Investigation into the circumstances surrounding the death of a man at hospital in October 2010 whilst in the custody of HMP & YOI Hull

Report by the Prisons and Probation Ombudsman for England and Wales

January 2012

This report considers the circumstances surrounding the death of a man at HMP Hull in October 2010. He had been diagnosed with lung cancer more than a year earlier and died as a result of the disease's progression. He was 66 years old.

I offer my sincere condolences to the man's family and all those who knew him.

The investigation was conducted by one of the Ombudsman's investigators. I would like to thank the governing Governor and his staff for their co-operation. I also extend thanks to the liaison officer. In addition, I thank the clinical reviewer who conducted a review of the man's clinical care. He was appointed by the local PCT.

The man was remanded into custody at HMP Hull in June 2006. He suffered from a number of health issues, most notably diabetes and heart problems. He saw a cardiologist on a number of occasions and underwent various medical procedures to help monitor and control his heart condition. In February 2009, an X-ray showed a shadow on his lung. Further tests in April confirmed that this was an inoperable tumour. He underwent five cycles of chemotherapy, but the cancer continued to spread.

His health deteriorated rapidly on 12 October 2010, some 18 months after his initial diagnosis. He moved to hospital where he died four days later.

My investigation has looked into the man's medical care, considerations given to compassionate release, and the use of restraints. I have also considered a number of issues raised by his family. I make three recommendations.

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.

Thea Walton
Acting Deputy Ombudsman **January 2012**

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SUMMARY

1. The man died in October 2010 at hospital. He was 66 years old and suffered from diabetes, arthritis and ischaemic heart disease. He was diagnosed as having lung cancer in February 2009, and died as a result of the progression of this disease.

2. The man was remanded into HMP Hull in June 2006, charged with serious offences. He was sentenced to eight years imprisonmen.

3. During his first reception health screening at Hull, the man said that he suffered from various medical conditions, had recently lost a lot of weight and an X-ray had shown a shadow on his lungs. A letter from his doctor in the community stated that there was no record of the X-ray.

4. He suffered from ischaemic heart disease and angina. He attended many outpatient appointments to see a cardiologist and was monitored closely. He underwent a number of medical procedures to help monitor and control his heart conditions, which appeared to be successful. He had a pacemaker fitted in 2009 and it was during his stay in hospital that an X-ray showed a shadow on his lung. A bronchoscopy proved inconclusive, and a positron emission tomography (PET) scan showed a cancerous tumour in his lung. This was non-operable and treated with chemotherapy.

5. He had four cycles of chemotherapy from July to November. He had a re-staging scan in December to establish whether the chemotherapy had had any effect. However, the scan showed that the tumour had grown and the cancer had spread to his lymph nodes. His oncologist explained that further chemotherapy treatment could reduce his life expectancy and make him feel very unwell. He had a positive outlook and said that he was going to prove his oncologist wrong.

6. During a follow-up appointment in March 2010, the man told the oncologist that he was feeling very well and was showing no symptoms of being terminally ill. He said that he believed he was improving every day and may be cured. He asked for another re-staging scan to prove this, but his oncologist said if he still felt the same way in three months time he would arrange for him to have a scan. A scan in July showed that the cancer had spread further. He was again told that he could be kept under review or have further chemotherapy and the risks were explained. He said that he wanted to see his oncologist to talk about his options in late August and a referral was made.

7. The man began to deteriorate in October and healthcare staff observed him regularly. They became concerned for his health and he moved to hospital. He deteriorated further over the next few days and treatment was discontinued on 15 October. He died at 11.52am the following morning.

8. I have investigated issues relating to the man’s clinical care, communication difficulties, the application for compassionate release and, most notably, the use of restraints towards the end of his life. I make three recommendations, of which the most important relates to the use of restraints.

THE INVESTIGATION PROCESS

9. One of my senior investigators was appointed to conduct the investigation on behalf of the Ombudsman. Notices of the investigation were sent to the prison for distribution and display, giving staff and prisoners the opportunity to contact him with any relevant information. Nobody came forward with any information in response to the notices.

10. The investigator spoke to the liaison officer on 19 October 2010 to ascertain some details about the circumstances of the man's death. The liaison officer sent him copies of documents relating to the man's time at Hull between 2006 and 2010.

11. One of my family liaison officers (FLOs) contacted the man's daughter to explain the investigation process and provide the opportunity for her to raise any questions or issues about the care he received whilst in prison. The investigator and FLO met with the man's family. They raised the following concerns:

    - Whether his pain was managed appropriately whilst he was in prison.
    - How he sustained a number of injuries that his daughter observed in the hospital.
    - Whether he was treated with dignity whilst in the hospital.
    - Whether his medication when at the hospital was appropriate.
    - The way in which restraints were used, particularly in the final hours of his life.
    - Whether hospital staff were proactive in administering his medication and giving him food.
    - The way in which the compassionate release application was managed.
    - Difficulties in contacting the prison's family liaison officer following his death.

12. Where possible, I address the family concerns as part of my report. Unfortunately, some of the family's issues regard treatment that the man received at the hospital during the last few days of his life. The clinical reviewer did not access records from the hospital and so has not commented on the care that he received there, and it is beyond the terms of reference for this investigation. However, the reviewer advised that the family should approach the relevant NHS Trust directly with any concerns or queries.

13. The local Primary Care Trust appointed a clinical reviewer to conduct a review of the man's care whilst in custody. The purpose of a clinical review is to examine the medical care that a prisoner received in custody, which should be an equivalent standard to what might have been expected in the community. He consulted the man's medical records to inform his review.

Response to the draft report

14. As part of the consultation period, copies of the draft version of this report were sent to the National Offender Management Service (NOMS) and to the man's daughter.

15. After considering the report, NOMS did not discover any factual inaccuracies. Two of the recommendations were accepted, and one was accepted in part. The response to the recommendations can be found further in the report.

16. The man's daughter told the FLO that she remained very concerned and upset about her father being restrained during the final hours of his life, and after he had passed away. She also felt that communication between the family and the prison could have been greatly improved, and wanted to highlight the importance of a dedicated liaison officer. Finally, she said she did not want another family to face a similar situation.

HMP & YOI HULL

17. HMP Hull is a category B local prison holding remand and sentenced adult male prisoners and young offenders. Since 2002 it has undergone a period of expansion and now holds over a thousand prisoners. The expansion included a purpose built healthcare centre offering 24 hour healthcare and a multi-bedded in-patient ward and cellular accommodation. In 2009 a terminal care suite was adapted. Medical services are provided by Hull Teaching Primary Care Trust.

Performance

18. Her Majesty's Inspector of Prisons last inspected Hull in an announced inspection in November 2008. The report, published in March 2009, complimented Hull on staff prisoner relations, activities, diversity, resettlement and time out of cell. The healthcare offered was judged to have "improved considerably" since the previous inspection.

19. The Inspector noted that Hull had strong support from the primary care trust, which had managed a significant shift from prison to NHS health provision. Staff recruitment was difficult but improving steadily. The inpatient area was described as impressive, with excellent facilities, good time out of cell and therapeutic activities. A comprehensive range of health services was delivered.

20. Each prison in England and Wales is monitored by an independent board of volunteers drawn from the local community. Members of the board have access to every part of the prison and all prisoners held there. The board must produce an annual report. The latest available report for Hull, covering the period 1 January 2008 to 31 December 2008, stated that:

> "The Healthcare unit is a purpose built unit providing clean and private rooms for consultation. There is a multi bedded ward, cellular accommodation, in recent months a Terminal Care suite has been adapted, this is a necessary addition due to the rising population of older offenders. It is clean, well equipped and pleasantly decorated. Within the unit there is an association room, which is well equipped with comfortable furniture, reading material and games, along with a television. All cellular accommodation contains a television and kettle, subject to individual risk assessment."

21. Education was reported to be provided in the healthcare centre on a daily basis. Recreational facilities were described as good, as was interaction between staff and inpatients.

Previous deaths at Hull

22. Since the Ombudsman was given responsibility for investigating all deaths in custody for England and Wales in April 2004, there have been twenty deaths at Hull, thirteen of which were due to natural causes. Prior to the man's death, the last death was in May 2010. After the death of a prisoner in April 2009, I found problems with communication between hospitals and the prison. I return to the same issue as part of this report.

KEY EVENTS

23. In June the man appeared before Magistrates Court and was remanded into HMP Hull pending a trial. When he arrived at Hull, a nurse and a doctor conducted a first reception health screening. This is a basic medical assessment that is undertaken for all prisoners when they arrive. He told the nurse and doctor that he suffered from blackouts, had Type II diabetes, angina, arthritis, psoriasis and that he had recently lost three stone in weight. He also said that an X-ray had showed a shadow on his lungs and that he suffered from pains in his chest. Referrals were made for him to see a neurologist and to attend the diabetic clinic. It was also noted in his medical record that he was to have a blood test and an echocardiogram (an ultrasound scan that produces an image of the heart). The nurse conducted a risk assessment to determine which wing he was to be located on. He asked to be classed as a vulnerable prisoner due to his offences and he was duly located on I wing, which accommodates vulnerable prisoners. (Prison Rule 45 allows Governors to remove prisoners from normal association with others, to maintain good order or discipline, or in prisoners' own interests. Prisons usually have a separate unit for those considered vulnerable. This can be for a number of reasons, including the nature of the offences.)

24. A letter was sent to the man's doctor in the community requesting confirmation of his medication and his medical history. His doctor replied, listing the medications that he had prescribed and confirmed that he suffered from diabetes. He said that the man's blood sugar level was always within the normal range. He further stated that he had seen him regarding three episodes of blackouts, but these were associated with alcohol and had no record of any other problems. He also had no record of the chest X-ray the man had mentioned, although this had been done in Ireland.

25. The man was provided with a blood sugar monitor to enable him to control his diabetes without having to go to healthcare to have his blood tested. On 7 August he had a review of his diabetes. The relevant entry in his clinical record states that he was happy caring for himself in terms of his diabetes. The nurse noticed swelling to his ankles and his legs. He regularly missed appointments for subsequent diabetic clinics and eye screening in the prison's healthcare unit.

26. The man attended an outpatient appointment with a cardiologist on 5 October. He was diagnosed with ischaemic heart disease (involving reduced blood supply to the heart muscle) and recurring limiting angina (severe chest pain due to the reduced blood supply). The cardiologist noted that he could be suffering from loss of consciousness due to a lack of blood supply to the brain while sitting or standing up, and that he was a smoker and had high cholesterol. He was referred for a diagnostic angiogram. (An angiogram involves a thin, flexible tube being inserted into a blood vessel in the groin or wrist. The tube is then

guided to the heart and a dye injected through the tube, so that X-ray images show the heart more clearly.)

27. The man was issued with a warning on 23 October as he had spoken with his grandchildren on the phone. Due to the nature of his offences, this was classed as a breach of public protection. He received another warning on 22 November for taking books out of the education classroom without signing for them.

28. On 30 November, the man was moved to H wing. This is another vulnerable prisoner unit but accommodates prisoners who have committed a range of offences. He was moved as he was unwilling to clean his cell on I wing, and was blaming his cell mate for the unsatisfactory standard of cleanliness. He told members of staff that within minutes of being on H wing, he had received threats, had items stolen from his cell, had been spat at and punched in the back. He was also concerned that his upcoming court appearance would be high profile. Wing officers had not seen any of the incidents he mentioned and no information was received from the prisoners on the wing, however he was moved back to I wing on 3 December.

29. The man's trial lasted for two weeks, from 4 December to 14 December, and he attended court daily. He was found guilty of the offences and a date for sentencing was scheduled for January.

30. On 12 January 2007, he attended an appointment for diagnostic angiography (a medical technique to show the arteries, veins and chambers of the heart). The results showed that he had heart disease in all three of his heart vessels and only moderate function in his left ventricle, which pumps blood to the rest of his body. A miniature electrocardiogram (ECG) was implanted in his chest to record the electrical activity in his heart. He was signed off work for a week so that he could rest and recover from the operation.

31. The man was warned about his behaviour on 22 January, as he was asked to go to the healthcare unit but declined and decided to go to the library instead. When he attended the healthcare unit the next day, he said that he had multiple joint pain from walking to and from education classes, as well as chest pain and pain from psoriasis (a skin condition that often results in visibly red, scaly areas). The doctor wrote a letter requesting that his education days were reduced from five to two or three.

32. On 25 January, the man attended court where he was sentenced to eight years imprisonment. There were no concerns recorded on his return to Hull and he went back to his cell on I wing.

33. He was seen in the healthcare unit on 3 March as his psoriasis appeared quite severe on his elbows. It was recorded in his medical record that he was reluctant to be seen and did not want any fuss.

34. Between 7 March and 28 June, he attended 60 sessions of the Sex Offender Treatment Programme (SOTP). At the end of the programme, during his review, he said that he had found it interesting and that he knew himself better. He wanted to do charity work on release and was 99.9% sure that he would not re-offend. The course facilitator said that he had contributed regularly during sessions, and that he had been good at giving praise and feedback to others. He still had certain areas that he needed to work on as he had only made a degree of progress on victim empathy and had treatment needs for managing life problems and relationships. His earliest parole date was in May 2010, and it was likely that his licence conditions would involve accommodation in a hostel. He did not like the idea of being in a hostel and questioned his licence conditions at length. The course facilitators regarded him as being at low risk of re-offending, but there was scope for him to do more work to address his offending behaviour while in custody.

35. The man applied to become a Listener. The Listener scheme is supported by the Samaritans. A Listener is an unpaid volunteer who provides emotional support to other prisoners. The support offered by Listeners is confidential, meaning that details of a prisoner's conversation with a Listener will not be passed on to prison staff unless the person they are supporting gives their permission. His application was approved in June.

36. In August, the man had a psychometric test. The results showed that he had outstanding needs and that he continued to minimise the effect his offending had on his victims.

37. It was recorded in the man's medical record on 31 August that the miniature ECG device implanted in his chest had made no recordings of abnormal activity or episodes of unconsciousness.

38. A nurse reviewed him on 27 September. He told her that he had not been taking any of his medications for some weeks and was feeling better as a result. She had a long talk with him about his diabetes and how it was a progressive disease. He declined offers to monitor his blood sugar level and to be seen on a regular basis to discuss medication options and educate him on diabetes. He said he did not like putting chemicals in his body. She advised him to contact the healthcare unit if he changed his mind.

39. Over the coming months, the man was assessed by various nurses who advised him of the risks and possible complications of not taking his prescribed medication. However, he remained adamant that he would not take it and that he felt better. He did allow nurses to take blood samples and the results were abnormal, but this was expected as he was not controlling his conditions with medication.

40. On 6 December, the man was warned about his behaviour after he wrote to his daughter regarding his grandchildren. This was prohibited due to the nature of his offences.

41. He made an application to see his SOTP facilitator on 6 March 2008. He said that he felt the post-programme progress review had a number of important mistakes in it and that the report would affect his future, therefore it was important that it was accurate. There is no evidence to suggest that the report was changed in any way as a result of this meeting.

42. On 11 March, he attended an outpatient appointment at the cardiac clinic. There were still no abnormal recordings or changes on the miniature ECG device, and he was told to return in six months' time.

43. The man was assessed by a nurse on 29 May. The nurse noted in his clinical record that he displayed a negative attitude as he walked into the consultation, saying he did not know why he was there and wished they would leave him alone. The nurse managed to persuade him to restart taking aspirin and simvastatin (used to control cholesterol) slowly and, if he felt well enough, to restart metformin (an anti-diabetic drug). He said that if he felt unwell he would stop taking them again. He also agreed to have his blood tested to see if the medications were working. He complained of pain and cramping in his legs, and the nurse referred him for a Doppler ultrasound scan. This is a procedure used to measure the blood supply to the legs.

44. In August, the man attended a follow-up cardiology appointment. The cardiologist reported that he was doing well and, whilst he was free from palpitations and symptoms of angina, he had symptoms of blocked arteries in his left leg. He said that the man also had a probable fast heart rhythm and recommended that he have a pacemaker fitted. He also prescribed Amiodarone (a medication used to treat an irregular heart beat).

45. In November, his blood platelet count was low and his full blood count was abnormal. This was expected by nurses as he was still not taking all of his prescribed medications, although his blood clotting screen test came back as normal. On 25 November, he had another angiogram procedure which showed his right coronary artery was blocked. He said that he felt well following the procedure and that he suffered no adverse affects.

46. The man had a diabetic retinopathy review on 12 December. The procedure screens the eyes for any retina changes caused by diabetes. His medical record shows that there were mild changes to his retinas and that no further treatment was needed at the time. He was to have another review in a year's time.

47. On 19 February 2009, the man was admitted to hospital to have his pacemaker fitted. As part of the procedure prior to having the pacemaker inserted, he had a chest X-ray, which showed a shadow on his lungs. A bronchoscopy was carried out in order to further examine this issue and attempt to arrive at a diagnosis. This involves a medical instrument being inserted through the nose or mouth to look at the inside of the airways. The result of the bronchoscopy was normal, though a note was made that it had not reached the mass shown on the X-ray. He was informed that further tests would need to be carried out, though he was also told that the shadow shown on the X-ray was likely to be a cancerous tumour.

48. The man returned to the prison on 26 February. He said that he felt fine and was in no pain, so he went back to his cell on the wing. His daughter sent a letter to the Queen, with a copy to Hull, asking her to grant him release due to his ill health and so she could care for him. The governor received a letter from solicitors acting on behalf of him and his daughter, requesting clarification that he had cancer, what his treatment plan and care plans were, whether he was coping on the wing and if he had applied for compassionate release. He had given consent for his medical documents to be released to his solicitors. At this point, he had not been diagnosed with cancer and was awaiting further diagnostic tests.

49. On 17 March, the man returned to hospital to have an angioplasty procedure on his left leg. (Angioplasty is the technique of mechanically widening a narrowed or obstructed blood vessel.) The procedure was successful and letters from the vascular surgeon stated that he could now walk up to half a mile and was to continue to take aspirin and Simvastatin. No follow up appointments were needed.

50. A Principal Officer (PO) wrote to the governor with information relating to the solicitor's letter on 24 March. He said that the man had expressed a wish to stay on the wing as he felt better able to cope being surrounded by his friends and had chosen not to go to the healthcare unit. He had not applied for compassionate release as he said he had only just been diagnosed and had not got around to it. He was advised to contact his offender supervisor should he wish to do so. The Head of risk management replied to the letter from the solicitors answering their questions.

51. The man attended the healthcare unit on 31 March. He asked if staff could find out any details regarding his recent diagnosis. He said that he had been diagnosed as terminally ill with cancer, but not told exactly what was going on. He was told he would be going back to hospital but had not heard anything.

52. On 1 April, he had another cardiac outpatient appointment. His cardiologist thought that he was doing well and would be reviewed again in due course. The next day, the healthcare unit at Hull received

a phone call from another hospital advising them that the former hospital had referred him to them to have a positron emission tomography (PET) scan on 15 April. A PET scan works by detecting a radioactive substance inside the body and making three-dimensional, colour images. It is often used for lung problems that cannot be diagnosed using bronchoscopy.

53. The man completed a questionnaire with a nurse prior to having the PET scan. His medical record shows he told the nurse that he was confused as to whether he had cancer or not. He had been told that he had a shadow on his lung that was highly likely to be cancerous, and then attended a GP clinic and was told that the bronchoscopy was clear. He had misunderstood and thought this meant he did not have a shadow at all. He was upset as he had told his family he did not have cancer. The nurse discussed this with the doctor and told the man that there was still a possibility of him having cancer, that the bronchoscopy may not have been able to see it, and that the PET scan would be able to confirm it. She apologised and reassured him.

54. On 15 April, he went to hospital to have the PET scan. (According to his prison records, they provided what was described as a secure location for the scan.) Unfortunately, as he had been non-compliant with his diabetes medication, his blood sugar level was high and this meant he was unable to have the scan. The blood sugar level required was between 4 and 8.3. An urgent appointment with the doctor was made, to help him control his blood sugar level so that he could have the scan. The healthcare unit at Hull was asked to telephone the hospital two days prior to his new scan date of 24 April, to let them know if his blood sugar level was within the required range. He agreed that he would be compliant with his medication to ensure he was able to have the scan.

55. A doctor reviewed the man's diabetes medication with him on 16 April. He told the doctor that he controlled his diabetes through his diet alone, and refused to take anti-diabetic medicine. The doctor wrote in the clinical record that the man was highly manipulative throughout the review. He advised him that if he was not compliant he would fail to meet the requirements for a further PET scan. At this point, he changed his mind and said that that was why he was there. He was prescribed metformin and advised to keep a regular check on his blood sugar levels. He received a warning on 18 April for having 95 books in his cell. On 18 April, his blood sugar level was recorded at 12.2.

56. The Head of Healthcare received information that the man was aware that his PET scan was scheduled for 24 April. Due to security reasons she had to cancel this appointment, but was able to rearrange it for 28 April. His blood sugar level on 27 April was measured at 7.9, within the required range. He went to hospital the next day and had the scan. When he returned to Hull, he said that he was fine and that the hospital would send the results to the other hospital.

57. It was not entirely clear from the medical record when he was informed of his diagnosis. However, letters sent from hospital staff to the prison indicated that the PET scan showed a cancerous, non-operable tumour in his lung. At the initial X-ray stage, there had been some indication that the tumour might be operable, though the PET scan had shown that this was not the case. The recommended course of treatment was chemotherapy.

58. On 13 May, the man's daughter's doctor wrote a letter to staff at Hull informing them that she had been to see him and was very distressed. She had said that her father had lung cancer and felt that no one was doing anything about it. The doctor wrote that he just wanted to make them aware of this and that there was some agitation and unhappiness from the family.

59. The man attended an appointment with the Consultant Physician in Respiratory and General Medicine at the hospital on 16 June. The doctor referred him to an oncologist and apologised for the length of time that had elapsed between being last seen and having the PET scan. This was due to the difficulty in finding a secure PET scanner (suitable for prisoners). He wrote in his letter to HMP Hull that he was not presenting any respiratory symptoms.

60. The man's daughter sent a letter to the governor at Hull. She said that she had seen her father on 27 April and he had told her that he had terminal cancer, with three months left to live. She wanted to know if he would be accepted for early release so he would be able to be with his family when he died.

61. On 3 July, he had an appointment to see the oncologist. He had his chemotherapy booklet in his possession and was aware of his hospital appointment dates and times. However, his appointment was cancelled for security reasons. The hospital said they would contact Hull with a new appointment.

62. The prison's Head of Operations responded to the man's daughter's letter on 8 July. He wrote that he appreciated her concerns over her father's health and reassured her that he had been advised of all the options available to him. He said that Hull actively supported a duty of care to staff and prisoners and all efforts would be made to assist her during this time.

63. The man started his chemotherapy treatment on 15 July. He returned from hospital with prescribed anti-sickness and steroid anti-inflammatory drugs. On the same day, his solicitors contacted Hull via letter stating that he had instructed them to write regarding compassionate release. They requested an urgent submission to the Secretary of State, and said that his family had had no response from Hull regarding the request for early parole or release on temporary

licence (ROTL). They requested a response by 17 July. A member of staff sent a fax to the solicitor's office on 17 July, stating that the application process had begun and the case would be dealt with as quickly as possible, however it was difficult to confirm a date for completion as reports had to be gathered from a range of sources. The solicitors wrote to Hull again on 21 July requesting information on his release application.

64. A doctor assessed the man as part of his early release application on 23 July. He had not met him before but read his medical notes prior to the meeting. He wrote that his responses were to the best of his knowledge and were corroborated by his physical appearance that day. He advised that his diagnosis was poor and that it was not likely that he could walk over 100 yards without suffering breathing problems. He said that he was unlikely to commit further crimes.

65. On 28 July, a meeting took place to discuss the man's application for early release. The minutes of the meeting show that his offender manager had requested a transfer to HMP Acklington, so that he could complete further work to address his offending behaviour. The minutes also stated that he was not eligible to go into approved premises (hostel accommodation) as he would need 24 hour care if he was as unwell as he claimed. Members of the risk review panel thought that he might use his condition to avoid doing programme work in the community. They judged him to be a high risk of serious harm and, if he were released, very high risk. It was therefore agreed that the application for release would not be supported. On seeing the report, he wrote a response as to why he saw himself as suitable for early release. He said that the report by the doctor on 23 July had been omitted from the report.

66. His solicitors wrote to the governor again on 31 July asking about his health, whether there had been an outcome from his application, and the outcome of the risk review meeting.

67. On 3 August a letter from the man's oncologist was received confirming that he had cancer and was undergoing chemotherapy treatment. If the chemotherapy worked, he would have a life expectancy of eighteen months. The oncologist had fully apprised him of his diagnosis, prognosis and treatment plan.

68. He was unable to have chemotherapy on 5 August as his white blood cell count was low. The oncologist asked for his temperature to be taken twice a day and, if it was 38 degrees or above, to contact the oncology department for advice. He was to remain on the wing at this time as healthcare inpatients were in an isolation area for swine flu. If he felt unwell or had a raised temperature, he was to go to hospital.

69. The next day, he began to feel unwell. He had not attended for his blood test and healthcare staff explained to the wing staff that it was

very important for him to attend. He had decided not to go as he had a probation appointment and was made aware of the consequences of not attending. If the clinic finished early, then someone was to go and see him on the wing, otherwise his appointment would be re-booked for the next day.

70. The man was admitted to healthcare on 7 August following a discussion with the Head of Healthcare. He was to be observed over the weekend due to his low immunity. He was initially anxious, but was reassured when his care plan was explained to him. He joined in with association and wing activities. The doctor took his temperature, which was 37.5 degrees. He advised the man was to have his temperature taken three times a day and his blood pressure twice a day. The man said that he was feeling well, although if he deteriorated, healthcare staff had a letter ready to accompany him to hospital. Preventative antibiotics were prescribed.

71. Over the next few days, he felt well, although he said he was very tired. His temperature and blood pressure remained stable and he appeared settled in healthcare. Nurse A recorded in his medical record that a decision was made for him to stay in the healthcare unit, as that was the best place for him at the time. He agreed and said that he did not wish to return to the wing, where it was noisier.

72. His solicitors contacted the governor again on 11 August. They said they had not received a reply to their previous letter, again asked about his welfare, and requested information from his probation and risk review reports. The solicitors wanted to know if a specialist had been approached for a report and if there was a date for his case to be put forward. Social workers visited his daughter and grandchildren as part of the application process. His daughter and her husband signed disclaimers stating that their children would not be allowed any contact with him, should he be released.

73. The man re-started chemotherapy on 12 August. He told Nurse B that, whilst he was at hospital, he had a long conversation with his oncologist and was going to seek help from telepathic faith healers to ensure that he did not die in prison. He wanted to be at home with his family, especially his daughter. Because of his strong beliefs and wish to die at home, she did not discuss resuscitation options at this time. He remained settled on the healthcare unit and staff reviewed his care plans on a regular basis.

74. During the early hours of 17 August, the man complained of light-headedness and generally feeling unwell. He told a nurse that he had gone to the toilet and passed out. The nurse recorded in his medical record that he had no signs of physical distress, although he appeared anxious and had asked to talk to a nurse later that morning. Nurse A recorded that he began to feel better as the day went on. He spent

some time drawing and writing, and said it helped him deal with the psychological side of cancer.

75. His solicitors wrote again as they had still not had a response to their two previous letters. They intimated that, if they did not receive the information they had requested by 4.00pm that day, they would initiate urgent judicial review proceedings.

76. Nurse A spent some time with him on 19 August. He was concerned about his chemotherapy and talked about his cancer and his emotions. He said he still felt quite positive and was hopeful about faith healing. He requested a walking stick and Nurse B arranged for a mobility assessment. She made an entry in his medical record that an end of life care package was to be implemented via the Liverpool Care Pathway (an outline of the level of care that patients can expect in the final few days and hours of life) when it was required. She advised staff to talk to him daily about his thoughts and wishes, and a care plan for his health and diabetes observations was created.

77. The man returned from chemotherapy that afternoon. He said he felt tired but had no nausea and was able to eat and drink. Nurse B recorded that he still had good spirits. The Head of Risk Management wrote to the man's solicitors informing them that he presented well and a dossier had been prepared and sent to the early release section, with a copy sent to them. He told them that for the risk review documentation they needed to speak to his offender manager. As his solicitors would not have received the letter immediately, they wrote again on 20 August, saying that as they had not received a response as requested, they would take steps to begin the process of judicial review.

78. On 24 August, the man felt dizzy while walking to his education class. He said that he had stood up too quickly. A nurse advised him to rest, but he said that he felt okay. He went into education ten minutes later, after having a cigarette. Nurse B checked on him in the afternoon. He said he felt better than in the morning and admitted that he had not eaten breakfast, although he knew he should to help control his diabetes. She recorded that he looked pale and had said, "I'm fine, I won't die in this place if that's what you are worried about." She said that she was just checking that he was not in pain, to which he said he was not.

79. The nurse discussed his preferred priorities for care with him on 25 August. She recorded in his medical record that he asked to remain in prison, but wanted to stay in his cell rather than the palliative care suite. He did not want to die in a care home, handcuffed to an officer. He said he did not expect to get parole, but believed his faith in God and support from telepathic faith healers would keep him going until his next parole hearing in May. She told him that the doctor had agreed to

oversee his palliative pain management while at Hull and would soon introduce himself.

80. His solicitors wrote again saying that they were disappointed that they had not had a full response to their letters. They were concerned about the lack of urgency in dealing with the matter and maintained that there had been unclear and contradictory information supplied. They had not received their copy of the release application dossier and asked for another to be sent. They expected the case to be progressed as a matter of urgency and stated that if they did not receive a satisfactory response they would consider legal steps as well as contacting the Ombudsman.

81. An officer from Public Protection Casework Section emailed the solicitors informing them that another copy of the release application dossier would be sent. He also said that the prison had not yet received a specialist medical report. No decisions could be made until that time. Another officer also wrote to the solicitor answering their questions in order. He enclosed copies of the man's risk assessments, medical and recall reports. He told them that he had contacted his offender manager and as some reports were restricted, they would have to request the risk review report themselves.

82. A healing trust based in the local area contacted Hull asking how to proceed with a request that the man had made to see them. They were told that if he wished to see them he would need to supply them with a visiting order. There is no evidence within his documents to suggest that the healing trust visited him at Hull.

83. The man was concerned he was not receiving all of his prescribed medication. Nurse B checked the list provided by his oncologist and confirmed he was being prescribed everything listed. She recorded that he appeared more settled since the discussion, but was angry about the Parole Board and that he seemed generally angry that day. She said that recording his temperature was not really necessary any more, but that it gave the nurses a good chance to talk to him about his concerns.

84. A doctor assessed him on 3 September. He recorded in the medical record that the man was still doing reasonably well and was not yet terminally ill. He had some shortness of breath on exertion, but had experienced such symptoms for a number of months. He was having no more cardiac surgery due to his condition, and denied any chest pain. The doctor said they would know more about his condition after his chemotherapy finished and he had a re-staging scan. He was keen to be resuscitated in the case of a cardiac arrest and the doctor said he would review him again in three weeks time.

85. By 9 September, the man had undergone two cycles of chemotherapy. The third cycle was dependant on his blood test results, however in a

letter from his oncologist it was noted that there was a delay in the third cycle due to communication difficulties between the hospital and the prison.

86. He complained of swelling to his feet and ankles on 12 September. He was examined by a nurse who advised him to elevate his legs and said that he would be reviewed daily. The swelling did not go down and so a doctor prescribed tablets used for the treatment of high blood pressure to remove excess fluid from the body. He was told that he sat for too long in his chair each day and was advised to lie on his bed four times a day with his feet higher than his head.

87. A doctor examined him on 18 September. He had been coughing through the night and was breathless and weak. The doctor noted that he had decreased air entry in his right lung, but was bright and alert and prescribed codeine for pain relief.

88. On 23 September, the Parole Board considered the man's application for early release. The case was deferred as the board felt that there was insufficient evidence and wanted to obtain a report on his medical condition. On 25 September, the Secretary of State rejected his request for early release. His grounds for rejection were that he was still mobile and had had no side effects after his first round of treatment and medication. There were also concerns in the reports that he did not fully accept his offending and attributed blame to the victim. The reports did not indicate that he was physically incapable of further offending at the time and assessed his risk as high.

89. Nurse C spent some time with the man on 27 September as he was feeling dizzy and having difficulty with his balance. He said that he had nearly passed out as he was getting out of bed. On examination, his blood pressure was within the normal range. He was anxious about upcoming hospital appointments. A doctor assessed him again the next day. He thought he appeared anaemic, possibly due to the chemotherapy, and would check with his oncologist if he could start on some iron tablets.

90. The man was worried about having to go back to a residential wing. Nurse B told him that unless there was a swine flu epidemic he could stay on the healthcare unit. He said he still wished to die at home with his friends and family. She noted in his medical record that he was not to be discharged from the healthcare unit without authorisation.

91. The nurse referred him to see the doctor on 12 October. He was urinating frequently during the night. On examination, the doctor found that his prostate was enlarged and prescribed medication to treat the condition. He said that he would review him in a month's time.

92. The man's white blood count was low on 20 October. A nurse made an entry in his medical record that he might need to be admitted to

hospital and was waiting to hear from his oncologist. Members of staff were advised to test his blood again the next day and, if they had any concerns, to telephone the hospital. He said that he did not feel right, however he was observed taking exercise and in his education class. The next day his blood test results showed that his white blood count was still very low. He was admitted to hospital for a blood transfusion where he stayed overnight. He said he felt okay and that he had felt okay before being admitted, but understood why he needed to go to hospital.

93. On 24 October the man told Nurse C that he was not going to take his medication or eat as of lunchtime that day in protest at his property being searched and books and pens being removed. She explained that the officers had to search for excess items in cells and remove them accordingly. She asked him to reconsider his decision as it could have serious implications for his health. He told her that he was going to die anyway, so it would just be sooner than he thought. She told him that the actions of the officers were not personal, and again asked him to reconsider. Ten minutes later he returned and told her that he would not stop his medication and would eat his lunch.

94. Nurse B saw him later that day. She noted in his medical record that he continued to have a sense of humour, was happy in the healthcare unit, continued to smoke regularly, and felt better after his blood transfusion.

95. Another risk review meeting was held on 27 October. All the actions required had been completed regarding his early release. He had possible places to live on release and people to care for him, although a few family issues were noted. The minutes of the meeting suggested that two of his daughters and a friend visited regularly, however his prison record showed that he had not had any visits since July.

96. The man asked to see a doctor on 2 November. He was complaining of acute constipation. When he was told there was no doctor on duty he said to Nurse C that she must do something and that she would take action if he was having a heart attack. He was reported to be hostile and demanding, asking for morphine for the pain. She asked him why he had not said anything sooner, and discussed his diet and fluid intake with him. The next day, he felt better and apologised for his behaviour.

97. On 11 November, he told Nurse A that he was worried that the hospital had forgotten about him. Nurse C said she would ask the doctor to talk with his oncologist and then inform him of his treatment plan. He attended for chemotherapy the next day, when he was advised that vitamin B12 injections may be beneficial to him. (Vitamin B12 injections are commonly used to treat anaemia.) He was to have one injection weekly for four weeks. He presented himself to Nurse A again on 14 November as he was concerned that he was not being informed

of his prognosis. The nurse left a message in the communication diary for a doctor to contact his oncologist and discuss his treatment plan.

98. Nurse B spoke with him on 26 November. She told him that they were awaiting an oncology appointment and further information about his condition. She advised him to write down any questions he had for his oncologist.

99. On 30 November, the man told a nurse that he had felt unwell in the morning but had not told the nurse as there would have been nothing that they could have done for him. He said that he was sitting in his chair and had a period of unconsciousness but then came round after about five seconds. The nurse arranged for the doctor to see him the next morning, but did not carry out any baseline observations as he said that he felt fine. He was observed in education and appeared to be engaging well.

100. He had an appointment with his oncologist on 2 December. He told a nurse that he was dismayed at having to walk to his transport because it had not been brought round to the healthcare unit. The nurse reminded him that he was capable of walking, just as he did on his visits. He replied that he had been told that he might not survive up to Christmas and would definitely not survive until next Christmas.

101. Nurse D had a one to one discussion with the man the next day. She said that he appeared low in mood after his appointment the previous day, and told him that the cancer had spread to his lymph nodes. He felt upset that he could not be with his family and that his prognosis was so poor. His oncologist had offered him more chemotherapy but had warned him that the treatment could shorten his life expectancy and make him very ill. He said that he still wanted to be resuscitated and did not want to make any changes to his end of life care package. She faxed his oncologist, asking for his prognosis to be sent to healthcare staff at the prison so that they could put care plans in place.

102. His re-staging scan results were received on 14 December. They showed that chemotherapy had not arrested the disease and that it had progressed significantly since his scan in February. His oncologist said that he would have a follow up review in two to three months.

103. Nurse B spent an hour discussing his prognosis with him on 16 December. He understood that the tumour had enlarged from the size of a golf ball to that of an orange and that his lymph nodes were affected too. He said he knew he would exceed his oncologist's prediction of dying before Christmas and would be pleased to prove him wrong. The nurse said his positive attitude was probably keeping him going. She discussed the Macmillan nursing team role and said she would contact them soon.

104. A nurse received a telephone call from the prison's control room on 19 December, saying that the man's daughter had called and voiced her concerns. Her father kept ringing her to say that he was going to die before Christmas because of his cancer. An officer had reassured her.

105. He refused to take his iron tablets as they had been making him feel unwell. Nurse A referred him to be seen by the doctor as soon as possible as he had also lost 3kg in weight. The doctor who saw him on 21 December advised that another blood sample should be taken and he was to be reviewed after that.

106. The man's daughter sent a letter to the healthcare unit stating that her father had told her he might die before Christmas. She wanted to know if it was true. A healthcare officer wrote to her saying that he had spoken with her father. The man had assured him that he would send a copy of the oncologist's report which had been recently received. He said that the man had been well enough to organise the Christmas competitions for inpatients in the healthcare unit and had told him that he intended to win all of them.

107. Nurse B reviewed him on 28 December. He said he was not in any pain and that he was in a low mood as his daughter had been unable to visit him. He said he was getting a lot of support from the Age Concern team who gave much of their time to him, and he had recently had a party in the chapel. He was still insistent that he was not going to die in prison and would seek parole early the next year.

108. Nurse D spoke with the man on 16 January 2010. He said he was angry that the prison would not release him and he felt that it was a personal vendetta. He added that his pain levels remained controlled and he was eating and drinking well.

109. He attended for retinopathy screening on 18 January. The results of the test were not clear and so he was referred to hospital for another eye exam. He attended hospital where he had drops put in his eyes, to show if there was any disease in them. The drops indicated that he had no eye disease present.

110. On 8 February, the man was discharged back to I wing. His health was stable and he was compliant with his medications. Members of staff on I wing were told that if his health became a concern, he was to be re-admitted for observation. He did not really want to be discharged from the healthcare unit, but a nurse explained that he would have better access to facilities on a residential unit.

111. He had an annual diabetes review with a nurse on 19 March. He told her that he had not been taking his diabetes medication or checking his blood sugar level, and that he had stopped smoking five weeks earlier without the help of patches. An appointment was made to discuss this with the doctor. A doctor assessed him on 22 March. He told the

doctor that he felt better without the medication and that, although he had not been taking blood pressure tablets for six weeks, his blood pressure was fine. He said he had not taken any diabetes medication for the previous 18 months. He was adamant that he did not want to take any medication and requested a copy of the report written by a doctor in July 2009. The doctor advised him to make an application for a copy of the report.

112. The man had a review with his oncologist on 25 March. The oncologist wrote that he was feeling very well and was displaying no symptoms. He believed he was improving every day and might be cured. He demanded a re-staging scan as he was convinced he could prove them wrong. His oncologist had explained that his tumour might be growing slowly and so not producing any symptoms yet. He agreed to see the man again in three months time and if he still believed he was improving he would arrange a re-staging scan.

113. A nurse examined him on 4 April as he said he was feeling dizzy. She advised him to take his blood pressure tablets and to drink plenty of fluids. She told him to put in an application to see the doctor and to contact staff if the dizziness continued. The doctor assessed him on 23 April. He recorded in the man's medical record that he was frail but okay, and had asked for compassionate release.

114. The man referred himself to the optician on 2 June. He said he had been applying for new glasses for over a year without success and was now nearly blind. He argued that as a diabetic he was legally entitled to new glasses every year and the last time he had received them was two years earlier.

115. On 15 June, he was eligible to be reviewed for parole. He completed the appropriate form to start the process. He attended an oncology appointment on 2 July. The oncologist said that his cancer was clinically stable and he had a re-staging scan.

116. An officer wrote a conduct whilst in custody report for the man as part of his application for parole on 7 July. He said that the man had minimised his offending as stated in his probation report in August 2009, and he did not appear to understand that he would encounter high risk situations if released. He was also unable to indicate what coping strategies he would put in place. The officer did not recommend him for early release on that occasion.

117. Prison Doctor A reviewed the man on 20 July. She discussed his reasons for not collecting his medications since February. He said that he did not think they were providing any benefit and he was not going to take them at all. He was interested only in his recent re-staging scan results. She also tried to convince him to see the mental health team, but he maintained that there was nothing wrong with his brain.

He was advised of the consequences of not taking his medication and to contact her if he changed his mind.

118. A pre-release risk assessment meeting was held. Those present were told that the man had cancer, had engaged in a rolling SOTP in 2007, and had received two adjudications (breaches of the prison rules). It was said that he was always polite to staff, associated well and read a lot in his cell. He had regular visits from his daughter as well as contact through telephone calls and letters.

119. The man asked healthcare staff to find out his recent scan results from the oncology department. He wanted to know if he was in remission or still had cancer as not knowing was affecting him psychologically. A letter from his oncologist was received the next day with a report showing that the cancer had spread. His oncologist said that one approach was to keep him under review and the other was to try further chemotherapy.

120. The Probation Trust telephoned the healthcare unit on 2 August. They said that they had sent two requests for information regarding the man's diagnosis of cancer and had not received any response. The healthcare manager, gave permission to send confirmation of the diagnosis via email and promised that a doctor would give them more detailed information as soon as possible.

121. Prison Doctor A discussed the outcome of the scan with the man on 10 August. She explained the content of the letter from his oncologist. She recorded in his medical record that he had chosen to remain under review, and asked for the nurse to check his blood. She advised him to return at any time if he changed his mind. A couple of days later he asked her to refer him to his oncologist to discuss his cancer treatment.

122. A nurse took a blood sample on 24 August. She discussed the recent letter and report from his oncologist. He said he was not really sure of what the doctor had said and he did not agree to the first option of staying under review. He had now thought things through and wanted to discuss chemotherapy with his oncologist. The nurse also gave him a copy of the report written by a doctor on 23 July 2009, which he had previously requested.

123. Prison Doctor A referred the man back to his consultant on 9 September. She challenged him about not taking his medication and he agreed to have his blood sugar level taken and to restart on metformin.

124. On 4 October, Prison Doctor A saw him as he said he had been experiencing pain in his shoulder for ten days. He asked for a letter to be sent to the Parole Board and requested something to help him sleep. He told her that he did not want to go to the healthcare unit or to

hospital. On examination, his chest was clear and he had full movement in both shoulders, though his heart rate was irregular.

125. Wing staff took the man to the healthcare unit on 8 October for a full assessment by Nurse B. He said that he did not want to stay in the healthcare unit and did not want to be there. She had a long chat with him and asked him to remain in the healthcare unit so they could offer him palliative care. He told her that he did not want this as he was not going to die. She wrote in his medical record that he was very frail and had not been eating. She went on to note that he had always been in denial about his condition and intended to get parole to see his family once more. Officers collected his personal belongings from the wing as this was the only way they were able to get him to remain in the healthcare unit.

126. A doctor reviewed the man later that evening. He noted that he was able to talk normally except for some hoarseness. He had pain in his upper ribs and had lost his appetite. He reassured him that he was strong despite his condition. The doctor advised that he was to stay in the healthcare unit while he stabilised, and opiate pain relief was to start. He was to be reviewed daily.

127. Nurse A observed him on 9 October. She recorded in his medical record that he had eaten two slices of toast and had two supplement drinks. He had been to see the chaplain and a telephone call with his daughter was arranged. She noted that he was able to mobilise with assistance and was in denial about his prognosis, saying “I have only been given a week, but I proved them wrong last time, I am not going to die”. He was resting on his bed and experiencing some pain, so she advised that he was to be reviewed by the doctor at the earliest opportunity.

128. Later that evening, Nurse A went to check on him again, but found she was unable to get a response from him. Once inside his cell, she was able to wake him and he sat up to take his medication. When asked how he was feeling, he said he felt average. She gave him some water and some of his supplement drink, before leaving him to rest on his bed.

129. On 10 October a nurse offered him the opportunity to move to the care suite. He declined, saying that it was the “death cell”. The nurse explained that he would have more space and a hospital bed. It would also be easier for nurses to meet his needs, but he still refused. An officer spoke to him at 10.00am. He explained that the move to the care suite would help him with regard to his application for early release and would be better for his visits. He then relented and moved to the care suite.

130. The man called for help from his cell at 6.10am on 11 October. A nurse attended and wrote in his medical record that she had found him

on the floor. He said he had gone to the toilet and fallen on the way back, but had not hurt himself. The nurse examined him but found no visible signs of injury. He was not complaining of pain. She advised him not to get up without staff assistance, however he was observed to have ignored this advice.

131. At 10.33am, he asked to see Prison Doctor A as soon as possible, as he had pain in his right arm and in his chest. Another doctor went to examine him at 12.32pm. He prescribed morphine sulphate to be given every two to four hours and advised that his family were to be informed that his death would be likely in the next few days. The head of healthcare was informed of the doctor's review. Resuscitation was discussed and he was adamant that he still wanted to be resuscitated. He asked about family contact and was told that a family visit was being arranged.

132. A nurse attempted to assist the man with food and fluids throughout the day, but he declined most of her offers despite being told he would feel weaker if he did not eat or drink. She also had telephone conversations with his son and daughter as they both requested an update on his condition. She informed them that he was comfortable and assisted him to speak to them himself on the telephone. Arrangements were made for his daughter to visit him in the healthcare unit the next day.

133. On the early morning of 12 October, the man lost his balance and had to be helped back to his bed. Nurse A recorded in his medical record that he appeared confused and disorientated. She offered him food and fluids, however he declined these again. He was placed on close observation to minimise the risk of further falls.

134. At 10.22am the same day, the Head of Healthcare made arrangements for him to move to hospital after his visit with his daughter in the afternoon. She spoke with the oncologist who was trying to arrange a bed on the oncology ward, but she was advised that this could take up to two days. Following his daughter's visit, he was still very confused and disorientated and appeared to have deteriorated, with his breathing being very shallow. An ambulance was called at 3.46pm and arrived at 3.51pm. He was examined and taken to hospital at 4.40pm.

135. A risk assessment was made prior to the man being taken to hospital. He was assessed as requiring handcuffs, with a two officer escort. Visits were not to be made without the approval of the head of operations, operations governor or duty governor. Restraints were to be removed for emergencies and with authorisation, but were not to be removed for treatments. Release on temporary licence was not considered at this time.

136. On arrival at hospital, he had an X-ray and at 8.30pm moved to a ward at another hospital. A nurse spoke with the bed watch officers (prison

officers responsible for escorting and supervising prisoners whilst in hospital) on 13 October, and they informed her that he was still much the same. He had an intravenous drip to replace his fluids and was awaiting transfer to the oncology ward.

137. During the afternoon deputy Head of Operations, was informed that the man's daughter had telephoned the hospital the previous evening to say that the governor had granted permission for the removal of restraints. He attended the hospital to inform the staff and bed watch officers of how bed watch and restraints were to be managed. He reiterated that an emergency risk review report stated that the man still posed the highest level of risk to females and children. Although he was extremely ill, the risk remained high and there was a possibility that he could receive help to re-offend. The telephone call was discussed and the Sister on the ward agreed that only male staff would be used to treat him where possible, but if not then staff would be made aware of the situation and would not work alone. Prison staff were to be present at all times to supervise. No children were to be permitted to visit and, if any incidents arose, they were to be reported to the police who had an open log ready and would respond immediately.

138. The Head of Operations went to the man's ward at 2.00pm on 15 October. He updated the risk assessment and met with the Matron. She mentioned that she had been asked to facilitate a supervised visit for him to see his grandchildren and she would carry out the supervision. The Head reiterated the risks presented by the man to children and females and the restrictions that had been placed on him. He relayed this information to the prison so that the chairman of the risk review panel and the man's offender supervisor could be contacted.

139. The man's offender supervisor returned the Head of Operations' telephone call. She said that there had been no changes made to the restrictions put on the man and that no child visits should take place. All the information had been passed on to the duty governor who was in charge of the establishment at the time. The Matron and the bed watch staff were informed that all restrictions were still in place unless alterations were authorised by the duty governor.

140. Two officers took over bed watch duties on 16 October. They had a handover at 6.45am and were advised that restraints were to be removed if the man's condition deteriorated, but authorisation still needed to be given by the duty governor. There had been a misunderstanding during the evening that he was in a coma; however he was asleep on his back and breathing heavily.

141. At 8.45am, one of the nurses attended to the man. Officer A wrote in his statement to the Governor that the nurse had told him that as the man's breathing was steady, his condition was considered stable and

he was not expected to pass away imminently. Until there were any changes in his breathing there was no indication as to when he might die. His breathing did not differ until 11.52am, when his breathing stopped and he passed away. A nurse pronounced him dead, and this was later confirmed by a hospital doctor. He was restrained in handcuffs until three minutes after his death, when the bed watch officers obtained authorisation from the prison to remove his restraints. His family members were informed of his death by hospital staff.

142. Officer B wrote in his statement that the man's family had contacted the hospital at 1.00pm and indicated that they did not intend to go to the hospital. At this time, a Senior Officer (SO) had been trying to contact the man's daughter but was unable to do so as the telephone line was engaged. The control room log shows that at 1.02pm, his daughter telephoned and asked for his cell to be cleared and all of his property to be sent to her. A chaplain managed to contact her at 1.15pm and offered his condolences. The duty governor then telephoned her five minutes later. An officer contacted her at 3.10pm and introduced herself as the prison family liaison officer (FLO).

143. A meeting known as a 'hot debrief' was held at 4.00pm. All staff who had been involved in the man's care and who had been present at the time of his death were asked how they were. No-one expressed any problems and the support of the care team was offered.

144. The governing Governor sent a letter to the man's daughter and son on 18 October, offering his condolences. He said that the post mortem results were not yet known and that the coroner would contact them with any information. All monies and property would be forwarded to them and financial assistance with the funeral costs was offered. His property was given to his daughter two days later.

145. The Matron wrote to the governing governor on 19 October. In her letter, she explained that she had been closely involved in the man's care. She reported that he had deteriorated rapidly at the end of his life, but had appeared stable, comfortable and settled during the morning. Bed watch staff had been told they would not be able to determine a time of death and that changes to his breathing would indicate this. In the event, there had been no changes to suggest that death was imminent and he simply stopped breathing and died at midday. She said that one of the bed watch officers had been quite shocked at his death as there had been no warning signs. She had reassured him that these things sometimes happen and patients just "slip away". She went on to say that she was very impressed with the professionalism and dignity shown by the prison officers. They had been respectful at all times, particularly when nursing staff were attending to his personal needs.

ISSUES

Clinical care

146. A clinical reviewer conducted a review of the man's medical care whilst at Hull. In order to complete the review, he had access to his clinical record. The clinical reviewer did not make any recommendations as part of his clinical review. When considering the issue of whether he received an equivalent standard of care to what might have been expected in the community, he wrote:

> "He received better care in some ways when compared to community care. There is a healthcare wing near to his location, he attended all outpatient and inpatient activities and had a pharmacy on site. He had regular blood checks and other monitoring during his time in the prison and more so when the chemotherapy was commenced. He was given access to healthcare appointments when he asked for them."

147. The standard of record keeping regarding the man's health was good. Detailed entries were made in his clinical record about the many appointments that he attended. He was offered a range of services and interventions as appropriate. He was not always compliant with his medication. It is, of course, for an individual to choose whether or not to take medication that is recommended and prescribed. He refused on a number of occasions, sometimes for sustained periods, to take medication recommended to manage his diabetes. There is evidence in the clinical record that members of healthcare staff talked to him about the possible effects of declining this medicine, and encouraged him to take it as prescribed.

<u>The diagnosis and treatment of the man's cancer</u>

148. When the man first arrived at Hull, he mentioned that he had undergone a chest X-ray which showed a shadow on his lung. The prison healthcare staff wrote to his GP in the community for further information, but there was no record of such an X-ray. It appears that no further follow-up action was taken at that time.

149. In February 2009, he underwent a chest X-ray, not because of any lung problems but because he was due to have a pacemaker fitted. This X-ray showed a shadow on his lung which was thought to be a cancerous tumour. A subsequent bronchoscopy proved inconclusive and so a PET scan was recommended. This did not take place until late April, and notes in his clinical record suggest that this was because of difficulties finding a 'secure' PET scanner. It also involved him travelling to Birmingham. This delay was later described by the Consultant Physician in Respiratory and General Medicine, as "unacceptable". In his clinical review, the clinical reviewer concluded

that although there was some delay in diagnosis, it would not have changed his prognosis or available treatment options.

150. After seeing the oncologist to discuss treatment options, the man began chemotherapy in July. He continued to receive such treatment until November. A scan showed that the chemotherapy had been ineffective. He was advised that he could continue with treatment or remain under review. Further scans in 2010 showed that the cancer continued to spread, although he said he felt few symptoms and remained adamant that subsequent scans would show remission.

151. The medical record indicates that the man was mobile and relatively well for much of 2010. Although he was frail, he was able to care for himself and did not want to live in the healthcare unit. His health deteriorated rapidly in the last few days of his life and he moved to hospital.

152. Although there was some evidence in the man's medical record of appointments that were cancelled by the prison, there did not seem to be any serious failings in respect of the treatment and medical intervention that he received. He was able to see an oncologist, and was kept fully apprised of his diagnosis, prognosis and treatment options. He was involved in his care planning and was clear about what treatments he did and did not want.

Communication

Communication between the prison and hospitals

153. During his diagnosis with and subsequent treatment for cancer, the man necessarily spent significant periods attending appointments in hospital. He saw the oncologist on a number of occasions, and regularly attended appointments for chemotherapy.

154. Members of the healthcare team at Hull were supportive, making efforts to talk to the man when he returned from hospital. However, they were not always clear about his treatment and care options, and relied on him to explain what had happened at the appointments. Following his appointments at hospital, the relevant doctors wrote to the prison with information about what had been discussed and agreed upon. However, these communications were sometimes received by the prison weeks later.

155. Whilst it was good practice for healthcare staff to speak to and support the man when he returned from hospital, they should not have had to rely on him to inform them about his medical intervention. He may well have been able to provide useful information, but could not be expected to remember everything that had been discussed during an appointment, particularly when it involved distressing news. I

appreciate that the prison did eventually receive details of his appointments, but this often involved a delay of several weeks.

156. Furthermore, it was clear that on some occasions, members of staff issuing appointments at the hospital did not understand the need for different considerations when dealing with a serving prisoner. Communication difficulties between the hospital and the prison also led to appointments being cancelled on occasion. A greater understanding of the specific needs of prisoners across the Primary Care Trust might lead to a more efficient and better service.

The Head of Healthcare and representatives from the local hospitals should develop a protocol for effectively facilitating outpatient appointments for prisoners.

Communication between the prison and the man's family

157. There was evidence of problems regarding communication between the prison and the man's family. It was clear that, from the time of his diagnosis, the family's solicitors felt that they did not receive timely replies to their letters. Furthermore, the questions that they asked were not always answered.

158. I appreciate that members of Hull's senior staff have varied responsibilities, and that responding to letters from the family members of prisoners is an additional task. However, the news that a prisoner has been diagnosed with a terminal illness is clearly likely to be distressing for his family. There are many reasons why a harmonious relationship between the prison and the family is beneficial for everyone concerned. As such, I believe that it would be useful for family members to have a named point of contact within the prison, so that they are better able to gain access to the information they need.

The governor should ensure that the family members of terminally ill prisoners have a named point of contact within the prison.

159. On a related note, it would almost certainly have proved beneficial for one of the prison's family liaison officers to become involved at an earlier stage. A period of 18 months elapsed between the man's diagnosis and his death, and I would not necessarily expect a family liaison officer to be involved for that entire period of time. I am also aware that his health deteriorated rapidly in October 2010. However, when he moved to hospital on 12 October, it was clear that he was nearing the end of his life. A family liaison officer was still not appointed until after his death. Given that he was receiving visits from family members during his time in hospital, and was escorted by prison staff at that time, it may have been a sensible and compassionate decision to involve a family liaison officer at that time, rather than waiting until he had died. Indeed, I have seen this work to good effect in other situations of terminally ill prisoners.

160. The family told my investigator and FLO that it was not easy to contact the prison's family liaison officer in the week following his death. They said that they were told the officer was not available, but their calls were not returned. Although I do not make a formal recommendation in this area, I invite the governor to ensure that family members are easily able to contact the designated family liaison officer or a suitable alternative person.

Compassionate release

161. The man applied to be considered for release on compassionate grounds, in light of his terminal illness, in July 2009. During July and August, a number of reports were prepared and a dossier was produced. This was sent for consideration by the Secretary of State for Justice in late August. On 25 September, a representative for the Secretary of State wrote to him to explain that his application had not been approved. He explained the principles of compassionate release, writing:

> "Under Section 248 of the Criminal Justice Act 2003, the Secretary of State may release a prisoner on compassionate grounds at any point in the sentence if he is satisfied that this is justified by exceptional circumstances. The criteria for such a release may be, for example, when the prisoner is suffering from a terminal illness and death is likely to occur within a very short period of time; or, when the prisoner is bedridden or severely incapacitated. Agreement to release is rare, and I am sure you will appreciate that it is only in the most compelling circumstances that the Secretary of State would intervene with the Court's decision regarding length of sentence, and take the quite exceptional step of authorising early release on compassionate grounds."

162. He went on to note that the man was assessed as a high risk of harm and a medium risk of re-offending. Reports in the dossier also suggested that he did not fully accept responsibility for his offences and attributed blame to the victims. Furthermore, the representative for the Secretary of State noted that the most recent medical reports suggested a life expectancy of six to 12 months, depending on the outcome of chemotherapy.

163. As the man presented a high risk of harm, was not infirm, posed a risk of reoffending, and was not expected to die within a very short period of time, his application was rejected.

164. I consider that the application for compassionate release was handled appropriately. The man survived for more than a year after the

decision was taken not to release him. Whilst the possibility existed for another application at a later stage, his medical record indicates that he presented as relatively well until a very short time before his death. When his health deteriorated, he died four days later. This did not provide sufficient time for a new application for release on compassionate grounds. In any case, he would almost certainly have remained in hospital for the last few days of his life.

The use of restraints

165. When the man's health deteriorated on 12 October, he moved to hospital. However, he remained in the prison's custody. The standard arrangement for prisoners in hospital is for handcuffs to be applied, and for a minimum of two prison officers to be present. Prisons must ensure that they take account of security and risk management, whilst also considering humane treatment of the prisoner. When prisoners are nearing the end of their lives, prisons should consider whether it is appropriate to remove restraints in order to afford them some dignity.

166. The man was convicted and imprisoned for very serious offences, and was considered a high risk to women and children. Although his health had worsened, he was not completely immobile. A risk assessment on 12 October concluded that, due to these factors, it was necessary for him to be restrained, and that prison staff should be present at all times. The bed watch officers kept detailed logs which contained a number of references to him attempting to stand up and move around. Though he was weak and unsteady on his feet, he was clearly not completely incapacitated.

167. A further risk assessment on 15 October concluded that the man's handcuffs should not be removed without authorisation from one of the prison's governors. At 8.20pm, an officer wrote in the bed watch log:

> "Telephone call to HMP Hull, spoke to the SO regarding the protocol should the man pass away. Cuff not to be removed until authorised."

168. The next morning, the man was sleeping heavily but his breathing was stable. According to the nurses at the hospital, he was not expected to die imminently. However, he stopped breathing and died without warning at 11.52am.

169. In November 2007, a judicial review took place in the High Court. It concerned two prisoners to whom restraints had been applied during hospital appointments. The review concluded that in one of the cases, the National Offender Management Service (NOMS) had breached Article 3 of the European Convention on Human Rights. This relates to inhumane and degrading treatment. In April 2008, the then Head of the NOMS security group, wrote to all prison governors explaining the judgement. He said:

> "The Judge found [NOMS] to be in breach of Article 3 (inhumane and degrading treatment), when restraints were applied to a prisoner who was undergoing a course of chemotherapy without, in his opinion, adequate evidence to support the view that their application was justified."

170. He went on to say that:

> "The judgement deems the restraining by handcuffs of a prisoner receiving chemotherapy (and, by implication, other life saving treatment) degrading. Such restraint would be likely also to be regarded as inhumane *unless* justified by other relevant considerations."

171. He mentioned that an urgent review of procedures had been recommended. In June 2010, the new Head of the NOMS security group wrote to all governors to inform them of an audit, which highlighted "a number of serious failings in the hospital escort and bed watch function". He explained that a concordat had been developed between NOMS and the NHS counter-fraud and security service. This covered not only prisoners receiving life-saving treatment, but also those serious or terminal illnesses. Paragraphs 5.6.1 and 5.6.2 of the concordat state that:

> "Levels of restraint used on prisoners must at all times be proportionate to the perceived security risks and be balanced by considerations of care and decency for the prisoner. Using handcuffs or other restraints on terminally or seriously ill prisoners is considered inhumane by the courts unless justified by security considerations.
>
> "Terminally or seriously ill prisoners may present a lower risk of escape and this should be considered as part of the assessment process. The use of restraints on terminally ill or seriously ill prisoners should be reviewed regularly, taking into account clinical input, and the level of restraints should be adjusted in accordance with any deterioration in the prisoner's clinical condition or the intensity of the treatment that they are receiving."

172. I accept that there is a balance to be struck between security and humane treatment. In the man's case, the primary risk was not escape but the potential for him to commit further offences. It is clear from the risk assessments and bed watch logs that he was considered a high risk of harm, and had the capacity to re-offend until very shortly before his death. I therefore understand why restraints continued to be applied for the majority of the time that he was in hospital.

173. On the morning of 16 October, the man was sleeping heavily. He had been asleep since 3.00pm the previous day. He was not necessarily

expected to die imminently, but it was clear that he was reaching the end of his life. The bed watch log indicates that he was not responsive in that he could not be roused. Nursing staff told the escorting prison officers that he was stable, and further deterioration in his condition would be indicated by changes to his breathing. However, this was not apparent before his death. Nevertheless, the fact that he was in a deep sleep, with no guarantee that he would wake up, constituted a deterioration in his clinical condition compared to that of previous days. He did not pose any risk of re-offending or causing harm whilst asleep.

174. Furthermore, I am deeply concerned that the man was restrained at and beyond the point of his death. I am extremely disappointed to find that, when he died, the bed watch officers felt it necessary to contact the prison before removing the restraints. The handcuffs were therefore not removed until three minutes after his death. This is clearly unacceptable. Whilst previous risk assessment had stated that the restraints were not to be removed without authorisation there was clearly no risk at all in removing the restraints after he had died. I do not intend criticism of the individual officers, who were following the actions set out in the risk assessment. However, policies around bed watch must take into account that risk is a dynamic factor. Members of staff at Hull should feel confident using their discretion in matters such as this, when the situation can change very quickly.

175. I am well aware that prisons must consider security and the risks posed by prisoners in hospital. However, the level of risk presented can change very quickly. I submit that at the time of being in a deep sleep, the man posed no risk at all. He was in the last stages of his life, and there was no expectation that he would wake up. Nurses talked to the bed watch officers only about what would happen when his condition deteriorated, not about improvements to his health. It was clear that he was reaching the end of his life. The most humane course of action would have been to remove his restraints. In the unlikely event that he had woken up, the restraints could easily have been re-applied. At the very least, a further formal review of the need for restraints should have been undertaken. Using restraints up to and beyond the point of death is deeply undignified for the prisoner and unnecessarily distressing for the escorting officers.

The governor should urgently review the processes for restraining seriously and terminally ill prisoners who are in hospital.

Issues raised by the man's family

176. The remit of my investigation ends, in its broadest sense, when a prisoner leaves the prison. The man's family members raised a number of issues which are beyond the scope of my investigation. The clinical reviewer helpfully commented on some of these issues in his

clinical review, and I summarise his findings below. However, I am unfortunately not able to offer further comment.

Pain management

177. The clinical reviewer did not report that pain management and relief was an issue for the man. I have not had access to his hospital records and so I am unable to comment further about the pain relief medication that was used during the last few days of his life.

Injuries

178. The man's daughter said that when she visited him on 14 October, she noticed bumps to his head, and cuts to his shins and toes. She wondered how he came to sustain these injuries.

179. In his clinical review, the clinical reviewer noted that, prior to the man's admission to hospital he suffered a fall in his cell on 11 October. However, no injuries were found. He had visible psoriasis on his body. The clinical reviewer wondered if the minor injuries observed were as a result of this fall in the prison before his transfer to hospital, caused by him being unsteady on his feet.

180. A note was made in the bed watch log on 14 October that at 1.15pm, the man attempted to stand up and fell to the floor. A nurse was called but no injuries were detailed in the bed watch log. As this was the same day as his daughter observed the injuries, it is possible that they were caused by this fall, but unfortunately I am unable with any certainty exactly how the injuries seen by his daughter were caused.

Dignity

181. The man's daughter reported that on another occasion, she visited the hospital to find him lying naked on the floor. I have been unable to substantiate this information as there was no mention of it in the bed watch logs. As such, I am sorry that I cannot offer further explanation or comment on this matter.

Medication

182. The man's daughter questioned whether the medication administered at the hospital was appropriate. I have not had sight of the hospital records and so cannot comment on this matter. The clinical reviewer wrote in his clinical review that the use of pain and distress relieving drugs in the final stages of life can produce confusion. However, he concluded that they are entirely appropriate in end of life care.

Administration of food and medicine

183. The man's daughter was concerned that hospital staff did not make sufficient effort in encouraging him to take his medication and to eat his food.

184. With regard to medication, the clinical reviewer commented:

> "The hospital staff are not permitted to force patients to take medicine. It would be a clinical judgement at the time as to how much persuasion could be allowed from the staff. In the final days of life it is quite common to be able to administer oral therapy only when the patient is conscious and alert. If any hospital treatments were deemed necessary then there are other routes to administer drugs … through the skin by syringe driver or by direct injection if so indicated."

185. The man had a history of not being co-operative when it came to taking medication. The bed watch logs indicated that he remained reluctant to engage, and was sometimes rude to the hospital staff. This may have been due to confusion caused by medication or the progression of his illness. There were documented instances in the bed watch logs of him not taking medication or eating his meals. The clinical reviewer thought it positive that his daughter had been able to encourage him to take medication and eat his food, but pointed out that hospital staff were not necessarily permitted to offer the same level of encouragement.

CONCLUSION

186. The man was sentenced to eight years imprisonment in January 2007. He suffered from ischaemic heart disease and angina, and underwent a number of medical procedures to help monitor and control his heart conditions. He had a pacemaker fitted in February 2009 and it was during this stay in hospital that an X-ray showed a shadow on his lung. Further tests showed that he had a cancerous, non-operable tumour in his lung.

187. Between July and November, the man underwent chemotherapy, but this did not arrest the progression of the disease. The tumour continued to grow and the cancer spread to other parts of his body. He remained in prison throughout most of 2010 and for much of this time appeared reasonably well, considering his poor health. On 12 October, his condition deteriorated and he moved to hospital.

188. The clinical reviewer, who conducted the review of the man's medical care, found no significant failings. He believed that his treatment was equitable, and in some ways superior, to what he might have expected in the community. There was evidence in his medical record that healthcare staff at Hull were attentive to his needs throughout his illness.

189. It is disappointing that one particular issue threatens to undermine several areas of good practice. The use of restraints in the very last stages of the man's life, and particularly their continued use after his death, is deeply worrying. Security is, of course, important, but prisons have a duty of care and must ensure that prisoners do not suffer inhumane or degrading treatment. I invite the governor to consider my findings and urgently review the arrangements for the use of restraints.

RECOMMENDATIONS

1. The Head of Healthcare and representatives from the local hospitals should develop a protocol for effectively facilitating outpatient appointments for prisoners.

   The recommendation was partially accepted. The time frames for the dissemination of information regarding outpatient appointments are in line with what is expected in the community. Performance monitoring against community protocols will be reviewed to identify any deviation from the expected targets.

2. The governor should ensure that the family members of terminally ill prisoners have a named point of contact within the prison.

   The recommendation was accepted. A system is now in place to ensure that a contact person is identified for the family members of terminally ill prisoners.

3. The governor should urgently review the processes for restraining seriously and terminally ill prisoners who are in hospital.

   The recommendation was accepted. All governors and duty managers will be made aware of the correct protocol to be adhered to in any such event.