

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at HMP Hull in
February 2013**

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is the investigation report into the death in February 2013 of a man at HMP Hull. He was 69 years old. The cause of death was established by post-mortem as bronchopneumonia due to cancer of the tonsil. I offer my condolences to the man's family and friends.

The investigation was carried out by one of my investigators and a review of the man's clinical care in custody was carried out by a clinical reviewer. HMP Hull cooperated fully with the investigation.

Overall, I am satisfied that the man was diagnosed appropriately in March 2012, and received very good care and support from staff at HMP Hull in the remaining months of his life. However, recommendations are made to ensure formal consideration of early release on compassionate grounds in cases such as this man's and to ensure that the use of restraints is always justified by appropriate risk assessments which fully take into account the prisoner's state of health.

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

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SUMMARY

1. At the time he was sentenced to prison in December 2009, the man was in remission from cancer of the tonsil which had been diagnosed and treated four years earlier. In December 2011, he began to experience dizzy spells and blackouts and a prison doctor referred him to a neurologist at a local hospital. Three appointments were cancelled – all for different reasons – and he did not see a neurologist until July 2012. In February 2012, an urgent referral was made to the Ear, Nose and Throat team at a local hospital when the man reported new symptoms in his throat. Tests undertaken in March showed that he had a new cancerous tumour.
2. The clinical reviewer concludes that the man was referred and diagnosed appropriately when he presented with the new symptoms. Nevertheless, we share his concern about the lengthy delays surrounding the neurology referral.
3. The man's cancer was assessed as untreatable. He was initially very unwell after diagnosis, and spent some time living in the prison's healthcare inpatient unit. In September, he was well enough to return to his wing, although he required the assistance of other prisoners to help with everyday tasks and was visited frequently by prison nurses. The man's health slowly deteriorated again and, in December, he returned to the healthcare inpatient unit.
4. In the weeks after his diagnosis, prison healthcare staff discussed with the man his wishes for future care. These were respected, and frequently checked. The Liverpool Care Pathway was initiated in February 2013, when he was very unwell and considered close to death. The man died later that month.
5. A principal officer (PO) kept in touch with the man's daughter after his diagnosis, and provided commendable support over the course of the year. As he is not a trained family liaison officer, another officer took over the formal liaison role after the man's death.
6. Early release on compassionate grounds was not considered at any stage following the man's diagnosis. The prison acknowledged that their processes for initiating an application were undeveloped and we recommend that early release is considered for all terminally ill prisoners. We also conclude that the man was inappropriately restrained when he went to hospital, and recommend in line with legal guidance and guidance from the Prison Service that greater consideration is given to a prisoner's health and mobility when determining the risk.

THE INVESTIGATION PROCESS

7. On 18 February 2013, notices were issued announcing the investigation to staff and prisoners at Hull, inviting anyone who had relevant information to contact the investigator. No one came forward.
8. The investigator visited Hull on 26 February. During the visit, he saw the healthcare unit where the man lived for the last two months of his life and A wing, where he spent much of his earlier time at the prison. He spoke to the prison's modern matron (a healthcare manager) and an officer who was in contact with the man's family. He also spoke to two prisoners who knew the man well.
9. The investigator returned to Hull on 29 April and interviewed two members of staff. He met the deputy governor to provide feedback on the initial findings of the investigation and followed this up in writing to the Governor.
10. A clinical reviewer carried out a review of the man's clinical care in custody on behalf of NHS Hull. He joined the investigator for the interviews on 29 April.
11. One of the Ombudsman's family liaison officers spoke to the man's daughter, his nominated next of kin, on 7 March, to explain the investigation. His daughter said she did not have any immediate concerns or questions for the investigation to address. She thought the care her father received in prison was better than he could have expected in the community and was very happy with the actions taken by the prison.
12. The report was sent in draft to the Prison Service, whose response to the recommendations can be found at page 19. The man's daughter declined to see the draft report, and reiterated her previous comments that she was happy with the care her father received.

HMP HULL

13. Hull is a local prison, which holds up to 762 remand and sentenced male adult prisoners and young offenders. There are ten wings. The man lived on I wing for much of his first two years at Hull, before moving to A wing in summer 2011.
14. Health services are commissioned and provided by NHS Hull. There is an inpatient unit with 24-hour nursing cover, which holds a mixture of prisoners with mental health conditions and physical health problems. GP surgeries are provided four days per week, with an out of hours service available at other times. The inpatient unit includes a specialist palliative care suite.

HM Inspectorate of Prisons (HMIP)

15. HMIP conducted an unannounced short follow up inspection of Hull in February 2012 of a full inspection in November 2008. The Inspectorate found that healthcare had improved since their previous inspection including a specific member of staff to lead on the care of older prisoners and those with disabilities. Inspectors were concerned that some prisoners had been admitted to healthcare inpatient beds without a diagnosed physical or mental health need. At the previous full inspection, HMIP found that palliative care arrangements at the prison were good.

Independent Monitoring Board (IMB)

16. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. There are no recently published annual reports from the IMB at Hull. However, the deputy Chair told the investigator during his initial visit that the IMB had some concerns about staff attitudes and some of the procedures in healthcare.

Previous deaths at HMP Hull

17. The man was the fifth prisoner at Hull to die since January 2011. Of the four previous deaths, one was due to natural causes. Our investigation into that death found that the man, who was elderly and had a significant medical history, received appropriate clinical care.

ISSUES

The diagnosis of the man's terminal illness

18. In 2005, four years before his imprisonment, the man was diagnosed with cancer of the tonsil. He had extensive surgery to remove the tumour, as well as follow up radiotherapy to reduce the risk of a recurrence which left him unable to produce saliva or swallow. He therefore received all food and medication through a tube fed into his stomach. He was diagnosed with various other chronic diseases and was prescribed a range of medications to alleviate his symptoms.
19. On 4 December 2009, the man was sentenced to eight years imprisonment and arrived at HMP Hull the same day. His community GP provided a detailed breakdown of his health needs. Other than some initial problems with his dietary arrangements, he appeared to settle well.
20. On 9 February 2010, the man had an annual cancer review with a consultant at outside hospital. The consultant found no evidence of recurrence, and asked that he return in one year for his next review. On two occasions later that year, prison doctors made referrals for suspected cancer in other parts of his body, but hospital consultants found nothing to indicate cancer. His next annual cancer review was held on 24 March 2011. As previously, the consultant found no evidence that the cancer had recurred.
21. On 16 December 2011, the man told a prison nurse that he had experienced some dizzy spells. Four days later, a prison doctor reviewed him and requested blood tests, including blood sugar levels, to help determine the cause. The results were available on 21 December and showed nothing abnormal.
22. The man had two further dizzy spells later that month and nurses were called to see him as he briefly lost consciousness. He recovered quickly each time. He saw a prison doctor on 30 December, who made a referral to the neurology department at outside hospital. An appointment was received for 14 March 2012, but this was later cancelled by the hospital and rearranged for 3 May.
23. The man reported no further dizzy spells until late January. He told a prison nurse on 12 February that the spells were increasing in frequency. A prison doctor noted at a review on 20 February that the man's voice had been hoarse for more than a month. He considered that this, and the man's other symptoms, might indicate a recurrence of the previous cancer, and made an urgent cancer referral to the Ear, Nose and Throat (ENT) department at outside hospital under the two week rule. In his referral, which was sent on 23 February, he highlighted the man's previous diagnosis and that he had been hoarse for over four weeks.
24. After an examination at his ENT appointment, on 8 March, the consultant speculated that the man might have a new tumour originating in his throat.

He arranged for an urgent magnetic resonance imaging scan (MRI, a scan that provides detailed pictures of the organs).

25. The man's health declined further and, on 19 March, he was admitted to outside hospital after experiencing vomiting, heartburn and a swollen face. He remained in hospital for one month and had the MRI scan on 22 March. This revealed a new cancerous tumour in the uppermost region of the throat behind the nose (a nasopharyngeal primary).
26. The clinical reviewer comments that the neurology referral contained only very brief clinical details and there was nothing to alert the consultant that it was an urgent matter. Nevertheless, he concludes that this type of referral was correct at the time and there was no information to suggest that it should have been made under the two week rule, a target for people with suspected cancer to be seen by a specialist within two weeks. The clinical reviewer adds that a two week referral was appropriate when the man presented with new symptoms in February and was correctly made by the prison doctor. Although we note a three day delay between the consultation and sending the referral, we are satisfied that his symptoms were recognised and the correct referral and diagnosis made.

Informing the man about his condition and treatment

27. When he made the two week referral on 23 February 2012, the prison doctor recorded that the man was aware of the potential diagnosis. The MRI scan that confirmed the diagnosis took place during the first days of a month long inpatient admission to outside hospital. Although not explicitly recorded in prison documents, we understand that the man was told of this diagnosis in hospital and that he was aware that the cancer was not treatable.
28. When he returned to the prison, the man moved into a cell in the healthcare inpatient unit. His discharge note indicated that only palliative care was possible. Several members of staff recorded that they had discussed the diagnosis with him and, on 23 April, he had a long discussion with a prison doctor about his future wishes. The clinical reviewer notes that there are extensive records of discussion of the man's treatment. We are satisfied that he received appropriate information and support after his diagnosis.

The man's medical appointments and treatment

29. The man had no further hospital appointments to treat his cancer after his diagnosis because only palliative care was possible. However, during his stay, the hospital also investigated his dizzy spells and blackouts. He saw a cardiologist (heart specialist) and had a pacemaker fitted on 3 April 2012, as doctors thought that the blackouts might have been caused by an irregular heartbeat. (A pacemaker is a battery-operated device inserted into the chest that sends electrical pulses which help keep the heart beating regularly.)
30. The man was very unwell after he returned to HMP Hull. He was found unconscious on several occasions and, at one stage, was checked every half

an hour by healthcare staff. An end of life care pathway was opened on 3 May 2012 but, although he still experienced frequent blackouts, the man's health improved. A neurology appointment (following a prison doctor's initial referral in late December 2011) for 3 May was cancelled because the man preferred to attend a visit planned for the same day.

31. The neurology appointment was rearranged for a second time on 23 May, but the man again did not attend as the prison could not provide sufficient escorts for the number of outpatient appointments that day. The healthcare manager explained that there are four appointment slots available each day (two in the morning and two in the afternoon). When there are more than this a senior nurse decides which four appointments should be prioritised. The others are then rearranged, although there are occasions when additional escorts are made available if there are three urgent appointments in the same session. It was determined that other appointments were more urgent than the man's that day and his appointment was rearranged for 31 July.
32. On 29 May, the man attended an appointment to check whether a faulty pacemaker might be a cause of his blackouts. The specialist concluded that the pacemaker was working well. By July, the blackouts were less frequent and of shorter duration and, by September, they had stopped.
33. At a review at outside hospital on 18 July, a consultant head and neck surgeon again confirmed that treatment for the man's tumour was not appropriate. The consultant concluded that, as they could offer no further treatment, no follow-up appointments were necessary. An appointment was inadvertently made for 8 August, at which the consultant repeated his conclusion.
34. The man's neurology appointment took place on 31 July, seven months after he was first referred. In his discharge letter, the consultant apologised for the delay, commenting that the clinics were "under huge pressure" (although the previous two appointments were cancelled by the man and then the prison). The consultant considered the extent of his recent blackouts and the new cancer diagnosis. He asked for an urgent CT scan of the brain and that he return to the clinic in two months to review the results.
35. An appointment for the CT scan at outside hospital was made for 10 August, but the man did not attend. The investigator was told that no appointment letter was received at the prison. The consultant neurologist wrote to the prison on 24 September about this. A second appointment was made for a scan on 21 November and follow-up clinic the next day, which the man attended, but the results of the scan were not available. The consultant neurologist noted that the man's health had deteriorated, and he was now very weak and had difficulty speaking. He advised an urgent referral to the specialist palliative care team.
36. The man had no further outpatient appointments before his death in February 2013. The results of his CT scan were available on 23 November, and were outlined by the consultant neurologist in a letter to prison healthcare staff.

The scan showed that his primary tumour was now “very extensive” and had spread to the basal bones (part of the jawbone). There was no evidence of any other abnormalities. The clinical reviewer explains that the man’s episodes of dizziness and blackouts were not therefore related to the spread of the tumour to his brain, and were more likely a result of a heart condition.

37. As we have noted, there was a delay of seven months from referral until the man saw a neurologist. During this time, three appointments were cancelled for varying reasons: the first by the hospital, the second by the man himself and the third by the prison. He also missed his first appointment for a CT scan, in August 2012, seemingly because the prison did not receive the appointment letter. As another appointment was not available until late November, this meant that it was nearly 11 months from first referral until he had the required scan.
38. The clinical reviewer addresses the issue in his review but concludes that the delays following the man’s neurology referral would not have made a difference to the overall outcome, because the cancer was identified and assessed by the hospital’s ENT team following a prison doctor’s two week referral in February 2012.

Palliative care plans

39. In April 2012, after his diagnosis, the man was admitted to the healthcare centre inpatient unit. Several care plans were created on his admission, detailing the assistance he required with mobility and daily living. He was very unwell in the first weeks after his admission to the healthcare unit and, on 23 April, a ‘do not attempt cardiopulmonary resuscitation’ (DNAR) order¹ was completed. The prison doctor who completed the order discussed it with the man beforehand and recorded that he had the capacity to make the decision.
40. On 3 May, the healthcare manager asked the man about his wishes for future care. He said he wanted to die with dignity and without “nurses crawling all over me”.
41. The man continued to live in the inpatient unit for several months. His health improved a little and he was able to carry out his personal care without assistance. Consideration was given to asking a Macmillan nurse to assess the man in June, when his throat became sore and difficult to treat with standard painkillers. However, it was agreed that he should have a review with the consultant instead.
42. In the autumn, the man began to experience frequent vomiting and nausea. On 21 November, healthcare staff contacted a specialist doctor in palliative care at a hospice, who agreed to visit him. She assessed and gave advice on various aspects of the man’s care, including pain control. She recorded that

¹ A DNAR order means that in the event of cardiac or respiratory arrest no attempt at resuscitation will be made. All other appropriate treatment and care will continue to be provided.

he was gradually deteriorating and suggested that his likely life expectancy was weeks to a small number of months.

43. The man was admitted to hospital for two days on 5 December with a chest infection. When he returned to HMP Hull, he was readmitted to the healthcare centre inpatient unit. (He had lived on A wing since mid-September.) As previously, various care plans were put in place. It was recorded that he now required support and encouragement with all aspects of daily living. The DNAR was reviewed and re-signed on 10 December.
44. In a palliative care review on 24 January, the man told a prison doctor that he felt ready to die. The doctor reiterated the man's wish not to be resuscitated and to remain in prison. His health deteriorated in late January and early February. The Liverpool Care Pathway² was initiated on 5 February, and its aims were explained to him. His cell door was left open overnight, to allow healthcare staff immediate access.
45. The Liverpool Care Pathway was closed on 7 February, when it was determined that the man was not yet close enough to death to meet the criteria. It was begun again on 13 February, when his health had deteriorated further and he died shortly thereafter.
46. The clinical reviewer comments that care plans were in place and regularly reviewed. He adds that "all necessary medication, nursing and comfort steps were taken and [the man] was involved in the entire decision making". He concludes that the Liverpool Care Pathway was implemented appropriately and at the right time. We agree.

The man's pain relief and medication

47. The man was prescribed buprenorphine as pain relief while a hospital inpatient in April 2012. Buprenorphine is a strong painkiller for moderate to severe pain, applied via a patch on the skin in order to provide continuous pain relief over a period of time. On 18 June, a prison doctor prescribed morphine sulphate (a strong painkiller, in this case prescribed as a liquid) as the man's throat was very sore. However, three days later, he told the doctor that he did not like the side effects of this medication. It was therefore stopped and the strength of the buprenorphine patch increased instead. On 24 June, he told the prison doctor that the new dosage provided suitable pain control.
48. Around the same time, various medications including diamorphine (a strong painkiller for severe pain) were added to the man's prescription chart to be available and administered if they were needed later in his life.
49. The strength of the man's buprenorphine patch remained unchanged for several months and he did not complain of any increase in pain at that time.

² The Liverpool Care Pathway is intended to provide the best quality of care possible for dying patients in the last hours or days of life, tailored to an individual's needs and in line with their wishes.

A prison doctor increased the strength slightly on 26 November, in response to a deterioration in the man's general health. At reviews on 27 December and 24 January 2013, he said he was in no pain or discomfort. The prison doctor reiterated to colleagues that diamorphine was available should it be required.

50. In February, the man refused much of his medication except his buprenorphine patches, as he said he had "had enough" and was just waiting to die. No doubts were raised about his capacity to make this decision. He reported no pain in the first ten days or so of the month, but later began to experience pain in his abdomen and from pressure sores. The patch was therefore increased in strength. The day before he died, with the man's agreement, a syringe driver³ containing diamorphine was commenced.
51. Pain control was not an issue for the man for much of his illness and, when he did complain of increasing pain, changes to his medication were made promptly. Anticipatory prescribing was completed at an early stage and frequently reviewed afterwards. The clinical reviewer comments that the man "had a range of therapy ... appropriate to each stage of his condition". We agree.

Liaison with the man's family

52. After the man returned to the prison in April 2012, healthcare and security managers agreed to allow him to have visits in the healthcare centre, where he lived at the time. A principal officer (PO) was appointed to facilitate this. The PO manages the prison officers who work in the healthcare centre, but is not a trained family liaison officer.
53. The PO first contacted the man's daughter, his nominated next of kin, on 23 April 2012. The man's daughter visited him in the healthcare centre around once a month until his return to A wing in September. On each occasion, she arranged her visit with the PO and was allowed to bypass the usual visiting arrangements. The PO gave the man's daughter his telephone number so she could telephone him anytime she had any queries about her father's health.
54. When the man was admitted to outside hospital on 5 December, the PO telephoned the man's daughter to tell her of his admission. The man then returned to the healthcare inpatient unit, where his daughter was able to visit him frequently over the following three months. At the man's request, the PO also telephoned one of his friends to tell him about his health.
55. During a visit on 7 February 2013, the PO spoke to the man's daughter about the processes to be followed in the event of his death. He also asked her how she would like the news of her father's death to be broken to her, if she was not present at the time.

³ A syringe driver is a small portable pump used to provide a continuous dose of painkiller or other medication.

56. The man died at around 9.40pm on an evening in February. In line with her request, his daughter was telephoned around an hour later by the duty governor.
57. A family liaison officer was appointed to provide ongoing support and oversee the prison's involvement in funeral arrangements. The man's funeral took place on 14 March. As he had paid for his funeral in full some years before his imprisonment, the prison did not need to make a contribution.
58. We are satisfied that throughout his illness the PO provided excellent support and contact with the man's daughter. Appropriate family liaison arrangements were also made after his death.

The man's location

59. The man lived on A wing before the month-long hospital inpatient admission in which he was diagnosed with cancer in April 2012. He was then admitted to the healthcare centre inpatient unit.
60. On 3 May, during a discussion with the healthcare manager, the man said he did not want to go to a hospice and wanted to die in prison. At interview, the healthcare manager added that the man was asked about this on several further occasions and was adamant that he wanted to die in prison, as he felt it was his home.
61. The man remained an inpatient in healthcare until September. During this time, his health stabilised and he attended education classes and the prison's age support group. He was independent and required no assistance with personal care. He then moved back to A wing on 12 September, to a cell on the ground floor near to the wing office. In the three weeks after his move, wing staff were concerned that he was finding it difficult to cope and agreed that his food and medication would be delivered to his cell. Two prisoners were assigned to help him. In discussion with wing staff on 9 October, the man reiterated that he preferred to stay on the wing.
62. In late October and early November, the man's health deteriorated. He began to vomit occasionally and had difficulty eating. He was offered admission to the healthcare centre on more than one occasion, but said he preferred to stay on A wing. It was therefore agreed that a nurse would visit him each day to monitor him.
63. On 7 December, after the man was discharged from hospital, he moved back to the inpatient unit. He remained there for the remainder of his life, initially in a standard cell before moving into the specialist palliative care suite (a large en-suite room next to the healthcare office with facilities including a hospital bed and electric hoist) shortly before Christmas. He reiterated that he wanted to die in prison. A prison doctor noted that the man had full capacity to make this decision and agreed that hospital admission was inappropriate.

64. We are satisfied that the man's apparent wish to remain on A wing for as long as possible was respected. Although he was terminally ill, he continued to be involved in prison life. He was helped with everyday activities when his health deteriorated. His preference to remain in prison, rather than move to a hospital or hospice, was respected.

Compassionate release

65. Early release on compassionate grounds is a means by which seriously ill prisoners can be permanently released from custody before their sentence has expired. The criteria for early release for determinate sentenced prisoners are set out in Prison Service Order (PSO) 6000. They include that the risk of re-offending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. Prisoners are usually expected to have less than three months to live. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) within the National Offender Management Service (NOMS).
66. Although the man said he wanted to die in prison, early release on compassionate grounds was never discussed with him or given any serious consideration at any time after his diagnosis in March 2012. He might therefore not have realised that this was a possibility.
67. Our view is that early release should be formally considered for all eligible terminally ill prisoners and, if an application is not immediately made, this should be kept under regular review. On 27 November, a visiting specialist doctor in palliative care gave a prognosis of "weeks [to] small months". This might have been an appropriate time to consider whether an application might be suitable. However, there was no clear process for initiating and handling applications for compassionate release at Hull.
68. The Governor accepted this in response to our initial feedback and said that the possibility of compassionate release should have been considered and undertook to change this. We welcome this approach.

The Governor should ensure that the possibility of early release on compassionate grounds is considered for all eligible terminally ill prisoners.

Restraints, security and bedwatch

69. The Prison Service has a duty to protect the public when escorting prisoners to hospital and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes into account factors such as the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that a distinction needs to be made between

the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgment indicated that medical opinion regarding the prisoner's ability to escape must be considered as part of the assessment process. It deemed that handcuffing a prisoner receiving chemotherapy (and, by implication, other life saving treatment) was degrading and that such restraint would be likely also to be regarded as inhumane unless justified by other relevant considerations.

70. An escort risk assessment was completed before the man's admission to hospital on 19 March 2012. The medical section, completed by a nurse, contained no details of the man's medical condition, symptoms or mobility and simply stated that it was "okay to cuff". He was assessed as a medium risk of escape and to the public (on a scale of low, medium, high). The assessment was authorised by the head of residence who concluded that two officers should accompany him and he should be handcuffed to one of them using a single pair of handcuffs. (This is a standard arrangement for the escort of a category C prisoner outside prison.)
71. Shortly after his arrival at hospital, it became apparent that the man would remain in hospital overnight. At this point, the escort became a 'bedwatch' and the handcuffs were removed and replaced with an escort chain⁴.
72. The risk assessment was reviewed on 20 March and 25 March. On both occasions it was concluded that the escort chain should remain in use. A further review was held on 2 April, when it was noted that the man was now terminally ill and agreed that the escort chain should be removed. The escort chain was not reapplied for the remainder of the man's admission.
73. Although no diagnosis had been made when he was first admitted, the man was very unwell having suffered numerous recent blackouts and vomiting. He had poor mobility and for some time had used a wheelchair when leaving his wing. This lack of mobility was not taken into account in his risk assessment and it is unclear how he could have been regarded as a medium risk of escape. Although two reviews of his risk took place in the week after admission, the second of these gave no consideration to the result of the MRI scan of 22 March that confirmed the presence of a cancerous tumour. We are pleased that this was recognised on 2 April and the escort chain removed accordingly, but consider that this could have happened several days earlier.
74. After his diagnosis the man attended several outpatient appointments. A risk assessment completed on 17 July judged him as a medium risk of escape, no risk to hospital staff, and a high risk to the public. In the medical information section, his wheelchair use was highlighted, with the proviso that he "can get out and walk". The assessment was authorised by the deputy head of operations, who concluded that two officers should make up the escort, using a single pair of handcuffs.

⁴ An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and another to an officer.

75. The risk assessment for a neurology clinic appointment on 31 July came to the same conclusions as previously. The risk assessment for an appointment on 8 August is not available, but in the absence of information we assume that the same arrangement applied. On 16 August, when the man saw a dietician, there is again no risk assessment available, but it is apparent from the PER that an escort chain was used rather than single handcuffs.
76. On 21 November, the man had a CT scan at outside hospital. He was now assessed as a low potential to escape and low risk to the public. The medical information section recorded that the man had “poor mobility” but made no reference to his wheelchair use. The risk assessment was authorised by the head of security who concluded that it should be a two-officer escort and a single pair of handcuffs should be used, despite the low assessed risk.
77. The man’s final outpatient appointment was the following day, 22 November. The information in the risk assessment was similar to that of the previous day, except his risk to the public was now assessed as medium. It was authorised by the head of operations, who again concluded that the escort should consist of two officers, using a single pair of handcuffs.
78. The man was subject to an emergency admission to outside hospital on 5 December. The initial escort risk assessment is not available, but it is apparent from the PER that an escort chain was used. A review of the risk assessment took place on 6 December, when the man’s terminal illness and treatment were noted, although no mention was made of his mobility. It was recommended that the escort chain remain in place. No further assessment or change was made before the man’s discharge on 7 December.
79. In response to the investigator’s initial feedback about the use of restraints, the Governor commented as follows:
- “[The man] had a long term illness, during which he demonstrated a varied degree of mobility. [His] risk assessments were reviewed regularly and the appropriate security levels were applied.
- “Taking into account the serious public protection offences committed by [the man], it was essential that whilst maintaining levels of dignity and decency for the patient, our other consideration was protection of the public and I am confident that the treatment of [the man] throughout his illness at HMP Hull should be commended and not criticised.”
80. Prison Service guidance is that restraints are not normally necessary on an escort when the prisoner’s mobility is severely limited. We acknowledge that, as his illness progressed, the man’s risk to the public and of escape was judged to have reduced from medium or high in summer 2012, to low or medium by the time of his appointments in November. Nevertheless, this did not result in any change to the level of restraints deemed necessary and the man’s limited mobility and wheelchair use was given little consideration. He was 69 years old and had been diagnosed with a terminal illness. While his offences were of a serious nature, the circumstances would not suggest that

he was any current risk to the general public. Our view is that, given his age, health and mobility, an escort of two officers without restraints should have been sufficient.

The Governor should ensure that the use of restraints for hospital escorts accurately reflects the prisoner's actual risk at the time and is kept under review.

RECOMMENDATIONS

1. The Governor should ensure that the possibility of early release on compassionate grounds is considered for all eligible terminally ill prisoners.

Accepted

The head of healthcare will inform the head of residence of all terminally ill cases. Individual cases will be considered in regards to eligibility for release on compassionate grounds. Each case will be reviewed on a month by month basis taking into account an individual's health status/condition.

2. The Governor should ensure that the use of restraints for hospital escorts accurately reflects the prisoner's actual risk at the time and is kept under review.

Accepted

All escorts are carried out in line with a full hospital risk assessment completed by the head of operations. The use of restraints is documented on the assessment, taking into account offence and risk posed. All cases are reviewed on an individual basis.