PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the circumstances surrounding the death of a man at hospital in October 2011 while in the custody of HMP Highpoint North

Report by the Prisons and Probation Ombudsman for England and Wales

September 2012

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This is the report into the death of a man, a prisoner at HMP Highpoint North who died at outside hospital in October 2011. He was 59 and diagnosed with pancreatic cancer. I offer my condolences to the man's family and friends.

The investigation was conducted by one of my investigators. A clinical review of the man's healthcare was undertaken by a clinical reviewer. I apologise that the report has been delayed.

The man arrived at Highpoint North on 8 September 2011, following his transfer from HMP Pentonville. His general health deteriorated two weeks after his arrival, and he was taken to hospital for tests.

On 7 October, the prison doctor told the man that he might have cancer. His condition worsened and, on 18 October, he was admitted to outside hospital. On 21 October, he was diagnosed with advanced metastatic carcinoma (cancer which had spread to other parts of the body). Three days later it was confirmed he had pancreatic cancer and had no more than a matter of weeks left to live.

After they learnt of the man's terminal prognosis, Highpoint North began to make plans for his compassionate release but these were not completed. Instead he was released on temporary licence at the end of his life. The hospital palliative care team saw him regularly as his condition continued to deteriorate and his pain was well managed until his death in October.

All the records suggest a clear and coherent approach to the man's clinical care. However, he was subject to restraints in hospital for too long before they were removed and I make a recommendation to the Governor about this. I was also disappointed that, while the man's family generally received good support from the prison, when his elderly parents went to visit him they were turned away because of a bureaucratic and incorrect issue about identification. Although Highpoint North has since changed its procedures, I recommend that the Governor apologises for this failing and ensures that there can be no repetition.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **September 2012**

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SUMMARY

1. Before his imprisonment the man was diagnosed with Type 2 diabetes in 2010, and was treated with metformin (a drug used to treat diabetes) and thiamine (a drug used to treat alcoholism). He also had a benign swelling of his right parotid gland (this produces saliva and is situated beneath the angle of the jaw) on his neck, which had been medically investigated.

2. On 11 May 2011, the man was sentenced to serve three years imprisonment for drug related offences and was sent to HMP Pentonville. On reception, it was noted that he was a diabetic, a heavy smoker and had previously been a very heavy drinker. His medication was continued, he was put onto a diabetic diet and diabetic educational programme.

3. In July, the man attended hospital for his annual diabetic eye screening, which showed no signs of eye disease. He later pulled a muscle in his right arm and received painkillers and physiotherapy treatment for this. In August, he attended two clinic appointments at outside hospital for his swollen parotid gland, and returned for a fine needle aspiration (a procedure used to obtain cell samples). This test found that the lump was not cancerous.

4. On 8 September, the man was transferred to HMP Highpoint North and placed on his usual diet and medication. Two weeks later, he complained of abdominal swelling. The doctor, suspecting possible liver disease, requested urgent blood tests and referred him to hospital for investigations. The man was admitted to hospital on 29 September.

5. The build up of fluid (ascites) in the man's abdomen was alleviated by the insertion of a drain. His medication was changed to try to prevent further build up of fluid. He returned to Highpoint North on 1 October. Prison healthcare staff followed instructions given by the hospital but the man complained that his stomach was swollen again on 7 October. The doctor noted that he had lost weight in his face and limbs, and a blood test confirmed his condition had deteriorated. Aware that the diagnosis might be cancer, the man attended hospital for scans on 14 October, which showed possible widespread liver metastases (cancer cells which had spread). Further tests were arranged.

6. On 18 October, the man was re-admitted to hospital, to undergo further investigation, and on 21 October, he was diagnosed with advanced metastatic carcinoma (cancer that had spread throughout his body). The man and Highpoint North were informed he had terminal cancer and only a matter of weeks left to live. The site of the primary cancer was found to be in the man's pancreas.

7. The man remained in hospital. Highpoint North staff began making plans for his release on compassionate grounds but these were not completed. The hospital palliative care team assessed him regularly as his condition continued to deteriorate. He was placed on an organised care plan but died in late October.

THE INVESTIGATION PROCESS

8. This office was notified of the man's death on 30 October. The investigator visited HMP Highpoint North on 4 November and collected documents relating to the man including his main prison record, medical records, escort records, bedwatch logs and records of actions taken before and after his death.

9. We apologise that due to workload pressures in the office there has been a slight delay in issuing this report,

10. One of the Ombudsman's family liaison officers contacted the man's parents to explain the purpose of the investigation and to provide them with an opportunity to raise any concerns or questions. The man's parents and brother later wrote to this office with the following concerns:

    - Why were they refused entry, despite providing photographic identification, when they visited their son at Highpoint North on 16 October? As senior citizens, they had travelled a considerable distance at great expense to see their ill son. The man's parents said that the prison's refusal to let them in and the abrupt way in which they felt they were treated caused them significant distress. They told the family liaison officer that they appreciate the need for security. However, they believe that the prison staff were unnecessarily bureaucratic.

    - Why was their son transferred to Highpoint North, some distance from his family, when he had already complained of having stomach pains at Pentonville?

    - What healthcare did their son receive at Pentonville and was this appropriate?

    - Why were the man's parents not made aware of their son's terminal prognosis sooner?

    - Why was their son restrained when he was in hospital, given his fragility at this time?

11. These concerns were followed up by the investigator and are addressed in this report which we hope helps the man's family better understand the circumstances surrounding his death.

12. Suffolk Primary Care Trust commissioned an independent healthcare consultant to carry out a review of the man's clinical care. We are grateful to the clinical reviewer for undertaking this review.

13. Her Majesty's Coroner was contacted by the investigator to inform him of the scope of this investigation. A copy of the post mortem report was made available to the office. A copy of this report will be sent to the Coroner to assist his enquiries into the man's death.

14. The investigation focuses mainly on the issues of the man's diagnosis and treatment, including his pain relief and palliative care, liaison with his family, and security arrangements including his location and possible release on compassionate licence.

15. The man's family provided extensive comments on the draft version of this report through their solicitor. In particular, they noted the following:

- The man's parents were particularly upset about the prison's refusal to grant them access to the prison on 16 October 2011 and how they were spoken to by staff. They were distraught when they were refused access, especially as someone had approached them saying their son was asking for them and how ill he looked. They had also travelled a considerable distance.

- The family felt there should have been better liaison with hospital and prison staff in relation to their son's treatment and death. The family notified the FLO at the prison the following morning. They feel strongly that there should have been more support. They were shocked when they first saw their son following his hospitalisation and the prison could have provided advice and assistance in relation to accommodation.

- On 28 October, their son's security category was reduced from Category C to D, but the application for release on compassionate grounds was not processed before his death. The family strongly believes that he should have been allowed to die at home and the man's father was devastated not to have been with his son during his final moments.

HMP HIGHPOINT

16. HMP Highpoint is actually a grouping of two prisons, Highpoint South which was originally called simply Highpoint, and Highpoint North, which was previously known as HMP Edmunds Hill. The two prisons are located in Stradishall, 13 miles from Bury St Edmunds in Suffolk. Highpoint North is a prison for category C adult male prisoners. (Category C prisoners are those who cannot be trusted in open conditions but who are unlikely to escape.) The man was held at Highpoint North.

Previous deaths at Highpoint

17. We investigated one previous death at Highpoint North in 2008, when the prison was still known as Edmunds Hill. This was a self-inflicted death and none of the circumstances are relevant to the death of this man.

Her Majesty's Inspectorate of Prisons

18. The most recent report published by HM Chief Inspector of Prisons is of an unannounced full follow-up inspection in September 2009 of the then Edmunds Hill. The Inspectorate judged that Edmunds Hill had progressed in a number of areas since their last visit and had begun to establish itself as an effective training prison. It was noted that healthcare was much improved.

Independent Monitoring Board (IMB)

19. Each prison is monitored by an independent monitoring board, members of which are drawn from the local community. Their role is to ensure that standards of decency and care are maintained. The most recent annual report published by the IMB for Highpoint North for 2010 when it was Edmunds Hill identified some communication problems with local hospitals and problems with prisoners from London prisons arriving without their medical notes. Overall it reported that during 2010 health services for prisoners continued to become more comprehensive. The board noted that the healthcare department worked well, staff morale was high and the physical surroundings had continued to improve.

ISSUES

The diagnosis of the man's terminal illness

20. Before he came into custody, the man was a heavy drinker, and stated he consumed up to 200 units of alcohol per week. He was also a heavy smoker, smoking up to 39 cigarettes a day and 15 cigars a day. When he was diagnosed with Type 2 diabetes in 2010, he stopped drinking alcohol and was prescribed thiamine (vitamin B1, which is used to treat alcoholism) 100mg tablets, one a day. His diabetes was also controlled with metformin tablets, 500mg, one a day. He also had a swelling of his right parotid gland (which produces saliva and is situated beneath the angle of the jaw) on his neck. This had been medically investigated before he went to prison and was not cancerous.

21. On 11 May 2011, the man was sentenced to serve three years imprisonment for drug related offences and was sent to HMP Pentonville. On reception, it was noted that he was diabetic, a heavy smoker and had previously been a heavy drinker. His medication was continued, he was put onto a diabetic diet and the diabetic educational programme.

22. When he jumped from the top bunk in his cell at Pentonville in mid June, the man caught his right arm and pulled it back. Later in July, he reported to a nurse that he had been experiencing pain between his shoulders which was worse after waking or sitting for long periods. Otherwise the nurse noted that he appeared well, but she referred him to a physiotherapist for assessment. She gave him painkillers, ibuprofen 400mg, three times a day.

23. The man attended hospital for his annual diabetic eye screening on 25 July, which showed no signs of eye disease. On 15 August, a physiotherapist specified some exercises. Over the next two weeks, he was treated by the physiotherapist and attended two clinic appointments at outside hospital for an investigation of his swollen parotid gland. He returned to the hospital on 31 August, for a fine needle aspiration (sample of cells taken, and then analysed).

24. The lump was found not to be cancerous, and it was agreed that the man would be reviewed in three months time and surgery to remove the lump would be postponed until his release from custody. No new medication was prescribed, he was judged fit and well to return to prison.

25. The physiotherapist saw the man again on 5 September. He told her that he was managing his pain better but it was still persisting, and he was doing his exercises regularly. He mentioned that he was feeling bloated and had a loss of appetite. He was advised to speak to a nurse.

26. On 8 September 2011, the man transferred from Pentonville to HMP Highpoint North. On reception, the man's medical conditions and dietary needs were noted and there is nothing in the medical records to indicate he

had any other health complaints. He was referred to a doctor to discuss his parotid gland and his diabetes

27. On 15 September, the man felt unwell and saw a nurse. He told the nurse he had general body aches and was given ibuprofen, 200mg, one or two daily. On 19 September, he was re-prescribed his metformin tablets by a doctor.

28. A doctor saw the man on 23 September. During consultation, the man complained of abdominal swelling and when examined, the doctor noted that he had a distended abdomen, dilated periumbilical veins and an umbilical hernia. His heart and lung function was stable. The doctor questioned in his notes whether the swelling was due to ascites (accumulation of fluid within the abdominal cavity due to severe liver disease) and requested urgent blood tests and a referral to hospital to ascertain the cause of the abdominal swelling.

29. A doctor examined the man on 26 September, when he noted the ascites and found that his chest was clear, he was not breathless, not pale (sign of anaemia) and not jaundiced (sign of liver failure). His blood pressure was stable. The blood tests confirmed that he was not anaemic, his kidney function was normal and that there was a disturbance of his liver function. The doctor discussed the case with the Medical Registrar at outside hospital and it was decided that he should have another blood test four days later.

30. On 29 September, the man became increasingly uncomfortable and was admitted to hospital immediately for treatment and investigation. He had a drain inserted into his abdomen, which drained 18 litres of ascites (fluid). His metformin was stopped because it is unsuitable for patients with liver disease and spironolactone (a diuretic that attempts to prevent the build up of ascites) was commenced. The hospital organised a follow up appointment and an outpatient ultrasound of the abdomen and requested that Highpoint North healthcare staff monitor the man's diabetes and kidney function. He was discharged with the provisional diagnosis of alcoholic liver disease as the cause of the ascites.

31. The prison healthcare team noted all the instructions from the hospital staff. The man was given a glucose-monitoring machine and told how to use it and at what levels of blood sugar readings he needed to alert the healthcare staff.

32. A prison GP examined the man on 7 October. The man's abdomen was still swollen, he had difficulty with defecation, he was getting a lot of pain in his back and he could not get comfortable. The GP noted that the man had weight loss in his face and limbs and he prescribed the appropriate pain relief (tramadol) and organised a blood test. The blood test confirmed that the man's condition had deteriorated as the liver function tests had worsened and that now his kidney function was abnormal. At this consultation, the man discussed a possible diagnosis of cancer with the doctor. Over the next week the healthcare staff saw the man often, his glucose levels were monitored regularly each day and he received effective pain relief.

33. On 14 October, the man attended outside hospital for an ultrasound of the abdomen and a detailed ultrasound of the liver. The scans showed widespread liver metastases (spread of cancer cells). The hospital arranged further tests and asked the prison healthcare staff to undertake a series of blood tests.

34. On 15 October, the man continued to be uncomfortable with the distended abdomen and back pain, so the prison GP wrote a letter to the hospital requesting that the further investigations be made more urgent. When the man became more uncomfortable three days later he was admitted immediately to outside hospital.

35. The clinical reviewer states in his report that the diagnosis of the man's terminal illness was made in an appropriate and timely manner. The man was admitted quickly to hospital. All the necessary and appropriate information was recorded in his medical record. The clinical reviewer stressed in his report that the man's diabetes, parotid lump and his shoulder injury did not contribute to the subsequent development of pancreatic cancer.

Informing the man about his condition and treatment

36. Following his admission to hospital, the man underwent further investigation and, on 21 October, was diagnosed with advanced metastatic carcinoma that had spread to the liver and surrounding tissues. The cancer had also caused the development of the ascites, biochemical disturbances in the blood and pulmonary emboli in the lungs (small clots). The site of the primary cancer was thought to arise from the stomach or the pancreas. The man and the prison healthcare team were informed that he had terminal cancer and had a matter of weeks to live.

37. The man was seen by an oncologist on 24 October, who informed him of the incurable nature of his illness and the possibility that chemotherapy might improve his symptom control. The palliative care team also saw him at this time and continued to see him regularly thereafter. An endoscopy (a tube inserted into the stomach with a camera attached) was performed to identify the site of the primary cancer and to ascertain the benefit of chemotherapy. It was concluded that the primary site of the cancer was the pancreas which would not be responsive to chemotherapy.

38. The clinical reviewer concluded that the man was given full information about his condition and treatment. He understood why he was being admitted to hospital on 29 September and, when he saw a doctor on 7 October, he was aware that he might have cancer and they discussed this possible diagnosis. The hospital knew that he had widespread cancer after the liver scan on 14 October, but delayed informing him until 21 October, after further tests had confirmed the diagnosis and extent of the spread. He was also informed at this time that the prognosis was poor. Overall, the man was informed in a timely manner when the hospital was certain of the diagnosis and the hospital's palliative care team supported him.

The man's medical appointments and treatment

39. On reception at Highpoint North, it was noted that the man was a tablet controlled diabetic and had received extensive treatment for his swollen parotid gland, including surgery. He was placed on his usual diabetic diet and medication, and was correctly referred to a doctor to consult about his parotid gland and his diabetes. When a doctor saw that the man had a distended abdomen he immediately requested blood tests and made a referral to hospital to find out the cause of the abdominal swelling.

40. At hospital, the man received treatment to drain the ascites and the staff made an appropriate adjustment to his medication. The hospital organised a follow up appointment, an outpatient ultrasound of his abdomen and asked the prison healthcare team to monitor the man's diabetes and kidney function. He was discharged with the provisional diagnosis of alcoholic liver disease.

41. Prison healthcare staff followed all the instructions from the hospital. The man was given a glucose-monitoring machine and educated in its use. When the doctor saw him on 7 October, he prescribed appropriate pain relief and organised suitable tests. The man was able to discuss his possible diagnosis with the doctor. His glucose levels were monitored regularly and he received effective pain relief.

42. The clinical reviewer is satisfied that, following the man's diagnosis, his subsequent appointments and treatment were conducted to an appropriate standard. All of his appointments with outside hospital were kept and on return to Highpoint North all the instructions given by the hospital were adhered to. There was good communication between Highpoint North and outside hospital.

The man's pain relief and medication

43. The man was provided with appropriate and effective pain relief and medication whilst he was in outside hospital. The palliative care team saw him frequently; he was put onto a side room and given an air mattress.

Liaison with the man's family

44. When the man's parents came to visit him on 16 October, they were refused entry by the gate staff at Highpoint North. They were told that they were required to produce one item of approved photo identification and one approved item to identify their address. This is contrary to the relevant Prison Service Instruction, PSI 15/2011, which requires only one form of specified identity – mostly photographic or two forms of other listed identity. The man's parents had their bus passes with them but no proof of their home address. They told the investigator that they had previously used their bus passes at Pentonville without a problem. PSI 15/2011 lists a 'senior citizen's public transport pass issued by a local authority' as an acceptable form of identification. A letter from their son with their address written on the envelope was not accepted as sufficient proof of identity.

45. The man's parents told the investigator of the distress this incident had caused them, particularly as they are elderly and had travelled a significant distance at great expense to visit their son. They were also upset at the manner in which they were spoken to and that they were made to wait for some time while this matter was dealt with.

46. Staff at Highpoint North told the investigator that this incident was regrettable and that they had reassessed their procedures shortly after the man's death. They have issued an instruction to all staff that visitors without correct identification are not to be turned away without the authority of the duty governor. We acknowledge this change but note that in fact the man's parents did have the correct identification and it was unreasonable for Highpoint to have rejected identification accepted at another prison. We make the following recommendations:

The Governor should apologise to the man's parents for their treatment at the prison on 16 October and offer appropriate recompense for their travel costs.

The Governor should ensure that identification requirements are in line with national guidance and that no visitor is refused entry without the authority of the duty governor, and that any such decision is explained in person by the duty governor to the visitor.

47. When the man was told he had cancer on 18 October, officers at the hospital with him asked if he wanted his family informed. He said he first wanted to know more about his prognosis. On Friday 21 October, he was told his cancer was terminal but it was unclear whether his life expectancy was days or weeks. He still said he did not want the prison to let his family know as they were due to visit him in hospital two days later on the Sunday and he would tell them then. Instead, at 6.00pm that evening, the man spoke to his parents on the phone and informed them of his diagnosis. It is understandable that the man's parents were distressed that they were not informed sooner about their son's terminal illness but we are satisfied that prison staff acted appropriately in accordance with the man's wishes.

48. The prison chaplain visited the man and his parents at the hospital on 25 October. The chaplain suggested to the man's parents, who are elderly and live in London and found the travel difficult, that he would be happy to pick them up from Bury St Edmunds station, visit their son with them and drive them back to the station.

49. On 26 October, staff at Highpoint North considered various options for the man's further care. These included transferring him to a prison nearer to his parents, such as Pentonville or Chelmsford and the potential of the palliative care unit at Norwich. Release on compassionate grounds was also considered. The prison chaplain discussed these options with the man and his family.

50. On 27 October, the compassionate release process was begun although the man was to die before this could be completed. However, on 28 October, he was released from custody on temporary licence. This meant he no longer needed to be supervised at the hospital by prison officers. The Deputy Governor spoke to the man's family, including his father, his niece and her husband. He explained the help and support that the prison could give and gave them his contact details. A Governor was appointed as the prison family liaison officer and met the man's mother and brother at the hospital on the day of the man's death. She offered her support and gave a telephone number she could be contacted on at all times.

51. Following the man's death, the prison chaplain went to the hospital on 30 October, where he joined the man's mother, brother and the prison's family liaison officer. The chaplain and the man's mother then travelled back to Highpoint North where they met the man's father, who had travelled there on the visitors' bus. They all then visited the chapel together to pray. The man's parents then left on the visitors' bus with their son's property.

The man's location

52. Every adult prisoner in the UK is allocated a security categorisation soon after they enter prison, for the purposes of assigning them to a prison. On conviction, the man was initially held at Pentonville, which is a Category B local prison holding remand, trial and short-term convicted prisoners. Following a period of observation, he was classified as a Category C prisoner (requiring a medium security prison) and allocated to Highpoint North. Although some way from London, this is a routine move from London prisons and at that stage no significant health problems had been identified to suggest that he should remain at Pentonville.

53. Once the diagnosis of terminal cancer had been confirmed a transfer from Highpoint North to another prison was considered. Norwich had palliative care facilities and Pentonville and Chelmsford would have been easier for his elderly parents to visit. The Primary Care Trust was also asked to look at other alternatives. Sadly, the man died very suddenly before alternative arrangements could be made.

Compassionate release

54. Almost immediately after the man's terminal diagnosis on 21 October, staff at Highpoint North took steps for his compassionate release including obtaining letters from doctors to support this. An appropriate decision was made to release him on temporary licence in the meantime. The supporting documents for an application for compassionate release had been put together with the intention they would be actioned on 31 October, but unfortunately the man died before this process could be completed.

Palliative care plans

55. The hospital palliative care team saw the man regularly from 24 October. Morphine was given to provide effective pain relief and he was also prescribed regular morphine solution. Other medications were prescribed to counter the high potassium level in his blood (calcium resonium), gastric symptoms (omeprazole) and the feeling of sickness (dexamethasone).

56. On 27 October, a permanent abdominal drain was inserted and the man was transferred onto a side room with a bed that had an air mattress to promote comfort and reduce the risk of pressure sores. The next day, the man's condition continued to worsen and he was placed on the Liverpool Care Pathway, which is an organised care plan used to achieve the best quality of care that a terminally ill patient can expect in the last days of life. The Pathway covers physical treatment, psychological support, support for carers and spiritual care. The man was noted to be comfortable and pain free on the day of his death and died with his mother by his side.

Restraints, security and bedwatch

57. In line with its duty to protect the public, the Prison Service will usually require some form of restraint and escort staff when prisoners are taken out of the prison for any reason. An individual risk assessment should be completed on each occasion covering the offences, the risk of further offending, as well as the prisoner's health and mobility.

58. The man was admitted urgently to outside hospital on 18 October. He was restrained by a single handcuff and escort chain (a 1.8 metre length of chain, with one cuff attached to himself and the other to an officer), and escorted by two officers. This is the recommended strength and composition for a standard Category C escort and bedwatch. However, staff did not complete an up-to-date risk assessment. They appear to have relied on the most recent assessment completed on 12 October. This assessed the man's risk of escape and risk to the public as low, yet it recommended the use of the chain.

59. On 24 October, a deputy governor visited the man at the hospital where he reviewed the risk assessment and decided that the risk of escape was extremely low and instructed the bedwatch staff to remove the escort chain. On 28 October, the man's security category was reduced to D and he was released on temporary licence.

60. When the man was admitted to hospital on 18 October for urgent tests, he was in pain and his mobility was reduced. On 21 October, he was diagnosed with a terminal illness with a poor prognosis. When members of his family visited him in hospital, they were shocked to see him restrained. It was not until 24 October that restraints were removed, by which time the risk of escape was assessed as 'extremely remote'. The man's most recent risk assessment (dated 12 October) indicated that he was a low risk. Staff should have completed a new risk assessment on 18 October. We consider that

there should have been no need for any restraints at that time and the presence of escort officers should have been sufficient to ensure security. Certainly, the restraints should not have been necessary from 21 October. It appears that a very risk adverse approach was taken to the use of restraints, contrary to the indications of the prison's own risk assessments. We therefore make the following recommendation.

The Governor should ensure that all relevant sections of the escort risk assessment are completed each day a prisoner is in hospital so that full account is taken of a prisoner's health and physical condition and the impact this has on his actual risk.

61. The investigator found that bed watch logs were completed by officers appropriately and sensitively. The escort officers demonstrated a commendably caring approach including frequently helping the man with his bodily functions.

CONCLUSION

62. The man was a heavy smoker and had previously been a heavy drinker. He was diagnosed with diabetes in 2010. The diagnoses of diabetes, the benign parotid lump and the shoulder injury did not contribute to the subsequent development of pancreatic cancer.

63. Carcinoma of the pancreas is the fourth most common cause of cancer death. It is an especially aggressive cancer that spreads widely soon after formation but rarely causes symptoms. It is often not diagnosed until it is advanced.

64. The clinical reviewer found that the diagnosis of the man's terminal illness was made in an appropriate and timely manner and he was given full information about his condition and treatment at all stages. It was not until he was given the full extent of his poor prognosis that he chose to inform his family about the extent of his illness. The clinical reviewer considered that his treatment and care, including palliative care at the end of his life, was good and equitable to that he would have received in the community.

65. Restraints were removed from the man in hospital for the last five days of his life which allowed him to die with dignity, but we consider this could have been done earlier. It is very regrettable that the man's parents were not allowed to visit him when they came to the prison but, other than that unacceptable incident, they received good support from the prison during their son's terminal illness.

RECOMMENDATIONS

1. The Governor should apologise to the man's parents for their treatment at the prison on 16 October and offer appropriate recompense for their travel costs.

   NOMS accepted the recommendation and commented: "The Deputy Governor personally met with the family members and apologized for this incident. He also gave reassurances that new instructions would be given to all gate staff to prevent such a reoccurrence. A letter of apology will be sent with recompense for the travel costs."

2. The Governor should ensure that identification requirements are in line with national guidance and that no visitor is refused entry without the authority of the duty governor, and that any such decision is explained in person by the duty governor to the visitor.

   NOMS accepted the recommendation and commented: "New instructions were issued following this incident. Clear instructions are now in place about the type of ID required and the requirement that no one is refused entry without referral to the duty governor of the day."

3. The Governor should ensure that all relevant sections of the escort risk assessment are completed each day a prisoner is in hospital so that full account is taken of a prisoner's health and physical condition and the impact this has on his actual risk.

   NOMS accepted the recommendation and commented: "Additional information will be included into the daily management check list to ensure that any changes in a prisoner's physical health is assessed and where necessary referred to the Duty Governor. This will take place on a daily basis and ensure where restraints are not necessary the decision to remove can be taken without undue delay."