access to the general practitioner (GP) service was good. There was a good range of nursing and specialist clinics in the healthcare centre, including some innovative programmes in holistic care. Procedures for the management of the terminally ill were satisfactory. Inpatient beds at a neighbouring prison were used when required.

Independent Monitoring Board (IMB)

16. Each prison is monitored by an Independent Monitoring Board of unpaid volunteers from the local community. Board members monitor all aspects of prison life to help ensure that proper care and decency are maintained. The most recent IMB annual report for Onley covers the period March 2011 to February 2012. The IMB reported that the main issue for healthcare was coping with staffing vacancies which had had a significant effect on the operational effectiveness of the team, particularly in mental health services.

Previous deaths at Onley

17. The man was the second prisoner to die of natural causes at Onley since 2004, when the Ombudsman began investigating all deaths in prison. There are no similarities between the previous investigation and this report.

ISSUES

The diagnosis of the man's terminal illness

18. The man was sentenced on 11 April 2011, to four years imprisonment for violent offences, and was sent to HMP Onley. He had a first reception health screen with Nurse A (the aim of the health screen is to identify any needs or health concerns that the prisoner might have). The man said that he had a family history of diabetes, but did not have any concerns about his health. There were no significant entries in the man's clinical record in the following months.

19. On 24 November, the man complained of a cough and headache and was examined by Dr A. The doctor noted that his chest was clear and diagnosed a viral infection. The man was advised to rest and was prescribed co-codamol for pain relief. His cough persisted and he was examined by Nurse B on 30 November. His chest was still clear and he was given cough syrup and paracetamol.

20. Nurse C reviewed the man on 5 December. The man said that he had a headache and had been seen by healthcare staff twice in the previous weeks. He said that paracetamol was not helping. The nurse advised him to continue taking paracetamol and ibuprofen. He was to be reviewed by the doctor in two days, but told he should let healthcare staff know if his symptoms became worse before then.

21. The following day, 6 December, the man returned to healthcare and was assessed by Dr B. The man said he had a sore throat and was coughing up sputum. He was also experiencing shortness of breath and felt weak, which he said was unusual for him. The doctor noted that his glands were raised and he had "crackles" in his chest and could not hear any air entering his right lung. She diagnosed pneumonia and prescribed antibiotics. The doctor asked for an urgent chest X-ray and to see him again in two days.

22. Dr B reviewed the man on 8 December. He was not any better, but she noted that had started the antibiotics only the day before (7 December). She advised the man to rest and said she would see him again in a week. An appointment for a chest X-ray was made for 12 December.

23. On 10 December, the man was taken to healthcare by wing staff as he was having difficulty breathing and complaining of pain across his chest and back. Nurse D examined him and noted that there was still reduced air entry to his right lung. The man was admitted to hospital for investigative tests. A chest X-ray at the hospital on 12 December showed that there was pleural effusion on the right side of his chest (fluid around the lung).

24. The man remained in hospital and had a scan which showed swelling of the lymph glands in the neck and chest cavity. After samples were taken from the lymph glands, cancer was confirmed on 3 January, although at this stage the type of cancer was unknown. It was not until 11 April that the hospital were

able to confirm that it was lung cancer and that the man was unlikely to live longer than three months.

25. The Clinical reviewer comments that there was no delay in referring the man for investigation when he had symptoms of serious illness, and the diagnosis of cancer was made quickly. She further comments that the ultimate cause of death was spread from the original cancer. Despite treatment this type of cancer is commonly found late in its development with "poor prospect of curative treatment".

Informing the man about his condition and treatment

26. The man was told he had cancer by hospital staff in December. On 8 January, he was given information on germ cell cancer, which at the time was considered a possibility.

27. On 9 January, the man's nurse key worker at the hospital explained to him that he would be having chemotherapy treatment. She explained what would happen and the side effects. She also told the man that they were still unsure exactly what the form of cancer was. The man was told that they were going to treat him for germ cell cancer as his blood tests and other symptoms had indicated it was either that or lung cancer. He was told that germ cell cancer was very treatable, but his condition would not be curable if it was lung cancer. Ongoing tests were carried out and it was thought that there would be more clarity of the diagnosis when chemotherapy was completed. Onley's family liaison officer (FLO), and the chaplain were present when the man was informed about his condition and offered him emotional support. At his request, the man's family were contacted so that he would have additional support from them.

28. The man was nursed at the hospital and in the prison during January, February and March. He was admitted to hospital on 10 April, due to deterioration in his condition. A computerised tomography (CT) scan (which creates an image of the inside of the body) was carried out on 11 April. This indicated that despite many sessions of chemotherapy treatment, the cancer was still active. His consultant told the man that his condition was terminal and he had a matter of weeks left to live. Prison records comment that he took the news with great dignity but was clearly upset and shocked. The consultant explained the future care the man would receive and the support mechanisms available such as through Macmillan nurses who specialise in caring for patients in the later stages of cancer.

29. The consultant contacted the prison's residential manager to let her know the man's prognosis. The prison's residential manager visited the man in hospital later that afternoon to offer support to him and his family.

30. It is clear from prison records that a structured and effective process was put into place to communicate with the man throughout his illness. The clinical reviewer concludes that the spread of cancer was explained to the man while he was an inpatient at the hospital. The information given to the man was

timely and appropriate and good communication between the hospital and healthcare staff at the prison enabled him to be kept informed at all times.

The man's medical appointments and treatment

31. Following the initial diagnosis of cancer, the man attended regular appointments with healthcare staff at Onley and Coventry University Hospital, to manage his treatment, medication and general health needs associated with his condition.

32. Between 12 December and 20 March, the man had four cycles of chemotherapy mainly as an inpatient, but with some day attendances. His condition deteriorated and he went back to into hospital on 10 April. At that stage the consultant responsible for his care concluded that further treatment was unlikely to be effective.

33. The clinical reviewer described the planning of the man's return to the prison after the initial diagnosis as exemplary. Multidisciplinary meetings were held regularly to ensure that all staff involved with the man were aware of his care needs. The Health Improvement Nurse at Onley, said that these worked well and that officers, a governor, the chaplaincy, healthcare and wing staff including the man's personal officer were involved. The purpose was to ensure that a care plan was put in place that would be no different than if he were returning to his home in the community.

34. The man was monitored as at risk of suicide and self-harm between 9 March and 10 April as he had become depressed and said that he "wanted to end it all" and that he was having thoughts of suicide. Prison and healthcare staff worked together to monitor the man closely, engaging with him in planning ways of reducing his thoughts of self-harm and helping him to build sources of support. Alongside the clinical care plan, this ensured the man was extremely well supported. The man was offered counselling by the prison, but refused it. His mental heath was continually reviewed and he was prescribed antidepressant medication.

35. The man's blood count dropped on numerous occasions. When this happened he was quickly admitted to hospital for blood transfusions and then discharged back to Onley once his blood count was stable. The man attended all of his hospital appointments. There is no evidence of any issues with arranging escorts or appointments being cancelled.

The man's pain relief and medication

36. The man's medication was reviewed at Onley on 26 January. The following medication was prescribed:

    Diazepam (used for sedative, anxiety-relieving and muscle-relaxing effects)
    Docusate (assists with bowel movement)

Fortisip yoghurt style liquid (nutritionally balanced dietary supplement)
Cyclizine (to treat nausea and vomiting)
Amitriptyline (antidepressant)
Benzydamine (an anti-inflammatory mouthwash, used for a painful mouth)
Chlorhexidine gluconate (to prevent gum disease)
Gabapentin (used to treat types of long-lasting pain caused by damage to nerves)
Paracetamol (pain relief)
Senna (laxative)
Zopiclone (to assist with poor sleep)
Oxycodone (pain relief)
Omeprazole (reduces the amount of acid produced in the stomach)

37. As the man had lost a lot of weight and was generally weak he was prescribed high calorie supplement drinks to help build up and maintain his weight. The man took these alongside his regular meals.

38. The man was prescribed strong pain relief and anti-sickness medication. The medications were kept in the wing healthcare room and staff were able to access his medications when needed. At the beginning of February, the man began to experience problems swallowing. His tablet medications were changed to a soluble form and he was provided with a soft diet.

39. As the man's condition deteriorated he became low in mood and was prescribed antidepressants. On 29 March, he was reviewed by Dr C. At this appointment the man said that he did not feel any change in his mood and he was also having trouble sleeping. The dose of his antidepressant medication was increased.

40. Dr C comments that the man was regularly seen and his medication reviewed by the prison doctor. Particular attention was given to try and help his low moods and physical discomfort which increased as the cancer progressed.

The man's location

41. On 19 January, healthcare and prison staff met to decide how they would facilitate the man's care when he returned to Onley from hospital. He was discharged from hospital on 25 January, and a care plan was created to help ensure that his needs were met. A multi-disciplinary meeting was held on the morning of his discharge to ensure that all staff were aware of his needs and the arrangements for his care during the night. The man had a ground floor single cell with a shower on a residential wing.

42. On 7 February, the man reported to wing staff that he was feeling cold during the night and needed extra heating. An additional heater could not easily and safely be arranged in his cell so he was moved to another cell where one was provided. He was also given a hot water bottle.

43. Although healthcare staff do not usually work at night at Onley, the prison had arranged overnight nursing cover when the man was discharged from hospital to ensure his needs were met. On 18 March, during treatment, he discharged himself unexpectedly from hospital as he preferred to return to the prison after his treatment was completed. It was not possible to arrange overnight nursing cover at such short notice but the man accepted this. Wing officers were told that if they had any concerns they could contact the hospital directly or ring for an ambulance.

44. On 19 March, the man said that he found his is bed was very uncomfortable, due to the amount of weight that he had lost. A special mattress and pillow were ordered, and staff contacted the PCT to see if they could obtain a hospital bed. The mattress and pillow arrived on 22 March. There is nothing in the records to say whether the hospital bed was obtained. The man was admitted to hospital just over two weeks later, and did not return to the prison.

45. On 4 April, healthcare staff contacted the healthcare department at HMP Leicester to ask about the possibility of the man transferring there for 24 hour healthcare. The move was not pursued as Leicester was able to offer only basic care. The man continued to be cared for in his cell at Onley. Healthcare staff provided 24 hour care with the help of agency staff. On 10 April, he became very unwell and weak. He was transferred to hospital for further assessment and treatment when it was recognised his condition was terminal. On 18 April, the man moved to the Leicester and Rutland Hospice, close to his family. He died there.

46. Although some prisoners said that the man was dissatisfied with his treatment, we found that he was given a lot of support from other prisoners and prison staff. One prisoner, who was particularly close to the man said that the prison were “amazing” with the treatment they provided him. As he became increasingly ill, he got his food for him, did his laundry and cleaned his cell. He said he spent a lot of time with the man to keep him company.

47. The Clinical reviewer comments:

> “The man was supported on the wing where he had friends and staff known to him. When his health deteriorated transfers to hospital were agreed and undertaken. Contingency planning for alternative care took place at an early stage, and when it became clear he only had a short time to live his admission to a hospice was agreed with him”.

48. We agree with the clinical reviewer that the man was properly located to suit his health and care needs at all times. The move to a hospice ensured he died with dignity and received appropriate end of life care.

Liaison with the man’s family

49. The prison chaplain and the Head of Decency visited the man in hospital on 3 January, after being told he might have cancer. The man asked them not to

inform his family at this stage, but gave the contact details of his sister in case of an emergency.

50. Officer A was appointed as the prison family liaison officer for the man and his family. The man was told of the support available to him.

51. On 5 January, a multi-disciplinary meeting was held to discuss how the man and his family could be supported. Many issues were discussed, such as early discharge, release on temporary licence (ROTL) and palliative care. An action plan was agreed, which included the officer being given time to visit the man to help build a rapport with him and his family, and to offer support.

52. Officer A told the investigator that she built a good relationship with the man, and when she felt his family should be contacted, she suggested it. The man agreed and on 9 January the officer spoke to his sister and explained the family liaison role. They discussed the man's treatment plan. The officer arranged for additional family members to be added to the list of visitors to attend the hospital.

53. Officer A met the man's sister at the hospital on 15 January. They discussed the uncertainty of his diagnosis and the treatment he was having. The officer kept in regular telephone contact with the man's sister. They discussed the changes in his condition and arrangements for his family to visit him both in hospital and at Onley. A special visit was arranged on 9 February, to allow the man's mother and sister to visit him on the wing.

54. On 11 April, Officer A, the prison chaplain and the residential manager met the man's family at the hospital. The man and his family had just been told that his cancer was terminal and his life expectancy was no more than three months. At the hospital the man was able to contact his family directly by telephone from his bed.

55. When the man's condition deteriorated on 21 April, Officer A and the prison chaplain went to the hospice to offer support to the man's mother.

56. The man died during the afternoon and his family were with him. The prison chaplain attended the hospice to ensure the family were appropriately supported. The prison remained in contact with the man's family, assisted with funeral arrangements, and in line with national policy offered a contribution to the costs. A memorial service was held on 25 April, enabling prisoners and staff to pay their respects. Commendably, two prisoners who were close friends of the man were allowed release on temporary licence so that they could attend his funeral.

57. The man's family have asked that we specifically highlight and give thanks to Officer A whose support they found invaluable before and after the man's death.

58. We are satisfied that the liaison with the man's family was of a high standard before and after his death. This is reflected in the feedback given to us by the man's family.

Compassionate Release

59. Early release on compassionate grounds is a means by which prisoners who are seriously ill can be permanently released from custody before their sentence has expired. The criteria for early release are set out in Prison Service Order (PSO) 6000, chapter 12. Compassionate release can be considered on medical grounds where a prisoner is suffering from a terminal illness and a death is likely to occur soon. A clear medical opinion on life expectancy is therefore needed.

60. When the man was first diagnosed with cancer in December 2011, the hospital was unsure which type it was and was not able to give a clear prognosis. Without a clear medical opinion on life expectancy it was not possible to progress an application for compassionate release at that stage.

61. It was not until 11 April that the man was given a prognosis, and on 12 April a medical report was sent to the Governor of Onley and the compassionate release process was started. The report said that the man's condition was poor and his life expectancy was less than three months. Compassionate release was recommended and it was suggested that accommodation should be sought from a hospice in the Leicester area. A probation risk assessment completed that day advised that the man's level of risk to the public and of re-offending was likely to reduce as his condition deteriorated. Unfortunately the man's condition got worse more quickly than expected and he died before a final decision on the application for compassionate release was made.

62. Although the man did not get compassionate release he had applied for release on temporary licence (ROTL) in January and February. This had not been allowed because of his perceived risk at the time. After he was diagnosed as terminally ill on 11 April, ROTL was reconsidered and agreed on 12 April, so long as he remained at the hospice at all times. Although released on temporary licence he was accompanied by an officer in civilian clothing.

End of life care plans

63. The NHS document 'The route to success in end of life care – achieving quality in prisons and for prisoners' sets out how an end of life care pathway might be implemented in prisons. Among the benefits of an end of life pathway are that it helps carers to plan when and how care will be delivered, and helps patients make choices about how they are cared for towards the end of their lives. There are various examples of end of life care pathways, including the Liverpool Care Pathway (LCP). The LCP includes a template which staff involved in caring for a dying patient complete. There is no record

of a written end of life pathway being completed for the man. However, once he was diagnosed with terminal cancer his death happened much more quickly than anticipated. It is clear that there was an effective care plan in place for him and both prison and healthcare staff met regularly to review his care.

64. The man was routinely consulted and informed of his diagnosis, prognosis and treatment. He was involved in decisions about where he lived and contact with family and friends. Multidisciplinary case meetings were held at the prison including the discussion of end of life issues.

65. The man needed 24 hour healthcare when he was discharged from hospital on 25 January. A care plan was created to ensure that his care needs were met appropriately. An agency nurse covered the night shift from 7.00pm to 8.00am. The man's cell door remained open during the night to enable staff to easily access. As his condition changed and his health began to deteriorate, the care plans were amended to reflect this and any changes in his care needs.

66. The clinical reviewer makes no specific comment about end of life care plans, however comments that "the prison planned and delivered medical, nursing and additional support resourced to a high level and with commitment to provide what was needed for his physical and mental health needs at all times".

67. We are satisfied that the man's care at Onley was well planned and delivered with sensitivity and many of the matters covered by an end of life pathway were included in his care plan. We make no criticism of his care but best practice would have been to use a formal documented pathway to help ensure that no matters were overlooked.

The Head of Healthcare should ensure that a formal end of life pathway is implemented when a prisoner nears the end of life.

Restraints, security and bed watch

68. When prisoners are escorted to hospitals, a risk assessment should be completed which considers the risk posed to the public by the prisoner, their potential for escape and the likelihood of outside assistance. The assessment informs the decision about the number of escorting officers and the type of restraint to be used if they are needed. The risk assessment should effectively balance security needs with the health and dignity of the prisoner, and be reviewed by prison managers each day that a prisoner is in hospital and amended as necessary. The assessment should include medical opinion about how the prisoner's condition impacts on his risk.

69. A risk assessment form was completed for the man's admission to hospital on 10 December. He was assessed as a medium risk to the public, though no details are given for that judgement, and a low risk for hostage taking, escape and potential outside assistance. He was restrained by an escort chain and a

single handcuff. The completed form referred to his previous convictions, and behaviour in prison, but there is no assessment of his health and its deterioration. The assessment indicates that as he was a "serving Category C prisoner" restraints were to be used.

70. The assessment completed on 10 December was reviewed daily until the man was discharged from hospital on 25 January. No changes were made and his risk was viewed as constant. The reviews records that he was to be handcuffed when outside of his room at the hospital, but that he should not be restrained at all when undergoing any treatment. The assessment stated that staff should be made aware that "due to his fear, the man may exhibit anger and aggression toward staff".

71. The man had many admissions to hospital for chemotherapy treatment and blood transfusions. On each occasion he was restrained using a handcuffs and an escort chain and was accompanied by two escort officers. The escort chain was generally removed when he received intravenous treatment. However, there was at least one occasion, on 13 February, when the log records that handcuffs were removed and the escort chain applied when he was receiving chemotherapy. No explanation is given. He was generally polite and quiet during the admissions, although there were some incidents when it was alleged that he made inappropriate comments to the escort and nursing staff, which were not believed to be a side effect of his treatment. On 9 February, he had asked if the restraints could be removed while he was an inpatient at hospital. This was refused because it was noted that he had been regarded as aggressive toward prison staff on 6 February. It was recorded in case review notes that his level of restraint would be reviewed subject to his behaviour and risk assessment.

72. When the man was taken to hospital on 10 April, he was not restrained. He was assessed as low risk to the public, of hostage taking, and of escape. While it does not go into details it concluded that due to his current state of health, no restraints were to be used. The residential manager completed the managers daily risk assessment for prisoners on escort on 12 April. The risk assessment shows that his condition had not changed, but the man's level of escort had changed as he had been granted ROTL. He was subsequently accompanied by one officer, not wearing uniform.

73. A concordat between the National Offender Management Service (NOMs) and the NHS, agreed in 2008, about security arrangements for prisoners at hospital notes:

> "using handcuffs or other restraints on terminally ill or seriously ill prisoners is considered inhumane by the courts, unless justified by security considerations"

74. We accept that it is possible that the man could have been regarded as some risk during his earlier hospital admissions, but the risk assessment used was based entirely on the prison's view of his security risk with little evidence that there was any consideration of how his health condition impacted on this risk.

The risk assessment form used at Onley does not include a prompt for a prisoner's medical condition and mobility to be considered. While it was agreed that restraints should be removed when he was undergoing treatment this was not always done. We are not satisfied that the risk assessment took fully into account all of the relevant circumstances, particularly his health.

The Governor should ensure that use of restraints for prisoners being taken to hospital is fully justified by risk assessments that take into account and record how the prisoner's health and physical condition impact on his risk while outside the prison.

CONCLUSION

75. When the man was first diagnosed with cancer in January, 2012 the exact type was unknown. Chemotherapy treatment was ineffective and in early April 2012 he learnt that he had untreatable lung cancer. The man's health deteriorated very quickly and he moved to a hospice on 18 April where he died. There was insufficient time after the clear diagnosis of lung cancer to arrange compassionate release, but he was released to the hospice on temporary licence. The man received good care at Onley while he was receiving treatment and a night nurse was employed specifically for that purpose. We agree with the clinical reviewer that the man's care was of a standard equal to what he might have expected in the community and some aspects were better, although there was no formal end of life care plan. We are concerned that risk assessments for the use of restraints when the man was in hospital did not take fully into account his state of health. Good arrangements were made to support the man and his family during his illness and after his death. We also commend the arrangements to allow two of the man's friends at the prison to be released on licence to attend his funeral.

RECOMMENDATIONS

1. **The Head of Healthcare should ensure that a formal end of life pathway is implemented when a prisoner nears the end of life.**

NOMS accepted this recommendation and make the following comment:

"The report recognises that all aspects of the Liverpool protocol were followed other than formally using the Liverpool care pathway documentation. The head of healthcare will in future use that documentation to evidence compliance."

2. **The Governor should ensure that use of restraints for prisoners being taken to hospital is fully justified by risk assessments that take into account and record how the prisoner's health and physical condition impact on his risk while outside the prison.**

NOMS accepted this recommendation and make the following comment:

"Governors responsible for completing escort risk assessments and authorising cuffing arrangements have been made aware of the Ombudsman's observations. Medical restrictions form part of the generic form and therefore we will ensure that it has been given due consideration as part of our risk analysis leading to cuffing instructions to the escorting officers."