PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into death of a man at HMP Nottingham in April 2010

Report by the Prisons and Probation Ombudsman for England and Wales

February 2013

This report considers the circumstances surrounding the death of the man at HMP Nottingham in April 2010. The man had been diagnosed with cancer in June 2009 and died as a result of the disease's progression.

I offer my sincere condolences to the man's family and all those who knew him. I apologise for the long delay in issuing this report and for the additional distress this is likely to have caused. I would also like to thank the man's family for their engagement with my investigation under the most distressing of circumstances.

The investigation was conducted by one of my investigators. We would like to thank the Governor of HMP Nottingham and his staff for their co-operation. We also extend thanks to the liaison officer to the PPO. In addition, we thank the clinical reviewer who conducted a review of the man's clinical care.

When at Nottingham, the man first complained of health problems in May 2009. He had previously complained of similar problems whilst at HMP Lincoln. The man was subsequently diagnosed with penile cancer. He underwent surgery and chemotherapy but these treatments were unsuccessful. Although he was given the option of moving to a hospice in the last few weeks of his life, the man said he preferred to remain in the prison. Consideration was given to him moving closer to his family, but he was thought to be too unwell to move such a distance. He died in April 2010.

This is the third death from natural causes at Nottingham since 2004, when the office began investigating deaths in prison custody. It is the first time that we have investigated the death of a terminally ill prisoner at Nottingham.

The investigation has examined the clinical care that the man received, the suitability of his accommodation at HMP Nottingham, delays in his diagnosis and treatment, and a number of issues raised by his family. I endorse one recommendation made by the clinical reviewer, which concerns the delays in the treatment he received. Whilst not the fault of the prison, these delays could have seriously impacted on the man's illness.

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 **February 2013**

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SUMMARY

1. The man transferred to HMP Nottingham from HMP Lincoln in March 2009. At the time of his arrival, no health issues were recorded. He did not attend appointments for more detailed health screenings which were scheduled shortly after he arrived.

2. On 11 May, the man complained of what was described in the clinical record as a "testicular lump". He was prescribed antibiotics and referred to the local hospital's urology department. (Urology is a surgical speciality, covering the diagnosis and treatment of disorders of the kidneys, bladder, prostate and male reproductive organs.) The man also said he had begun to bleed when passing urine, which was painful. He was prescribed painkillers.

3. The man moved to the urology ward at Nottingham City Hospital on 16 May. He underwent a circumcision operation the next day and returned to the prison. A biopsy was also taken for analysis at this time. He did not appear to be in discomfort and could move around the wing, but he did have a urethral catheter (used to drain the bladder) that required regular attention. Throughout May and June, he was seen almost daily for attention to his wound dressing and catheter. The clinical record noted that he became skilled at managing this himself.

4. In late May, the man saw a doctor at the prison and said he felt as if he needed to pass urine very frequently, and was also passing blood. On 5 June, the prison healthcare staff were notified that the man had been diagnosed with penile cancer. They were asked to refrain from breaking this news to the man, who would be given his diagnosis and treatment plan at his next hospital appointment.

5. The man was made aware of his diagnosis on 12 June. He was shocked and felt that he had been let down by other previous prisons and subject to incorrect diagnoses. Throughout June and July, he attended numerous appointments with prison healthcare staff, and his care plan remained under review. On 20 July and 5 August, he underwent MRI scans (tests that can provide detailed images of inside the body). The man continued to attend appointments with prison healthcare staff throughout August and September.

6. Between 30 September and 12 October, the man underwent major and traumatic surgery, a partial penectomy (the surgical removal of part of the penis) and inguinal lymphanedectomy (the removal of the lymph glands in the inguinal canal), at Leicester General Hospital. He was seen by healthcare staff at the prison when he returned on 13 October. He seemed generally positive and socialised with other prisoners on the unit.

7. Between October 2009 and February 2010, the man continued to receive regular medical attention from medical staff within the prison, and when attending outpatient appointments at hospital for chemotherapy. He received antibiotics for post-operative infections, and was seen almost daily by medical staff in the prison whilst his wounds healed. Numerous entries were made in

the clinical record, often more than once per day. On 18 February, a nurse noted that the man was becoming increasingly withdrawn and spending a lot of time in his cell, sleeping.

8. On 11 March, the man attended a hospital appointment with the oncologist (a physician that specialises in treating cancer) and was told that the chemotherapy had been unsuccessful. Throughout March, various arrangements were made to accommodate his deteriorating health. A protocol was developed so that a nurse could visit the man during the night, and a named nurse helped to co-ordinate his care and support. Authorisation was given for a more comfortable mattress to be provided, and he received visits from Macmillan nurses.

9. An occupational therapist and a Macmillan nurse visited Nottingham on 9 April to discuss various pieces of medical equipment that would be necessary for the man's end of life care. Three days later, his condition had deteriorated and end of life care was implemented. The man was not eating, had difficulty holding things, and suffered periods of confusion.

10. On 13 April, an open door policy was agreed, so that the man's cell would not be locked overnight. A member of the healthcare team was present throughout the night to offer support. An application for release on compassionate grounds was accepted, with permission given for the man to move to a local hospice. However, he was adamant that he did not want to die in a hospice, and chose to remain in the prison. Consideration was given to the man moving closer to his family, but he was thought to be too unwell to make the journey. He continued to be cared for at the prison.

11. The man was awake and alert on 15 April and was asked if he wanted to move to a hospice. He replied that he would not. Over the next few days, his condition deteriorated and nurses continued to offer him support. He died at 8.00am in April.

12. I have investigated the man's clinical care, his accommodation at Nottingham, delays in his diagnosis and treatment, and a number of issues raised by his family. I endorse one recommendation made by the clinical reviewer.

THE INVESTIGATION PROCESS

13. One of the senior investigators was appointed to conduct the investigation. Notices of the investigation were sent to the prison for distribution and display, giving staff and prisoners the opportunity to contact the investigator with any relevant information. No-one came forward in response to the notices.

14. The investigator visited HMP Nottingham to open the investigation on 2 June 2010. During the visit, he met with:
    - the liaison officer to the PPO
    - the head of healthcare
    - the healthcare service team leader
    - the liaison officer to the man's family
    - Chair of the Independent Monitoring Board (IMB)
    - from the Prison Officers' Association

15. During this meeting, the investigator discussed with the people present some of the circumstances of the man's time at Nottingham and the way in which he had been cared for during his illness.

16. The investigator visited the unit and the cell where the man had died. He also collected copies of his prison record, including his medical file.

17. The investigator returned to HMP Nottingham on 28 and 29 September. He interviewed eight members of staff. The interviews were recorded and transcripts are included as annexes to this report. He also spoke to a prisoner who was a friend of the man and helped him with his personal care.

18. One of the family liaison officers (FLOs) contacted the man's family to explain the purpose of the investigation and provide them with an opportunity to raise any issues or questions about the care that the man received in prison. The family liaison officer and the investigator subsequently met with the man's mother and three of his sisters. A number of questions and concerns were raised during these meetings, most notably:
    - Disappointment at the way in which the prison communicated information about the man.
    - The visiting arrangements at HMP Nottingham.
    - Whether HMP Nottingham was suitable for the man, given his medical condition.
    - Various aspects of the man's medical care, including pain relief, sedation, palliative care, and the implementation of the Liverpool Care Pathway (LCP).
    - The professional boundaries of staff at HMP Nottingham.
    - The application for release on compassionate grounds.
    - The way in which the family were informed of the man's death.

    I hope this report will help them to better understand the circumstances of the man's death.

19. A clinical reviewer was appointed 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. The clinical reviewer consulted the man's medical records to inform her review. My investigator asked the clinical reviewer to comment on a number of issues raised by the man's family about his medical care, and she has done so. The clinical reviewer produced an addendum to her report, in which she wrote about delays to the man's diagnosis, surgery and chemotherapy. She also wrote a short report about the man's medical treatment prior to his arrival at HMP Nottingham. The clinical reviewer's findings are summarised within this report, and her full reports are included as annexes.

20. Following the publication of the draft version of this report, we received written comments from the man's father and from the National Offender Management Service. The man's mother and sisters requested a visit from the investigator and FLO. The comments from these parties are summarised below.

Comments from the man's father

21. The man's father asked why the man was moved from HMP Lincoln to Nottingham. We have amended the first paragraph in the Key Events section of this report to more accurately reflect the man's sentencing. He was moved (via HMP Ranby and HMP Leeds) as his trial was being held at Nottingham Crown Court.

22. The man's father asked us to note that he thought that the man should have been moved to an open prison, a hospice or a prison closer to his family. He said that he was disappointed that Nottingham did not have a hospital wing.

23. While the man's father understood why the man had chosen to remain at Nottingham towards the end of his life, he questioned why the man was not moved before he became so ill.

24. He did not think that he was allowed to spend enough time with the man, and did not think that this time was private enough. He also said that there should better facilities for relatives to visit ill prisoners, such as a hospital wing or hospice.

25. The man's father expressed his gratitude to the liaison officer to the man's family, and said that the man had been comforted by his presence. He added that he thought that the prison authorities had done their best for the man, for which he was grateful.

Comments from the man's mother and sisters

26. The investigator and FLO visited the man's mother and sisters on 25 November 2011. Where possible, they answered their concerns during this meeting, which was followed up in writing. However, some issues remained outstanding, which are dealt with below.

27. The man's mother and sisters felt that there was an "overwhelming sense of reluctance" by the Prison Service to take responsibility for what happened and to acknowledge their role in the man's death. They also found it difficult to understand how the man had slipped through the net of so many healthcare professionals.

28. They thought that the prison's liaison officer to the man's family should be interviewed as part of this investigation as they remained concerned about the appropriateness of the relationship she had with the man. The investigator discussed this with an Assistant Ombudsman, who decided that there was clearly a difference of opinion between the family and the prison about the prison's liaison officer's role and it was unlikely that interviewing her would add any new information at this stage.

29. The man's mother and sister were distressed by many of the personal comments made by prison staff when interviewed. They thought that the transcripts of these interviews might have influenced other parties and that their interests might have been prejudiced. We believe that transcripts are relevant documents to the investigation and that it is appropriate under our terms of reference that they should be disclosed to the proper parties.

30. The man's mother and sister were concerned that their involvement in the man's care was not accurately represented in the report. In particular, they mentioned that they visited him every day and played a key role in supporting him through his illness.

31. The man's mother and sisters told us that they felt misled by staff about their grades and seniority. They were frequently told that they were speaking with senior governor grades and were not aware that there are several different grades of governor working in prisons.

32. The man's mother and sister remain concerned that the prison claims there were no missed or cancelled appointments during the man's treatment. However, there is a complaint form which suggests the man's MRI scan was cancelled in July 2009 due to problems with transport. They feel strongly that the prison has no right to delay appointments when a prisoner has a progressive condition and that priority must be given to these appointments. They are pleased this is recognised in the report and that a recommendation is made to improve practice in this area for the benefit of other prisoners.

33. The man's mother and sister were concerned about discrepancies in the man's medical notes. They believe that although the notes suggest that he

was on IV drip towards the end, this was not the case as the only noticeable line was the one in his chest for the syringe drive.

34. The man's mother and sisters were concerned that his cell was not closed following his death. They noticed that there was no syringe driver or catheter, and everything was clean and tidy. They are concerned that evidence was lost.

35. The man's mother and sisters were concerned that the conditions of the man's compassionate release licence were changed from the original application. As explained in the report, the prison initially sought an address in Birmingham for release, but after medical advice suggesting that the man was too unwell to travel, a hospice in Nottingham was used as the approved release address. No other conditions of the compassionate release application were amended.

36. The man's mother and sisters were concerned by information from the Coroner that the man's first reception healthscreen check was carried out by a prison officer and not a healthcare professional. We have updated the report to reflect that this healthscreen was completed by Nurse A.

37. The man's mother and sisters were concerned that the man missed medical appointments, and that they could not be sure that he had been collected for these. They were also concerned that he was not seen by a doctor on a daily basis and that medication was once increased over the telephone. They questioned the appropriateness of this.

38. The man's mother and sisters were concerned that the man was kept at the prison rather than being moved to a hospice so that the prison could learn how to care for a terminally-ill prisoner. (We have found no evidence of this.)

39. The man's mother and sisters also said that there was an urgent need for a protocol to be developed to ensure that the prisoner, staff and family understand what is expected of them at key stages of a terminal illness. The protocol should include visiting arrangements, the role of the FLO and what happens when an individual is no longer well enough to make decisions for themselves. (Since the man's death, the Prison Service has issued a new instruction – PSI 64/11 – which states that prisons must ensure that arrangements are in place for an appropriate member of staff to engage with the next of kin or a nominated person of prisoners who are either terminally or seriously ill.)

HMP NOTTINGHAM

40. HMP Nottingham is a local prison serving the courts in Nottinghamshire and Derbyshire. During 2009, when the man was there, it accommodated 550 adult male prisoners, approximately half of whom were on remand awaiting trial. The other half were convicted and either awaiting sentence or undergoing assessment before being transferred to a suitable alternative prison. In February 2010, Nottingham became a community prison holding up to 1060 prisoners. The expansion of the prison included a new offender management unit, reception, visits suite, healthcare centre and workshops.

HM Chief Inspector of prisons' report

41. The then HM Chief Inspector of Prisons conducted an announced inspection of Nottingham in February 2010. The HM Chief Inspector of Prisons made the following comments:

> "Health services were commissioned by NHS Nottingham City Primary Care Trust. CitiHealth NHS Nottingham provided primary care services and Nottinghamshire Healthcare NHS Mental Health Trust provided a mental health in-reach service.
>
> "The healthcare centre provided GP and specialist clinics. The mental health in-reach team was based in the same building that housed pharmacy and dental services. Medicine administration and, on occasion, minor treatments were carried out in treatments rooms on each of the wings. All areas used for the treatment and care of patients were appropriately equipped, clean and well decorated.
>
> "Health services provided 24-hour cover. A range of clinics was available, including some provided by visiting specialists. Good arrangements with the PCT facilitated the acquisition of specialist equipment when required.
>
> "There was an in-possession [medication] policy and steps had been taken to increase the provision of medicines in possession. In-possession risk assessments were documented and could be carried out by doctors, nurses or the pharmacist.
>
> "There was a good mental health service, including six mental health nurses in primary care, who met twice weekly with the secondary care in-reach team. Routine referrals were seen within seven days and urgent ones within 24 hours."

Previous deaths at HMP Nottingham

42. The Prison's and Probation Ombudsman's office has been responsible for investigating deaths in prison custody since April 2004. Prior to the man's death, I have investigated five deaths at Nottingham and also two deaths which occurred shortly after prisoners were released from Nottingham. Two of these were from natural causes, two were a result of illicit drug overdoses,

and three were self-inflicted. This is the first occasion on which I have investigated the death of a terminally ill prisoner at Nottingham.

KEY EVENTS

43. The man was convicted of serious offences in 2005, and sentenced to five years imprisonment. He was released on licence, but was arrested again in 2008. His licence was revoked and he was taken to HMP Lincoln. After short stays at HMP Ranby and HMP Leeds, the man was taken to HMP Nottingham in March 2009 as his trial was being held at Nottingham Crown Court. He was sentenced on 8 April 2009 and was given an indeterminate sentence (which means that a prisoner will only be released after serving a tariff determined by the trial judge, and then satisfying the Parole Board that the risk of harm to the public has been reduced to a safe level.) The man was required to serve a minimum of four years.

44. An initial health screening was completed when the man arrived at Nottingham by Nurse A. No health issues were recorded. He did not attend appointments for a secondary health screening (a more detailed screening, offered to all prisoners) on 30 March and 1 April.

45. On 11 May, the man saw one of the prison doctors and complained of what was described in the clinical record as a "testicular lump". A penile swab was taken for testing, and the man was prescribed antibiotics. He was also referred to the urology department at the local hospital. Five days later, he saw Nurses B and C and said his penis had begun to bleed when he passed urine. He also said that passing urine was painful. The man was advised to drink plenty of fluids and try to pass urine as normal. He was offered painkillers and later moved to the urology ward at Nottingham City Hospital. The following day, 17 May, he underwent a circumcision operation and returned to the prison. A biopsy was taken for analysis during the man's time in hospital. Nurse A noted that the man did not appear to be in discomfort, and was moving around the wing without problems. He did, however, have a urethral catheter that required regular attention. Throughout May and early June, he was seen almost daily by nurses for attention to his wound dressing and catheter. The clinical record notes that he became skilled at managing this himself.

46. On 29 May, the man saw Dr A, and said he felt as if he needed to pass urine very frequently. Blood had also been present in his urine. The doctor noted that there did not appear to be any infection and thought the problem was likely caused by irritable bladder. He prescribed a 14 day course of tolterodine (a medication used to treat urinary incontinence).

47. A member of healthcare staff wrote in the clinical record on 5 June that he had received a telephone call from the Queen's Medical Centre. The biopsy taken during the man's time in hospital had been analysed, and he was diagnosed as having penile cancer. The prison healthcare staff were asked to refrain from breaking this news to the man, as the diagnosis and treatment plan would be given at his next hospital appointment.

48. The man was made aware of his diagnosis on 12 June. He was also told that he was on the waiting list for a magnetic resonance imaging (MRI) scan to

obtain more detailed information about his cancer so that decisions could be made about his treatment. Another member of healthcare staff noted in his clinical record that it would need to be done "very urgently". Nurse D wrote in the clinical record that the man was "understandably rather shocked". He said he felt let down by previous prisons and had been subject to incorrect diagnoses. The next day, Nurse E saw the man to offer support and to review his care plan.

49. Throughout June and July, the man attended numerous appointments with prison healthcare staff, and his care plan remained under review. On 20 July, the man attended hospital for an MRI scan of his groin. He underwent a similar scan of his penis on 5 August. Throughout August and September, he continued to attend appointments with healthcare staff at the prison.

50. Between 30 September and 12 October, the man was in Leicester General Hospital. During this time, he underwent major and traumatic surgery, a partial penectomy and inguinal lymphaenectomy. Following his return to the prison on 13 October, the man was seen daily by healthcare staff whilst living on a residential unit. Entries were made in the clinical record about care planning, wound care, and management of the man's catheter. His mood seemed generally positive, and he associated with other prisoners on the unit.

51. On 22 October, the man was seen by Dr A, who noted that the wound site was infected and an abscess was present. The man was admitted to Leicester General Hospital and remained there until 10 November. During this time, regular entries were made in the clinical record and the clinical team manager visited the man in hospital.

52. When he returned to Nottingham, the man continued to receive daily post-operative care from the nursing staff. He continued to associate with other prisoners, seemed upbeat in mood, and was able to manage his own wound dressings. Part of the care plan involved the man moving to G wing, to an adapted cell on the ground floor, with a hospital bed.

53. The man attended an appointment at the hospital in Leicester on 19 November. The clinical team manager wrote in the clinical record that the doctor did not know the man's medical history, and this led to a breakdown in communication. Throughout November and December, the man continued to receive daily care from the medical staff at Nottingham. Lengthy entries were made in the clinical record about the ongoing care plan and the contact with nursing staff.

54. On 5 and 6 January 2010, the man attended hospital for outpatient appointments and was told that his wounds had healed. The oncologist told the man that he would need to determine whether inflammation to the lymph nodes (part of the immune system which helps the body recognise and fight infection) was due to an infection or progress of the illness. This would determine the type of chemotherapy given. (Chemotherapy is a treatment for cancer which uses medication to kill cancerous cells. The treatment can vary

according to the type of cancer, how advanced it is and a person's general health.)

55. Over the next few days, the man was seen regularly by healthcare staff at Nottingham. However, he also said he did not want people "fussing round him" and wanted to be treated like anyone else. On 13 January, he attended an appointment with a nurse for support, prior to him going to hospital to start chemotherapy. The next day, he attended an appointment with the oncologist at Leicester General Hospital. The proposed chemotherapy was discussed, including the possible side effects. The man consented to the treatment.

56. The man did not attend a mental health clinic appointment on 15 January. He told a nurse that he wanted to concentrate on his physical health problems. The nurse advised him that the chemotherapy might cause him to feel physically and mentally low, and that he should let healthcare staff know if he wanted any support from the mental health team.

57. On the same day, a multi-disciplinary meeting was held to discuss the man's ongoing care, including end of life care if necessary. A referral was made to the Macmillan nursing team (Macmillan nurses specialise in cancer and palliative care, providing support and information to people with cancer, and their families, friends and carers), and the end of life care team (a service provided by the PCT but based outside the prison) were invited to the next review meeting, scheduled for 29 January.

58. The man was admitted to hospital to start chemotherapy, and returned to the prison on the evening of 19 January. Over the next few days, he was seen regularly by nurses. He was prescribed antibiotics due to a fever, but was found to be stockpiling them in his cell. The man explained to nurses that he did not want to take them as he did not believe he had an infection. Notes in the clinical record state that the man felt unwell for several days after returning from hospital, but by 27 January he had started to feel better. The same day, he saw two nurses from the Macmillan team, who reported that he engaged easily with them and agreed to see them again.

59. During the same period, paperwork relating to the man's application for release from prison on compassionate grounds was completed. Such release has to be approved by the Secretary of State for Justice and, although it is considered on the basis of a prisoner's medical condition, it is granted only in the most exceptional cases. A probation officer at Nottingham, completed a short report about the man's family circumstances, his level of risk in the community, and proposed accommodation arrangements for release. The probation officer wrote that the man presented a medium risk of reconviction for a violent offence, and posed a high risk of harm to the public and to a known adult.

60. On 28 January, the man attended an appointment at hospital, but refused intravenous antibiotics that were to be provided to manage the side effects of his chemotherapy. He returned to the prison the same day and told nurses that he wanted to 'fight it on his own'. The next day, Dr B, one of the doctors

based at Nottingham, spoke to the consultant at the hospital, who was keen for the man to return and have the antibiotics as he was concerned about possible septicaemia (blood poisoning). The doctor spoke to the man, who said he felt well and did not want to go back to the hospital. He agreed to return if he became unwell. The doctor told the man that he might jeopardise having further chemotherapy if the specialists felt that they could not follow him up closely enough.

61. A case conference was held on Friday 29 January, involving the residential governor, offender management unit, family liaison officer, healthcare staff and the end of life care team. The discussion was primarily centred around the man's refusal to attend hospital for treatment. It was reported that he had agreed to return to the hospital the following Monday (1 February) but did not want to go over the weekend. He accepted that this might mean remaining in hospital for a few days.

62. After further discussions with members of healthcare staff, the man accepted that he required treatment from the hospital, and was admitted the same day. He returned to the prison on the evening of 31 January, and reported that he felt well.

63. On 3 February, Dr B completed a report about the man's medical condition. This was part of the compassionate release application. He wrote that the prognosis was "very poor" and went on to say:

> "His condition is likely to deteriorate in the near future so that he requires 24 hour care. He currently requires strong painkillers and his pain control will become more difficult in the [coming] weeks and months. He is undergoing chemotherapy which is not likely to be curative."

64. The deputy governor at Nottingham, considered the man's application for release on compassionate grounds on 12 February. He wrote that the man's behaviour in prison had not been good, and that he had failed to comply with the regime. He also noted that the man posed a risk of re-offending. In terms of moving to a hospice, the deputy governor said it had been considered for the man as the condition progressed. He did not support the application for compassionate release, based on "nature of offence, sentence and behaviour in prison".

65. In terms of medical treatment, the man was seen by members of healthcare staff almost daily between 1 February and 3 March. Numerous entries were made in the clinical record, frequently more than once per day. The clinical reviewer noted that the man was "offered numerous opportunities to share any concerns but clearly [was] not willing to discuss any psychological aspects in great detail". A mental health referral was made, although the man was reluctant to engage with this process. On 18 February, a nurse reported in the clinical record that the man was becoming increasingly withdrawn and was spending a lot of time in his cell, sleeping. The same night, he fainted in his cell but recovered quickly. He was reviewed the next morning but had not suffered any injuries.

66. The clinical reviewer wrote in her clinical review that, during the week of 9 March, it became clear that treatment options were severely restricted. Indeed, the clinical record shows that on 11 March, the man attended a hospital appointment and was told that the chemotherapy had not been successful. She noted that healthcare staff continued to see the man daily, and there were "frequent documented assessments of his pain control and mental well-being". She summarised the entries in the clinical notes that she felt were pertinent to his care, and these are described below.

67. The clinical record indicates that on 10 March, the Acting Head of Residence, was writing a protocol for the night staff so that a nurse could visit the man during the night, and this would be reviewed and the frequency of nursing visits increased as necessary. In addition, the night officers on G wing were instructed to alert a nurse when the man required assistance, including pain relief. A named nurse was specified to help co-ordinate care and support.

68. Authorisation for a more comfortable mattress was given on 11 March. Six days later, the probation officer at Nottingham completed another short assessment for a renewed application for compassionate release. He wrote that the man's family members were fully aware of his medical condition and were supportive of him returning home during the last stages of his illness. Regarding the risk presented by the man, the probation officer wrote:

> "The man was convicted of a serious violent offence, for which he received his current sentence. From conversation with his offender supervisor I am well aware that the man is in a significantly weakened physical condition. I therefore consider that the risk of his offending has decreased in these circumstances."

69. The probation officer went on to write about the involvement of healthcare staff both within and from outside the prison.

70. On 19 March, the Macmillan nurses visited the man and discussed pain management with him. Three days later, his pain relief medication was increased after a recommendation by the Macmillan nurses. On the same day, the man was again assessed by Dr B regarding compassionate release. The doctor again concluded that the man's prognosis was "very poor" and went on to say:

> "The man is suffering pain, shortness of breath and extreme lethargy. He struggles to walk up one flight of stairs or more than thirty yards. His condition makes it very unlikely that he would commit violent acts in the future."

71. Nottingham's governing governor, considered the man's application for compassionate release on 24 March. He wrote that it was "very unlikely that the man would have the physical capability of violent or other offending". He went on to say that: "The man is nearing the end of his short life. Early release would be appropriate."

72. The paperwork relating to the man's application for release on compassionate grounds was sent to the National Offender Management Service (NOMS) on the same day. This was followed by information from the man's probation officer in the community about the suitability of the proposed release address.

73. On 28 March, the dosage of the man's pain relief medication was increased again after discussion with the palliative care team at Nottingham City Hospital.

74. On 31 March, another prisoner told members of healthcare staff that the man 'put on a brave face' when dealing with officers and healthcare staff, but was often in tears, angry or in pain. Two days later, a nurse spoke to the man, who told her about some of his fears as well as his anger.

75. On 1 April, the man's probation officer in the community emailed the national offender management to inform her that a full risk assessment of the man and his proposed home circumstances had been carried out.

76. The clinical team manager spoke to another prisoner on 5 April. This prisoner was a close friend of the man, and had been helping him with his personal care for some time. Although both the man and the other prisoner were adamant that they were coping with the situation, the clinical team manager felt that the man's needs were becoming too onerous for another prisoner and would be better managed by healthcare staff. A case conference would discuss the gradual withdrawal of the other prisoner in terms of personal care needs.

77. On 7 April, the man's probation officer emailed the national offender management to ask if there had been any progress with the compassionate release application. The national offender management replied on 9 April, and said the report had gone to the Parole Board for their consideration.

78. An occupational therapist and a Macmillan nurse visited the prison on 9 April to discuss various pieces of medical equipment that would be necessary for end of life care. The end of life care team (based outside the prison) was contacted to discuss the provision of a syringe driver. This was delivered the same day, with support provided around using it correctly.

79. The clinical reviewer reported that by 12 April, the man's condition had clearly deteriorated. She also noted that end of life care was "clearly being implemented at this stage". The man was not eating, had difficulty holding things steadily, and had periods of confusion. She concluded that "this deterioration was likely to be the result of disease progression and end of life changes".

80. The next day, 13 April, a multidisciplinary team meeting was held. It was agreed that an open door policy would be implemented from that night, so that the man's cell was not locked overnight. An additional member of the healthcare team would be present throughout the night to offer support. The man required assistance with all aspects of his personal care, and with food

and fluid intake. The Liverpool Care Pathway (an outline of the standard of care that a patient can expect in the final stage of life) was in place. On the same day, discussions took place between healthcare staff about the man's ability to make decisions for himself. It was agreed that he no longer had the capacity to make decisions, and that healthcare staff would act in his best interests. A syringe driver was set up to administer pain relief medication.

81. The same day, conversations took place between the national offender management and the man's offender supervisor about the suitability of the man's proposed release address. Because his health had deteriorated, the release address was no longer considered suitable for addressing his complex medical needs. In an email to the man's offender supervisor, the national offender management said the application would be sent to government ministers for their consideration. Dr B also emailed the national offender management:

> "I can confirm my opinion to be that the condition is extremely poor and the deterioration in the last 12 days has been extreme. I feel that the patient is unlikely to survive more than two weeks, and that death may be sooner than this."

82. Although consideration was given to the man moving to Birmingham, closer to his family, Dr B noted in the clinical record that he was "extremely ill, and the risk of dying in transit … is high". A decision was made that the man would continue to be cared for at the prison. The clinical reviewer wrote that "it may have been inappropriate and clinically unsafe to have moved him at such a stage unless the care he was receiving was inappropriate".

83. On 15 April, the man was awake and alert, and was asked directly if he would like to go to a hospice. He replied that he would not. The following day, the national offender management informed that a bed was available at a local hospice, and asked whether this would be approved as a release address. She said she had no objection but knew that the man did not want to move to a hospice. (She noted in an email to the man's offender supervisor that this had been "evidenced by a number of staff who have been working with [the man].) The compassionate release application was approved, with the hospice listed as the release address in the event that the man changed his mind. The only change to the conditions of the compassionate release from the original application to its approval was the release address. All other conditions remained the same.

84. The clinical reviewer wrote in the clinical review that over the following few days, the man's condition continued to deteriorate. She thought the clinical record indicated that he was nursed closely and well, and that both personal and pain management care were prioritised. The man died at 8.00am in April.

85. At the time of the man's death, his mother was already on her way to the prison. As a result, she was informed of her son's death when she arrived at the gate. This caused her considerable distress and is discussed in the next section of the report.

86. Liaison between the prison and the man's family following his death was not harmonious and eventually broke down. This is again discussed in the next section.

ISSUES

The man's medical care before his transfer to HMP Nottingham

87. The clinical reviewer wrote a brief report about the man's medical care before his transfer to Nottingham. She noted that the first time the man complained of any problems relating to his subsequent illness was on 11 August 2008. He was examined by a doctor at HMP Lincoln because of a penile lump. This was diagnosed as an infection, and the man was prescribed antibiotics as a result. He was referred to the genitourinary clinic within the prison. The clinical reviewer thought this course of action was appropriate.

88. On 23 September, the man was reviewed but he had not been seen by the genitourinary clinic. The appointment was chased, and he was seen by a sexual health nurse on 20 November. The man told the nurse that he had had a lump 'for some time'. He was advised of appropriate hygiene measures, and the possibility of circumcision was discussed. The medical reviewer noted that sexual health nurses see genitalia frequently and on this occasion, nothing suspicious was observed.

89. The man saw a doctor again on 15 December with another infection. There was no reference to a lump on this occasion, but the man was referred to the urology outpatients department to determine whether circumcision would offer a definitive treatment. However, he was transferred out of Lincoln on 7 January 2009, and as a result did not see an urologist until he was referred by staff at HMP Nottingham.

90. The clinical reviewer concluded that:

> "When [the man] did present to healthcare he was seen and appropriately examined, treated and referred. As he was seen by three different healthcare professionals within four months, one of whom was a specialist in genitourinary medicine and hence very familiar with conditions of genitalia, I assume that the appearance of the condition was not one which caused concern."

91. The clinical reviewer went on to say that she could not comment upon whether the delay of approximately four months in the man seeing an urologist would have made any difference to the outcome.

Delay between diagnosis and treatment

92. The clinical reviewer examined delays between the time of the man's diagnosis and the commencement of his treatment, as part of her clinical review. She obtained the man's hospital records from Nottingham City Hospital and Leicester General Hospital.

93. The clinical reviewer reported that, following the man's referral and diagnosis, his case was referred to the joint multidisciplinary team for Nottingham and Leicester hospitals. His case was discussed at the next available meeting,

which was on 3 June 2009. At this point, an MRI scan was recommended and the need for surgery was discussed.

94. The man underwent MRI scans on 20 July and 5 August. These scans showed the spread of cancer to a lymph node in the groin. After the initial scan, he was seen on 24 July by the urology consultant at Leicester General Hospital. The man's case was discussed at a multidisciplinary meeting on 5 August, when surgery was recommended and chemotherapy was considered as a possibility.

95. Surgery took place on 6 October. The clinical reviewer wrote that when the man's cancer was first diagnosed, it was 'Grade 2 keratinizing squamous cell carcinoma', but by the time of the surgery, it was classified as 'Grade 3'. His prognosis was stated to be "probably very, very poor".

96. On 17 November, further scans showed possible spread of the cancer into deeper pelvic areas. Discussion at the multidisciplinary meeting took place about the possibility of further surgery or chemotherapy. By January 2010, the cancer had spread to the man's lungs, and chemotherapy was recommended.

97. The clinical reported on a number of delays. She noted that there was a 60 day wait from the initial diagnosis of cancer to the first MRI scan, and a delay of 47 days from the time that the MRI scan was first recommended at the multidisciplinary meeting. The clinical reviewer described this as "unacceptable". She found that, although the multidisciplinary meeting on 3 June agreed that the man would be referred to Leicester for treatment, he saw the urologist at Queen's Medical Centre, Nottingham on 22 June. Only at this point was a formal referral made to Leicester, even though the decision had been made some 19 days earlier. In fact, the consultant urologist had written to the urologist at Queen's medical centre on 4 June, the day after the meeting, confirming that he had agreed to take over the man's care. The clinical reviewer concluded that "the referral [process] between hospitals following multidisciplinary meetings is not smooth and certainly in this case delayed follow-up investigation and treatment".

98. In addition to the delays in the further investigation of the man's cancer, the clinical reviewer looked into the time that elapsed between diagnosis and surgery. She said this was 136 days, and 125 days from when surgery was recommended at the first multidisciplinary meeting. The clinical reviewer again concluded that this was unacceptable. Some three months after the man's care had been referred to the urology consultant at Leicester, he was seen by the urologist at Queen's Medical Centre at Nottingham. The urologist at Queen Medical Centre then wrote a letter to the urology consultant in, which explained:

> "The man arrived at my clinic today, probably through some administrative problem at our end. He is still awaiting surgery under your care and I said I would write to you to make sure that arrangements are in hand for this."

99. The clinical reviewer provided the predicted survival rates for penile carcinoma, which state that when one lymph node is involved at presentation, there is an 80 percent chance of survival after five years. When two lymph nodes or abdominal lymph nodes are involved, there is a 40 percent chance of survival after five years. Regarding these statistics and the man's case, the clinical reviewer wrote:

> "It is always impossible to know whether delays in treatment affect the final outcome in cancer cases, but from the medical records it appears the man presented with a Grade 2 moderately differentiated cancer with one affected lymph node which, by the time of surgery had progressed to a Grade 3 poorly differentiated cancer. Scans four weeks later revealed likely spread into the pelvis. Earlier surgery with chemotherapy may have given a chance of slowing disease progression, or even cure."

100. In addition, the clinical reviewer commented that although chemotherapy was discussed at multidisciplinary meetings in August and November 2009, it was not recommended until January 2010.

101. The clinical reviewer concluded that the man was "let down badly, possibly negligently, by the hospital system". She said it was surprising that the hospitals relied on letters between the consultants, particularly when the investigation and treatment of the man's illness was delayed. Furthermore, the clinical reviewer was disappointed that, for someone of such a young age with a very rare form of cancer, no healthcare professionals at the prison seemed concerned about the delays. Despite the fact that the man was receiving regular treatment from the healthcare team at the prison, "the delay of four months seems to have caused no concern from the point of view of wondering whether there had been a system failure".

102. The clinical reviewer recommended a further independent investigation to specifically examine delays in the man's investigation and treatment, as she believed that his death may have been preventable. I endorse this recommendation.

The Chief Executive of Nottingham City Primary Care Trust (PCT) should undertake an independent investigation to examine the delays in the man's investigation following diagnosis, and his subsequent treatment.

Cell accommodation

103. HMP Nottingham does not have an inpatient medical facility therefore it was not possible to locate the man on a dedicated healthcare wing. For most of his time there, the man lived in a normal, residential cell. Towards the end of his life, when his medical needs became more complex, he moved to a specially adapted ground floor cell.

104. The clinical reviewer viewed the cell where the man spent the last part of his life, and was shown by prison healthcare staff how it was arranged for palliative care. She commented that the cell was en-suite and comparable in

size to a side room in a hospital. It was also located opposite a room which was used to facilitate visits to the prison by the man's family. The clinical reviewer concluded that the space was adequate for the delivery of palliative care and that the en-suite facility was likely to have greatly assisted the delivery of personal care.

105. The clinical reviewer noted in her clinical review that the exercise yard for the wing was outside the window of the man's adapted cell. This meant that the curtains had to be drawn for around 90 minutes every day to afford him privacy whilst other prisoners were exercising. She said that although this was unfortunate, it was a reasonable negative aspect to accept given that in all other ways, such as size, location and en-suite facilities, the cell was the most appropriate in the prison.

106. In addition to concerns about the exercise yard, the clinical reviewer mentioned that "prisons are inherently noisy environments and perhaps … not how one would design the acoustics of a perfect palliative care setting". She did not know if the man found it problematic and there is nothing in his clinical record to suggest that this was the case.

107. In general, when referring to palliative care, the clinical reviewer concluded that the man received "exemplary medical care within the prison setting". She went on to say:

> "He had access to all aspects of palliative care available in the community, including psychological support and Macmillan nursing, and community pathways for end of life care were adopted. He was supplied with an appropriate hospital bed, mattress and allied equipment. Pain control was appropriate and delivered as in a community setting. Family visits were facilitated and towards the end of [his] life the man had a continuity and intensity of nursing care which is often not possible in a community setting."

108. The man's family members were concerned that he should not have been in a prison setting at all, given his deteriorating medical condition. However, the man made it clear to members of staff at Nottingham that he did not want to move to a hospice. According to a number of staff, he felt supported on the residential units and did not want to be treated significantly differently from other prisoners. Whilst he clearly had additional care needs, particularly towards the end of his life, the man was keen to stay in the same environment as other prisoners. The clinical reviewer concluded that the care he received was equitable to, and in some cases superior to, what might have been expected in the community.

Specific aspects of the man's medical care

109. The man's family members asked questions about some specific aspects of the man's medical care. My investigator asked the clinical to comment on these issues, and her findings are summarised below.

The Liverpool Care Pathway (LCP)

110. The clinical reviewer commented that the LCP is designed to guide care at the end of life, to ensure a holistic approach to the dying patient. It encompasses physical, emotional and spiritual care needs. The Pathway documentation includes paperwork prompting the healthcare team to consider these areas regularly when caring for the patient.

111. The clinical reviewer concluded that "during the last two weeks of his life, the physical and emotional needs of the man were well attended to and that his clinical management was appropriate". She went on to say that all aspects of the LCP were considered, and that it was followed daily.

Fluids

112. The man's family members were concerned about the man's fluid intake during the last few days of his life. The clinical reviewer commented that there were detailed nursing notes covering the last five days of the man's life, and these record fluids being offered. The man was passing urine via a catheter. This was recorded daily and, the day before his death, he passed 500ml of urine. The clinical reviewer said this suggested he remained hydrated.

113. The clinical reviewer said that although there was not a formal record of the fluids taken orally, there was no evidence that fluids were withheld from the man. She went on to explain that:

> "During the end stage of life it is often difficult to maintain a good state of hydration as patients are often very drowsy and unable to swallow without choking. Within a community setting parenteral (intravenous or subcutaneous) fluids are rarely if ever given in the terminal stage of life. As mentioned previously, the fluid balance records show that urine output indicated a reasonable state of hydration for this stage of life. Even in hospice settings, intravenous fluids are not often given as the drip can cause distress to the patient and add little to quality of life. Mouth care is the more important aspect of comfort in the last few days of life."

114. In response to the draft report, the man's family members said that they were concerned that Nottingham might have been referring to out of date guidance on the LCP, and that current guidance states that fluids should be maintained and not withdrawn. The clinical reviewer, however, is satisfied that the man was appropriately hydrated during the final days of his life. The healthcare department at Nottingham confirmed that they used version 4 of the LCP, which was current at the time of the man's end of life care.

Pain relief and sedation

115. The clinical reviewer noted that, during the last week of the man's life, his pain was managed during a syringe driver. This facilities the administration of pain relief and other drugs to help with agitation and nausea during the end stage of life. The medication can cause sedation and the aim is to achieve a balance whereby there is adequate relief from pain and agitation, with minimal unnecessary sedation. He went on to say that disease progression causes patients to become very drowsy in the end stage of life.

116. The clinical reviewer did not have concerns about the man's pain relief and sedation. She emphasised that the main aim is compassion, to ensure that the patient is comfortable and free from pain and distress. The dose of morphine and sedative in the man's syringe driver was increased on 17 and 24 April 2010, and his medical notes indicate that this was in response to increased pain and agitation.

Application for compassionate release

117. The man's family members were unhappy with the way in which the application for compassionate release was handled. The man's mother had sought to have her address, or a hospice close to her address, approved for the man's release. She felt that, as compassionate release was granted by the Ministry of Justice, the prison should not have had any influence over the man's release address, and that they could have avoided him dying in prison.

118. The investigator interviewed a number of staff at Nottingham who told him that the man was adamant that he did not want to go to a hospice. This proved problematic in terms of finding a suitable release address, because his medical needs were complex. Although the man's mother thought she could care for him at home, the medical professionals involved in the man's care concluded that he needed intensive support. Furthermore, when the compassionate release application was approved, the man's health had deteriorated quickly, and the doctor at Nottingham thought he might not survive the journey. A bed at a hospice local to the prison was secured, and his release papers were prepared with that address, in case he changed his mind about going to a hospice.

119. I understand that the man's mother finds it particularly distressing that her son died in prison when she would willingly have accommodated him at her home. However, the healthcare staff at Nottingham had a duty of care to the man, and were responsible for ensuring that he received medical care commensurate with the seriousness of his condition. He had told a number of staff that he did not want to go to a hospice, even when a place was available.

120. The investigator found no indication, during interviews with members of staff at Nottingham, that there was any motive to keep the man in prison. Numerous members of staff had facilitated the compassionate release application and had attempted to expedite the process. During interview, members of prison staff spoke of their concern that the man received

appropriate medical treatment and that the last stage of his life was in accordance with his wishes. Release was approved to a hospice near the prison, but this was not what the man wanted.

Liaison with the man's family

Communication about the man's medical condition

121. The man's family members were concerned about the level of information that they received with regard to his medical condition. In particular, the way in which they discovered that the man was unwell was distressing for them. Someone describing herself as an old friend of the man had called at their house and told them that he was dying, and that they should contact the prison. The man's mother felt strongly that a representative from the prison should have told her about her son's illness. (In response to the draft report, Nottingham said that when the man decided to tell his family about his illness, he only had limited contact details for them.)

122. After the man's family members started to visit him in prison, they continued to experience difficulties obtaining information about his diagnosis, his ongoing medical treatment, and his prognosis. They thought the healthcare team at the prison could have been more forthcoming in relaying information to them.

123. My investigator asked the acting head of prison health, about this issue. She said:

> "If the patient requested that healthcare staff inform the family then they would do, or if the patient asked healthcare to be present while they inform the family to give them more information than we would do. But we wouldn't go and share that information without patient consent."

124. There are confidentiality issues associated with most medical matters. In the community, medical staff would not routinely inform the family members of an adult about a medical diagnosis. It would be for the adult in question to decide whether or not to inform other people. The same principle is applied in the prison setting. At the time of receiving his diagnosis, the man was an adult capable of making independent decisions. He could, therefore, have informed his family members about his illness had he chosen to do so. It would have been inappropriate for medical staff at Nottingham to disclose information about the man's illness to third parties without his consent. Whilst the manner in which the man's family members found out about his illness was distressing, this was unfortunately beyond the control of the prison. In response to the draft report, Nottingham asked us to point out that "conveying private medical information was a confidential matter for the man himself and not for the prison or healthcare professionals".

125. In terms of ongoing issues regarding information about the man's condition, the same principle applies. Until shortly before his death, the man was

capable of deciding how much information to share with his family members about his illness.

Concerns about the man's medical care

126. The man's family members said he developed open wounds in his groin from abscesses and was having to dress his own wounds for a number of months. They questioned how this was possible if he was receiving 24-hour care.

127. The clinical record suggests that, following his surgery, the man received regular and intensive medical intervention to help with wound care. He was taught how to care for his wounds and dress them by himself. This is not an unusual state of affairs and indeed, with his wound in such a sensitive area, the man may well have preferred this arrangement. His wounds were checked regularly by medical staff and he was treated for post-operative infections. The clinical reviewer did not criticise the arrangements regarding the man's wound care.

Visiting arrangements for family members

128. Towards the end of his life, the man was too unwell to receive visitors in the normal visits area of the prison. As such, visits from his family members were facilitated in his cell. However, both the man's mother and father explained that there had been a number of problems. Although the man's mother was told that no visiting order was required, she experienced problems at the gate with members of staff who did not appear to understand the special arrangements that were in place. The man's mother also felt that she was not afforded sufficient privacy with her son when visiting him in his cell. Furthermore, two of the man's sisters were not permitted to visit him in his cell, because they were under 18. The man's father said that on one occasion, the man was too ill to go to the visit centre and he had to return home without seeing him.

129. My investigator spoke to one of the governors, who acted as the liaison officer for the PPO about these issues. He was aware that there had been some 'teething problems' with the arrangements for visits without visiting orders, but he felt that this was rectified quickly. A notice was produced and displayed in the gate area so that staff members on duty at the gate were aware of the arrangements that were in place. A letter was sent to the man's mother informing her of steps that had been taken, and advising her to present the letter at the gate if she continued to experience problems.

130. The man's mother did not feel that the issues were resolved quickly, and that this issue added further inconvenience and distress to what was already a very difficult situation. I acknowledge positive attempts by the prison to rectify the problem, but I also suggest that the policy around this issue is considered and updated.

131. Regarding the issue of privacy, the governor who acted as the liaison officer for the PPO explained that the prison had a responsibility to ensure the safety and security of the man, his visitors, and the other prisoners on the wing. Furthermore, towards the end of his life, the man had medical equipment in his cell that would not ordinarily be kept on the wing. Members of staff interviewed felt that the man's family members were afforded some privacy, but the unusual nature of the visiting arrangements meant that they were not usually left alone in the cell.

132. In terms of the man's sisters being unable to visit him on the wing, the governor who acted as the liaison officer for the PPO again spoke about issues of safety and security. He emphasised that family visits taking place on the wing is an unusual arrangement, and that ensuring the safety and well-being of those visitors was of paramount importance. He explained that the wings of a prison hold a number of prisoners who have been convicted for various different offences, and that a number of unplanned incidents could occur on any given day. The decision to restrict visits on the wing to over-18s was made on the basis of ensuring that children were safe and did not witness anything unnecessarily distressing that might occur.

133. I understand that the man's sisters were very upset about not being able to say goodbye to their brother. However, I also accept that the visiting arrangements had become difficult for everyone concerned. The man was too unwell to receive visits in the main visiting area, and he did not want to move to a hospice. It would therefore appear that facilitating visits in his cell was the best option open to the prison. I also accept that, for issues of safety and security, a decision was made to restrict those visits to adults.

Professional boundaries of staff at HMP Nottingham

134. The man's mother thought that professional boundaries had not always been respected at Nottingham. In particular, she felt that the family liaison officer to the man's family had become too involved with the man. On one occasion, she had greeted the family for a visit with red eyes, and it was clear that she had been crying. Although the family appreciated her empathy, they said they would have found it more helpful had she maintained composure in front of them. On other occasion, the man's mother was shocked to see her attending to the man's intimate personal care needs, something that she felt should have been done by medical staff. (In response to the draft report, Nottingham said that the family liaison officer for the family had definitely not been crying before this meeting, and had at no time attended to the man's personal needs beyond giving him a glass of water.)

135. The family liaison officer was appointed in November 2009. It is clear from the extensive records kept that she was in contact with the man and his family members on an almost daily basis. During interview, the Acting Head of Residence, explained that between November 2009 and April 2010, the family liaison officer for the family built up a close but professional relationship with the man, as well as liaising with his family about visits and the progression of his illness.

136. My investigator was not able to interview the liaison officer for the family during the course of the investigation, and so it was not possible to ascertain how onerous she found this task. Nevertheless, interacting on a daily basis with a person of declining health over a period of five months, whilst also liaising with family members in what was not always an easy relationship, cannot have been easy.

137. As we have not interviewed the liaison officer for the family, it is difficult to determine whether she went beyond her role as family liaison officer, and if she did, whether this was to the man's benefit or detriment. It is clear that she spent a lot of time interacting with the man, helping him to reinstate contact with his family members and providing a source of support. However, the primary role of the family liaison officer is, ultimately, to engage with the family, act as a point of contact, ensure the family's needs are met in terms of access, information and engagement, and help them to prepare for what to expect following the death. Whilst she kept extensive logs of her contact with the man's family, it was not always completely harmonious, particularly after the man's death. In the end, the relationship between the man's family and the liaison officer broke down.

138. I do not intend criticism of the liaison officer for the family, who clearly took on a very demanding role. However, there is no evidence to suggest that the scope and nature of the role was given sufficient consideration prior to her appointment. In the future, the Governor may wish to consider whether it is appropriate to have a single member of staff responsible for such wide-ranging responsibilities. (In response to the draft report, Nottingham commented on this paragraph as follows:

> "The Governor has commented that this paragraph is inaccurate speculation. He has commented that the phrase "I do not intend criticism…" comes across as exactly the opposite. There is ample evidence of the nature and scope of the role being given sufficient consideration. The matter was frequently reviewed after the daily operational meeting and the liaison officer for the family was supported by two senior managers – the governor who acted as the liaison officer for the PPO and the acting head of residence")

139. After the relationship between the family and the liaison officer for the family broke down, no alternative liaison officer was appointed. The family did not receive a letter of condolence from the prison. The Governor will want to look into how the family liaison role is continued in such circumstances, and that bereaved family members receive letters of condolence.

140. In response to the draft report, Nottingham commented on this paragraph as follows:

> "The Governor has noted that the relationship with the family and the family's liaison officer did not break down. But different members of the family had different opinions and this made it difficult for the prison to deal

with them. … He explained that Nottingham had spent so much time supporting the family that a letter did not seem appropriate."

Informing the man's family about his death

141. The man died at 8.00am on 20 April 2010. At the time of his death, his mother had already left home and was on her way to the prison to visit him. She said that when she arrived, she was informed in the gate area that her son had died earlier that morning. She felt that this obviously distressing news was delivered insensitively, with other members of staff and building contractors present.

142. My investigator spoke to the governor who was the liaison officer for the PPO about this issue. He explained the thought process that had been involved in deciding how to break the news to the man's mother, and the difficulties in doing so anywhere other than at the gate. He felt that it was not feasible to take the man's mother to another area of the prison, such as an office on the wing, as it would take around five minutes to get there and would almost certainly involve a conversation about the man. During interview, he recalled that on a previous occasion, he had wanted to speak to the man's mother about an issue, but she rightly insisted on seeing her son first. He thought the same issue might arise if he had tried to take her to an office on this occasion. He therefore decided that the best course of action was to break the news to the man's mother when she arrived at the gate.

143. The governor who was the liaison officer for the PPO told my investigator that he personally ensured that no other members of staff were in the gate area when the man's mother arrived and was informed that her son had died. This is contrary to the account presented by the man's mother, but he felt that the news was delivered as sensitively as possible given the circumstances.

144. Informing family members that a loved one has died is always difficult and will inevitably result in distress. This was a particularly difficult situation, and it is unfortunate that the governor who was the liaison officer for the PPO and the man's mother do not agree about the news being delivered appropriately and sensitively.

145. I accept that the governor who was the liaison officer for the PPO considered how best to break the news to the man's mother, and that the decision he took was based on nothing but the best intentions. However, it is clear that it caused the man's mother considerable distress. In general, the gate is not an appropriate place to break such news to family members. The Governor may wish to consider how this situation might be resolved before it arises again.

146. In response to this paragraph, Nottingham asked us to delete the final two sentences. We have declined to do so, as we remain of the opinion that the gate is not the best place to break such news (although we understand why it happened on this occasion). Nottingham said that there is a clear difference

of opinion as to who was in the gate at the time, which they do not think is resolvable. Nottingham added:" The prison did its best to convey the information in the right way. It is unfortunate that [the man's mother] does not agree."

Consideration of the man moving to a hospice or to the family home

147. Members of staff at Nottingham were clear that the man's wish was to remain in prison. However, his family members told my investigator that, during a meeting about the man's needs, they informed members of staff that he had told them his only wish was not to die in prison. The man's mother said the liaison officer for the family took a note of this at the meeting, but later denied all knowledge.

148. I have not been able to find evidence that the man had a strong desire to leave the prison before his death. Certainly, he was afforded the opportunity to do so, with a place at a hospice available for him to move to if he so desired. I do not intend to cast doubt on the information presented by the man's family. Unfortunately, however, I have been unable to substantiate it.

149. A further issue raised by the man's family members was the conclusion that the man was too unwell to return home. In particular, they felt that this was inconsistent with him being transported the 20 miles to Leicester for treatment in a taxi.

150. The man last travelled to Leicester for treatment in March 2010. By mid-April, when his compassionate release application was being finalised, his condition had deteriorated. The conclusion that the man was not well enough to move to Birmingham and that such a move would risk him dying during the journey was reached by a doctor, not by managers at Nottingham. It was for this reason that the approved release address for the compassionate release application was a hospice local to the prison.

The man's property

151. The man's family members were concerned by a lack of hospital appointment letters in his property. They questioned what had happened to these. They also said that the man had made legal enquiries about a medical negligence claim, but only one letter about this was found amongst his belongings. In response to the draft report, Nottingham have asked us to add that, because of security reasons, prisoners are never given hospital appointment letters and do not know in advance when they will be going to appointments

152. I am unable to offer an explanation as to why there were no further appointment letters, or documents relating to a legal claim, amongst the man's property.

CONCLUSION

153. The man first complained of a penile lump in August 2008, whilst at HMP Lincoln. Until December of the same year, this was treated as an infection. When he transferred to HMP Nottingham, he did not initially complain of the same problem.

154. When the man complained to healthcare staff at Nottingham about the problem, the matter was investigated and he was diagnosed with penile cancer. However, there were long delays between his diagnosis and the commencement of treatment, to such an extent that the clinical reviewer, thought that his death might have been preventable. I am sure that the coroner and the Primary Care Trust will want to investigate this matter further.

155. The man remained in HMP Nottingham until his death in April 2010. Although release on compassionate grounds was agreed, the man was too unwell to travel to his mother's home, and there were concerns about the level of medical intervention that he would require. Although a place was obtained at a hospice local to the prison, the man did not want to go there.

156. The clinical reviewer concluded that the man received an exemplary level of palliative care, equivalent to and in some ways superior to what could be expected in the community.

RECOMMENDATIONS

1. The Chief Executive of Nottingham City Primary Care Trust (PCT) should undertake an independent investigation to examine the delays in the man's investigation following diagnosis, and his subsequent treatment.