PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the circumstances surrounding the death of a man in February 2012 at HMP Rye Hill

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 man at HMP Rye Hill in February 2012. He was 53 years old and died as a result of pancreatic cancer. I offer my condolences to his family and friends.

The investigation was carried out by an investigator. The local PCT commissioned a clinical reviewer to conduct a review of the clinical care the man received at Rye Hill. Staff at Rye Hill co-operated fully with the investigation.

The man was sentenced to life imprisonment in 1996 and transferred to Rye Hill in 2001, when the prison opened. Shortly after he arrived at Rye Hill he began to experience ill health. In 2007, he was diagnosed with cancer of the oesophagus and had surgery to remove the affected part. In 2011, he had further surgery to remove fluid from around his lungs.

He became unwell again in January 2012 and was admitted to hospital. On 18 January, he was diagnosed with advanced pancreatic cancer and was told that he was terminally ill. He returned to Rye Hill on 7 February where he continued to live on a residential unit among his friends. Several days later he alerted staff because he was struggling to breathe. They sat with him until he died very shortly after.

The investigation has identified some minor areas for improvement in information sharing between community and prison healthcare and the provision of equipment for seriously ill prisoners. We were also not persuaded that the use of restraints when the man was in hospital was fully justified by his risk assessment. However, overall, he received a very high standard of care from prison and healthcare staff. He and his family and friends were treated with commendable sensitivity and compassion. His clinical care was equal to the care he might have received in the community, and he was helped to die with dignity.

I am very grateful to the man's family and friend for considering the report at the draft stage. This final version of the report reflects their comments and G4S's response to the recommendations made.

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 **September 2012**

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SUMMARY

1. In May 1996, the man was convicted of two counts of murder and sentenced to life imprisonment. He transferred to HMP Rye Hill in 2001 and, began to experience a number of health problems. In November 2007, he was diagnosed with cancer of the oesophagus and underwent surgery to remove the affected part.

2. He was diagnosed with the build up of fluid around the lungs in June 2011 and the fluid was removed in hospital. He had fluid removed from his chest on two further occasions. Tests confirmed that he was not suffering with cancer and he was treated with medication.

3. In early January 2012, he told healthcare staff that he found it difficult to eat because he had no appetite and felt sick. A prison doctor examined him on 16 January and became concerned that he had cancer. The doctor referred him to the local hospital where he was admitted as an inpatient that day. Because the doctor was quite sure that he was very seriously ill, prison staff began to explore whether the man could be moved to a hospice or released early from his sentence.

4. On 18 January, a scan revealed that the man had advanced pancreatic cancer. He was told of the diagnosis and that he was terminally ill the following day. His family and friends were contacted and visited him in hospital.

5. The man was discharged from hospital on 7 February and returned to Rye Hill. He was offered a bed in the prison inpatients unit but chose to return to the unit on which he had lived for over a decade. Two of his friends were asked to help him with tasks such as tidying his cell and collecting his food.

6. Over the following few days, he was regularly checked by healthcare staff and efforts continued to find a hospice space for him. He said that he did not want to be resuscitated if he stopped breathing and this wish was communicated to officers on his unit.

7. The day before he died the man was visited several times by prison and healthcare staff, including, for the last time, at 10.15pm. He was breathless but otherwise cheerful.

8. At 2.09am the next morning, the man pressed the emergency bell in his cell and an officer responded. He said that he could not breathe and three officers sat with him until he died a few minutes later. The post mortem examination confirmed that he died as a result of pancreatic cancer.

9. We conclude that staff at Rye Hill cared for the man with compassion and dignity. Both he and his family and friends were kept fully informed of his diagnosis, prognosis and treatment. Arrangements for him to move to a hospice and be released early were ongoing at the time of his death. We make three recommendations as a result of the investigation. These relate to effective sharing of information between community and prison healthcare, clarification

over the provision and funding of equipment and aids for seriously ill prisoners and the use of restraints on prisoners in hospital.

THE INVESTIGATION PROCESS

10. The Ombudsman's office was notified of the man's death on 13 February 2012. An investigator from this office visited Rye Hill on 17 February and met members of the prison management team, staff and prisoners involved in the man's care and a member of the Independent Monitoring Board. He also visited Hastings unit, where the man lived at Rye Hill.

11. Another investigator issued notices informing staff and prisoners of the investigation and asking them to contact her with any relevant information. There was no response to the notices.

12. She was given copies of the man's medical record and relevant aspects of his prison records. The local PCT appointed a clinical reviewer to review the clinical care he received at Rye Hill. The clinical reviewer was also given a copy of the man's medical record.

13. The clinical reviewer and investigator returned to Rye Hill in April to conduct interviews with staff and prisoners. The Director was provided with verbal and written feedback following the interviews.

14. HM Coroner for the Northamptonshire district was informed of the investigation and provided the results of the post mortem investigation. The Coroner will be provided with a copy of this report to assist with her enquiries.

15. One of the Ombudsman's family liaison officers contacted the man's family and a close friend outlining the purpose of the investigation and inviting them to raise any concerns. They wrote to our office and praised the care and consideration he had been shown by staff at Rye Hill. They had no questions or concerns about his treatment.

16. The family and friend received a copy of the draft report as part of the consultation period. In their response, they said that they did not think he would have received better treatment and care in the community. The family agreed that restraints should not have been applied and welcome the recommendation made in this respect.

17. 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 RYE HILL

18. HMP Rye Hill is a category B training prison, privately run by G4S Care and Justice Services. It holds up to 625 sentenced adult male prisoners who must have been sentenced to at least four years in prison and have at least 18 months left to serve. Around 20 percent of prisoners at Rye Hill are serving a life sentence.

19. Twenty four hour healthcare services are also provided by G4S, including an eight bed inpatient unit. There are a number of nurse-led clinics and doctors, dentists and other specialists run regular clinics at the prison.

HM Inspectorate of Prisons (HMIP)

20. HMIP last carried out an inspection at Rye Hill in June 2011. The subsequent inspection report noted that relationships between staff and prisoners were reasonable and highlighted the good management of indeterminate sentence prisoners (where the court sets a minimum term of imprisonment the prisoner must serve before being considered for release).

21. Prisoners surveyed as part of the inspection reported dissatisfaction with the healthcare provision, but the Inspectorate found that it had improved since the last inspection. There was a range of clinics for long term health conditions and a reasonable waiting list for the doctor. Prisoners had good access to external hospital appointments. HMIP reported that Rye Hill had a palliative care pathway and an end of life policy.

Independent Monitoring Board (IMB)

22. 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 ensure that proper care and decency are maintained. The most recent IMB annual report for Rye Hill covers the period April 2010 to March 2011.

23. The IMB reported that staff stability in the healthcare centre was problematic but they were positive about prisoners' access to external hospital appointments.

24. The investigator spoke to a member of the IMB at his initial visit who said that Board members were impressed by the level of compassion and care shown by staff to the man. The IMB was involved in a multi-disciplinary care planning meeting held to discuss him on 7 February 2012.

Previous deaths at Rye Hill

25. The man was the twelfth prisoner to die of natural causes at Rye Hill since 2004, when the Ombudsman began investigating all deaths in prison. In 2007, we recommended that the prison consider how information sharing with local hospitals could be improved, which is something we mention again in this report.

ISSUES

The diagnosis of the man's terminal illness

26. The man was convicted of two counts of murder in May 1996 and received a life sentence. He transferred to Rye Hill on 9 May 2001, shortly after the prison opened. From 2001 onwards, he suffered a number of health problems. In 2007, he was diagnosed with cancer of the oesophagus and had surgery to remove the affected area. In early 2011, he began complaining of being short of breath and having a cough. He was prescribed antibiotics and the problems were resolved. However, in June, he suffered chest pain and was referred to the local hospital for assessment. He was diagnosed with pleural effusion (the build up of fluid around the lungs) and underwent a procedure in hospital to remove the fluid.

27. In mid-October 2011, the man had more fluid drained from his chest and, on 26 October, he was referred to a respiratory specialist at hospital. The following day, a hospital registrar discussed him with one of the doctors at Rye Hill. The registrar said that his health problems might be caused by cancer and that further tests were required. On 24 November, the doctor told the man that the tests results had not shown any sign of cancer and that he was suffering with a severe infection which was treated with medication.

28. On 2 January 2012, healthcare staff began to worry about the man because he was not eating much. He said that he was unable to keep food down and was struggling to drink his prescribed build-up drinks. (Build-up drinks have a high calorie content and are prescribed to patients who need to put on weight.) The doctor examined him on 4 January and thought that fluid might be building on his chest again. He was encouraged to try to eat and drink. He was seen by a member of healthcare staff on an almost daily basis.

29. The doctor examined him again on 16 January and found him to be very poorly, with jaundice (the yellowing of the skin caused by poor liver function), visible weight loss and an enlarged liver. The doctor recorded details of his assessment in the man's medical record, writing that, because of the symptoms, he was sure that the man had cancer. He was admitted to hospital that day.

30. On 18 January, the man underwent a computerised tomography (CT) scan which uses X-rays to produce a detailed picture of the body. The scan showed that he had a cancerous tumour in his pancreas which was described as rapidly progressive and possibly spreading to his liver. Hospital staff concluded that the pancreatic cancer was not linked to his earlier oesophageal cancer.

31. Two days later, on 20 January, the acting clinical manager at Rye Hill telephoned the hospital for an update. A hospital doctor said that they were unable to give a definite diagnosis because the man had cancerous lesions on his pancreas and liver and they could not tell which was the primary site. The doctor said that the man would undergo further tests over the coming days. On 1 February, a hospital doctor confirmed that the man had pancreatic cancer.

32. The consultant heptologist (who specialises in problems affecting the liver) wrote to the prison on 2 February. He explained that the man's pancreatic cancer could not be operated on and that palliative care should be offered.

33. The clinical reviewer concludes that the man's cancer was diagnosed as soon as definite signs emerged. She writes that pancreatic cancer is commonly found very late in its development and so the prospect of successful treatment is poor. Symptomatic relief is often the only form of treatment offered.

Informing the man about his condition and treatment

34. On 16 January, the prison doctor told the man that he might have cancer. On 19 January, he was told that he had a tumour on his pancreas, which was causing jaundice. He was told that the tumour was in an advanced stage and that the CT scan had also identified a problem with his liver. Hospital staff said that chemotherapy might stop the tumour from growing or spreading further, but that there was no treatment which would cure the cancer. The man was also told that he would need to undergo a procedure to unblock his bile duct.

35. Another hospital doctor spoke to the man on 1 February and confirmed the diagnosis of pancreatic cancer.

36. Over the following few days, hospital staff discussed aspects of the man's treatment with him. The consultant heptologist noted in his letter to the prison that the man was aware of his poor prognosis. On 3 February, a hospital doctor advised him that resuscitation would not be attempted if he stopped breathing (because this occurred in hospital, there is no information about whether the man was consulted about the decision).

37. The prison's acting clinical manager and the prison doctor visited the man in hospital and spoke to staff to ensure that they were fully informed about his condition. They helped him to understand what he had been told.

38. While in hospital, the man was accompanied at all times by two prison officers. The lifer liaison officer at Rye Hill said that she often arranged to be one of his escort officers when she knew that he had consultations with the hospital doctors. She said that the man found some of the information he was given confusing and she was able to help explain it to him.

39. The man returned to Rye Hill on 7 February. The following day, the doctor visited him in his cell to discuss his condition. He advised the man that he probably had about three months left to live. The man said that he did not want to be resuscitated if his condition deteriorated.

40. On 10 February, the doctor, lifer liaison officer and the acting clinical manager discussed resuscitation again with the man. They concluded that he fully understood his condition and prognosis and a Do Not Attempt Resuscitation (DNAR) form was completed and shared with healthcare staff and officers on his unit.

41. We and the clinical reviewer conclude that prison and healthcare staff made concerted efforts to help the man understand his diagnosis and prognosis. The clinical reviewer writes that his file shows evidence of a structured and effective process to ensure that he was kept fully informed. She concludes that, in this aspect, the care he received at Rye Hill was at least equal to if not better than might be the case in a community setting.

The man's medical appointments and treatment

42. The man received confirmation of his terminal diagnosis while he was in hospital. Initially, chemotherapy was suggested to try to prevent the cancer from growing or spreading. He was referred to a cancer specialist at hospital before he was discharged to the prison; however, the rapid deterioration in his health meant that he had not yet been given an appointment by the time of his death.

43. On 7 February, the day the man was discharged from hospital, the prison convened a multi-disciplinary meeting involving healthcare staff, chaplaincy, Hastings unit staff, the lifer liaison officer, the safer custody team and the IMB. The group devised a care plan, which not only covered the man's medical needs but also other aspects of his care. Healthcare staff were instructed to check his blood pressure, pulse, blood oxygen levels and temperature at least once a day, which they did.

44. The clinical reviewer concludes that the man received appropriate treatment for his cancer at Rye Hill. However, she notes that prison healthcare staff sometimes had difficulty getting information about his treatment from staff at the hospital when he was an inpatient, particularly when they tried to do so by telephone. She writes that this was presumably because of the hospital's confidentiality policy. This did not materially affect the care the man received but she notes that, in other cases, it could cause a delay in ensuring that the prison is ready to receive a terminally ill prisoner on their discharge from hospital. She writes that patient information is routinely shared amongst healthcare staff in the community to ensure the proper transfer of care. She makes the following recommendation, which we reframe and endorse:

    The Head of Healthcare should develop a protocol with local hospitals to ensure that patient information is shared with prison healthcare staff in the same way that it is shared with community services.

The man's pain relief and medication

45. The man was prescribed tramadol modified release tablets in September 2011 when he was diagnosed with pleural effusion. (Tramadol is a strong pain relief medication prescribed to those suffering moderate to severe pain. Modified release tablets are designed to slowly release medication over the course of 24 hours to give a more prolonged and even effect.) Having received his cancer diagnosis, he continued to be prescribed this medication. The prison doctor also continued the man's existing prescriptions relating to his other health problems.

46. Once back at Rye Hill, the man was prescribed codeine 30 milligram (mg) tablets. Codeine is prescribed to combat mild to moderate levels of pain. He was also prescribed paracetamol.

47. He complained of pain on 9 February and was given a dose of his pain relief medication. On 12 February, healthcare staff monitoring him noted that he was finding it more difficult to swallow liquid and, therefore, his tablets.

48. The clinical reviewer identifies no issues with the management of his pain. The clinical transition manager explained that currently, none of the nurses at Rye Hill are qualified to deliver pain relief medication from a syringe-driver (which gives a continuous dose of medication). Had he continued to struggle to swallow his tablets, he might have required this method of pain management. She said that, if necessary, the prison would have used suitably qualified agency nurses. The clinical reviewer considers this to be an appropriate approach.

Liaison with the man's family

49. On 17 January, the lifer liaison officer telephoned the man's nominated next of kin, his aunt and uncle, and a close friend to tell them that he had been admitted to hospital. Two days later, a multi-disciplinary meeting was held to discuss his ongoing care and family liaison was discussed. The group agreed that although the lifer liaison officer was not a trained family liaison officer, she had a good relationship with the man and knew a lot about his extended family. She agreed to continue to liaise with his family and friends with supervision from the prison's trained family liaison officers. The man was told about the meeting and the decisions made.

50. The lifer liaison officer wrote to the man's step-mother on 31 January because she could not reach her by telephone. Members of his family visited him in hospital. The lifer liaison officer continued to liaise with various members of the family once the man was back in prison and, on 11 February, his friend visited him. His aunt and uncle were aware of his wish not to be resuscitated.

51. The man died one morning in February. Later that morning, the lifer liaison officer telephoned his aunt and uncle, who live in Gloucestershire, to break the news to them.

52. The man left written instructions for his funeral, which he wished to pay for himself. The lifer liaison officer said that, in line with national guidance, the prison offered to contribute to the cost. She and other members of prison staff attended the funeral and, at the time of interviews, hoped to arrange a memorial service at Rye Hill.

53. We find that Rye Hill, in particular the lifer liaison officer, offered an effective and compassionate service to the man's family and friends. They were kept well informed about his condition, treatment and prognosis. Prison Service guidance notes that, generally, it is better for news of a prisoner's death to be broken to the next of kin in person. In this case, we are satisfied that the decision to telephone his family was appropriate. Because of their ongoing contact with her, they knew

that he was terminally ill and his death, although coming sooner than anticipated, was not unexpected. In letters to our office, both the man's relatives and his friend praised the lifer liaison officer, and the prison generally, for the care and compassion showed to them and to the man.

The man's location

54. On 4 January 2012, the man was accepted as suitable for a transfer to HMP Buckley Hall, a category C prison. His move was dependent upon a space becoming free at the prison. However, in February, staff concluded that, even if a space did become available, he was not well enough to move and should remain at Rye Hill.

55. He had lived on Hastings unit since he first arrived at Rye Hill in 2001. On his discharge from hospital he was offered a bed in the prison inpatients unit, but declined. All of those interviewed agreed that the man considered Hastings unit to be his home. However, he was moved from the cell he had previously lived in to a disabled access cell on the unit which could accommodate a wheelchair and was fitted with hand rails near the bed and toilet. The lifer liaison officer said that she ensured that all of his belongings were moved into his new cell and arranged exactly as they had been in his old cell. She also arranged for an extra mattress and extra bedding to be provided and a wheelchair was purchased for him.

56. A Prison Custody Officer (PCO) said that the man's return to the unit caused no problems for unit officers. He explained that two of the man's friends were asked to act as "buddies", to help him with certain tasks such as tidying his cell or collecting his food. Interviewees agreed that he was popular on the unit and had a number of friends there.

57. One of the man's buddies told the investigator that he had been close friends with him for some time and had informally begun to look after him during his illness in 2011. He said that he and the man shared their faith and spent time praying together. He explained that he and another prisoner would help the man to tidy his cell and do his laundry. He said that, having agreed to act as the man's buddy, he was offered a great deal of support by unit officers.

58. The clinical transition manager explained that unit officers were given sufficient information about the man's condition to offer him care and support, while not breaching patient confidentiality. She said that it was possible to manage his treatment on the unit but that he had been told that, if his healthcare needs required it, he would be moved to a large room in the inpatients unit. She said that he understood this. The doctor agreed that he could be managed on Hastings unit.

59. The clinical reviewer writes that, although the man was provided with a special mattress quickly after his return to Rye Hill, there was some uncertainty about how special equipment should be funded and provided. We make the following recommendation based on the reviewer's concerns:

The Head of Healthcare should agree a protocol with local community health services for obtaining additional nursing aids and equipment for seriously ill prisoners.

60. Consideration was also given to whether the man should be moved to a hospice. The doctor instructed healthcare staff to begin this process on 16 January, and they did so. On his return to Rye Hill from hospital, he said that he would like to be placed in a hospice nearer to his family in Nottinghamshire. The lifer liaison officer agreed to look into this for him although she thought this would prove difficult to arrange because it meant liaising with different primary care trusts.

61. The lifer liaison officer told the investigator that, initially, they approached a hospice in Rugby, close to Rye Hill and with whom the prison already had contact. On 10 February, the hospice replied that they would not be able to accommodate the man and suggested that the local PCT be contacted for help. Later that day, Macmillan Cancer Support suggested that the prison approach another hospice in Northampton. Unfortunately, the man died before a suitable place had been found.

62. We find that Rye Hill appropriately considered where best to locate the man once he was diagnosed with cancer. The decision making took into account his wishes, his healthcare needs and whether those needs would be best met by a specialist service outside the prison.

Compassionate release

63. 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 for indeterminate sentenced prisoners are set out as follows in Prison Service Order (PSO) 4700:

    a. the prisoner is suffering from a terminal illness and death is likely to occur very shortly (although there are no set time limits, three months may be considered an appropriate period for an application), or the prisoner is bedridden or similarly incapacitated, for example, those paralysed or suffering from a severe stroke; and

    b. the risk of re-offending (particularly of a violent or sexual nature) is minimal; and

    c. further imprisonment would reduce the prisoner's life expectancy; and

    d. there are adequate arrangements for the prisoner's care and treatment outside prison; and

    e. early release will bring some significant benefit to the prisoner or his/her family.

64. 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). Caseworkers in the unit consider the application and have a target of advising the prison of the outcome within two weeks of receipt (or sooner if the application is very urgent). Various reports are required to make up the application, including reports by the prison doctor (usually supported by further information from the hospital consultant or equivalent expert), the prison's probation officer and the Governor.

65. On 16 January, when the man was admitted to hospital, the doctor advised the prison that, in his opinion, he was terminally ill and that compassionate release should be considered. On 20 January, the acting clinical manager asked the hospital to provide written confirmation of the man's diagnosis and prognosis as part of the compassionate release process. The consultant heptologist's letter of 2 February made clear the seriousness of his condition but did not discuss his life expectancy.

66. The prison doctor wrote a letter supporting the man's release on compassionate grounds on 8 February, noting that he had less than three months to live. The lifer liaison officer also completed a section of the application form. She said that the completed parts of the application had been sent to the man's offender manager in the community who was also trying to compile the necessary information. Due to the rapid deterioration in his health, no further progress had been made by the time of the man's death. We find that the prison's actions were efficient and appropriate.

Palliative care plans and end of life pathway

67. 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 prisoner complete. There is no record of a written end of life pathway being completed for the man. However, his death happened much more quickly than anticipated, which may account for this. In any case, we are satisfied that all of the principles of an end of life pathway took place for him at Rye Hill.

68. The man was routinely consulted and informed about his diagnosis, prognosis and treatment. He was actively engaged in decisions about resuscitation, where he lived and contact with his family and friends. Multi-disciplinary case meetings were held and discussed the range of end of life issues. The prison ensured that his spiritual needs were met in hospital and in prison.

69. We consider that the support offered to the man in his final moments is worthy of particular note. Having rung his cell bell at 2.09am on the morning of his death, a PCO went into the man's cell. The PCO said that he realised that the man's health was deteriorating rapidly and so he pressed the alarm button on his radio. Two more PCOs arrived soon after and the three officers sat with the man,

holding his hands and talking to him until he died a few minutes later. This was a commendable, humane and decent action by the officers concerned.

70. Following the man's death, the prison continued to act in accordance with the end of life pathway. The clinical reviewer agrees that his palliative care needs were anticipated and planned for.

Restraints, security and bed watch

71. The man was an inpatient at hospital between 16 January and 7 February. When a prisoner is taken out of the prison, a risk assessment should be carried out to decide the level of restraints to be applied. The assessment carried out on 16 January noted that the man was too ill to pose a risk to the public. Staff had no information to suggest he might try to escape but considered that he was physically well enough to escape unaided. Healthcare staff said that there was no medical reason for him not to be restrained. The member of staff completing the assessment noted that due to the nature of his offence, the man was considered high risk. As a result of the assessment, staff decided that he should be restrained by handcuffs.

72. The Head of Safer Custody told the investigator that once the man was settled in a private room on one of the hospital wards, the restraints were changed to an escort chain. (An escort chain is approximately six foot long with a handcuff at each end. The prisoner wears one cuff and an officer the other.) According to the logs completed by officers with the man, the escort chain was removed so that he could have a private conversation with the hospital chaplain.

73. The Head of Safer Custody said that the fact that the man was very poorly and had only a short time left to live had been balanced against the very serious nature of his offence and the possible risk to the public. However, the purpose of the risk assessment process is that restraint decisions are made according to the specific risk the individual poses at the time. The assessment made on 16 January contained contradictory information, noting on one hand that the man was too ill to pose a risk to the public but on the other, that he was well enough to escape unaided. There is a concordat between the National Offender Management Service (NOMs) and the NHS, agreed in 2008, regarding security arrangements for prisoners at outside hospital. The concordat covers the use of restraints and states:

> **"**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 believe that the decision to restrain the man, particularly after the hospital confirmed that he was terminally ill, was not fully justified by the risk assessment and we make the following recommendation:

The Director should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents.

CONCLUSION

75. The man was diagnosed with terminal pancreatic cancer on 18 January, two days after being admitted to hospital from Rye Hill. He died in his cell at Rye Hill in February. The investigation found that Rye Hill treated him with care and compassion and in line with national guidance. We conclude that he received a standard of healthcare equal to what he might have received in the community.

RECOMMENDATIONS

G4S Care and Justice Services' response is detailed in italics beneath each recommendation.

1. The Head of Healthcare should develop a protocol with local hospitals to ensure that patient information is shared with prison healthcare staff in the same way that it is shared with community services.

   This recommendation has been accepted. G4S write that "HMP Rye Hill will seek to reach an appropriate information sharing agreement with the local health area and share that agreement with other health areas if this should become applicable". The action should be completed by the end of October 2012.

2. The Head of Healthcare should agree a protocol with local community health services for obtaining additional nursing aids and equipment for seriously ill prisoners.

   This recommendation has been accepted. G4S write that "HMP Rye Hill will seek to reach an appropriate protocol with local community health services for obtaining additional nursing aids and equipment for seriously ill prisoners". Again, this action should be completed by the end of October 2012.

3. The Director should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents.

   This recommendation has been accepted. G4S write that "The Director will ensure that Duty Directors and Managers responsible for completing escort authority risk assessment receive refresher training to ensure that individual circumstances are always taken into account and the need to update the risk assessment following new or changed information and risk. Ensuring, the decision reached and reasons are recorded appropriately". This action should be completed by 14 September 2012.