Investigation into the circumstances surrounding the death of a man, a prisoner at HMP Acklington, at Morpeth Cottage Hospital in January 2008

Report by the Prisons and Probation Ombudsman for England and Wales

March 2009

The man was 57 years old when he died on 25 January 2008 of natural causes at Morpeth Cottage Hospital. He was a prisoner who was serving his sentence at HMP Acklington. My report shows that the man had been diagnosed with cancer at an early stage of his sentence.

My investigator and I offer our sincere condolences to the man's family and friends for their sad loss.

I wish to thank the Governor of Acklington for making the necessary facilities and information available to my investigator, and for the assistance of the Liaison Officer. In the course of the investigation, I also asked for a clinical review to be carried out into the care and treatment the man received in custody. I am grateful to the Doctor from the North of Tyne Primary Care Trust for his assistance and report.

My investigation identified a number of issues which required action on the part of HMP Acklington. I am pleased to say that once my investigator made the Governor aware of concerns regarding hospital referrals and the use of disclaimers by prisoners who declined hospital appointments, the governor of Acklington gave the investigator an assurance they would be corrected immediately. As a result, I have only made one formal recommendation (to the Durham Probation Area). However, the investigation has, like so many others I have issued, drawn attention to the risk averse approach that is taken to the use of restraints on seriously ill and dying prisoners. In paragraph 82, I have described "a macabre pantomime" in which handcuffs were first removed, then re-applied, then removed again from the man, a man who was frail and just days from dying.

This report also raises a matter for the Parole Board, and I will send a copy to the Board for their consideration.

I must apologise for the length of time it has taken to complete and issue this report.

Stephen Shaw CBE
Prisons and Probation Ombudsman **March 2009**

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SUMMARY

In October 2005, the man was sentenced to six years imprisonment, which included a two year extension to his sentence, after he had been found guilty of a serious offence against a child. He was initially sent to HMP Hull but later transferred to HMP Acklington where he settled in well.

The first noticeable problem with the man's health was when he was referred urgently by a doctor at Acklington to a dermatologist at the Royal Victoria Infirmary, Newcastle, in August 2006, with what was described as a "suspicious skin lesion". Unfortunately, the urgent referral, which should have meant he was seen within 14 days, was not dealt with correctly by Acklington's healthcare department and the referral was not sent. However, a further urgent referral was made in September that same year and a new appointment made for the following month. On the day of the appointment, the man decided not to attend the hospital and a new appointment was requested and made by Acklington's healthcare for the following month.

After attending the re-scheduled appointment on 19 October, the man was diagnosed as having a malignant melanoma. He was treated in hospital and returned to prison. Over the following months he returned to hospital for routine assessments and for a CT scan. The clinical reviewer identifies further hospital appointments that were cancelled at the man's request.

During this time the man was eligible to apply for release on licence, which he did. However, because of a failure by his home probation office to return the parole documents within the correct timescale, his application was not dealt with and the documents were returned to the prison for rewriting.

Over the next few months the man's health deteriorated and he was eventually transferred for end of life care. He died on 25 January 2008 at Morpeth Cottage Hospital.

THE INVESTIGATION PROCESS

1. Following notification from the Prison Service that the man had died, the investigation was allocated to my investigator. He contacted the Governor of HMP Acklington and arranged for the relevant prison files to be forwarded to him. In addition, my investigator asked for my notice of investigation to be displayed to all prisoners and prison staff inviting anyone with any information to make themself known. I can confirm that no one responded to the notices.

2. In March 2008, the investigator and one of my family liaison officers visited the man's family at their home address and met three members of his family. The man's family made my staff very welcome and asked them to look at a number of issues and concerns they had relating to the man's care and treatment whilst in custody. I hope that my investigation has covered all their questions.

3. After reviewing the files, my investigator went to the prison on 21 April 2008 where he met the clinical reviewer appointed by the doctor from North of Tyne Primary Care Trust and the prison's liaison officer and Acting Deputy Governor. The investigator and Doctor spoke to members of the prison medical team. Before leaving the prison to complete his clinical review, the North of Tyne Primary Care Trust Doctor was given details of the family's concerns and asked to comment in his review on those within his competence.

4. Over the following two days, my investigator met a number of prison staff and managers, all of whom cooperated fully with my investigation. The purpose of speaking to prison staff was to try and answer the family's questions and to assess how well the man's needs were catered for.

5. On 23 April, the investigator met the Governor and liaison officer and fed back his findings at that time. The Governor accepted the feedback and agreed to implement a number of changes (as a consequence, this report contains fewer formal recommendations than would otherwise be the case). However, the investigator reminded the Governor that there could be additional recommendations resulting from the clinical review.

HMP ACKLINGTON

6. HMP Acklington is a category C establishment, situated close to the village of the same name in Northumberland. It was built on the site of a former RAF base and accommodates convicted adult male prisoners including men serving life sentences. About half the population are vulnerable and/or sex offender prisoners. The prison can hold a maximum of 871 prisoners. It provides employment in farms and gardens, education and a variety of workshops.

7. Between Monday and Friday, prisoners are unlocked in the morning at 7.55am. They are locked up for the night at 7.15pm. At weekends, the prison is unlocked at 8.30am and on Saturday is locked up at 7.15pm. On Sunday the prison is locked up for the night at 5.20pm.

Bedwatch

8. Bedwatch is the term used by the Prison Service to describe a prisoner who has been admitted to hospital and usually requires a minimum of two officers to be present throughout the stay. In the majority of cases, the prisoner is handcuffed to an officer.

Healthcare

9. Acklington does not have 24 hour medical cover. Outside the normal operating hours, the prison relies on the services of an on call doctor or, if necessary, the emergency services.

Her Majesty's Chief Inspector of Prisons' Reports

10. In April 2003, Her Majesty's Chief Inspector of Prisons, made an unannounced follow up inspection of the prison. The inspection found that Acklington was largely a safe establishment. However, in her report the Chief Inspector commented on suicide prevention and anti-bullying, highlighting the need for more extensive training especially for permanent night staff.

11. Three years later in December 2006, Her Majesty's Chief Inspector of Prisons carried out an announced inspection of the prison. In the introduction to her report, she said she was disappointed to find that, despite raising concerns over three years earlier about expanding the prison, those concerns had gone unheeded. She said that the expanded prison had not only failed to provide sufficient purposeful activity places, it had struggled to sustain a safe and decent environment. However, the chief inspector acknowledged that there were few incidents of self harm. She also described commendable examples of care for those at risk. She said that a new group of senior managers had been transferred into the prison.

12. The Chief Inspector recommended that emergency resuscitation equipment and emergency assistance should be immediately available to all staff and prisoners.

Independent Monitoring Board (IMB)

13. Each prison has its own IMB made up of volunteers from the community. The Board's role is to ensure that the prison is properly run and that prisoners are treated decently. Each Board produces an annual report for the Secretary of State.

14. In line with my normal practice, my investigator asked to speak with a representative of the Board. He was told that, on the occasions when a death had occurred at the Acklington, the Board had been properly notified. The Board did not raise any concerns regarding healthcare.

Prison Service Orders (PSO)

15. Prison Service Orders are long term mandatory instructions which are intended to last for an indefinite period. Any mandatory instructions to Governors are written in italics. Each PSO is given a title and unique reference number.

PSO 4400 Incentives and Earned Privileges Scheme (IEP Scheme)

16. All prisons operate a local IEP scheme for prisoners. The scheme is intended to encourage and reward responsible behaviour, participation in constructive activity including addressing offending behaviour, and progression through the prison system.

17. There are three levels to the scheme (Basic, Standard and Enhanced). Prisoners assessed as being at basic level are given the minimum allowable regime and facilities. Those on standard and enhanced levels are allowed access to higher spending power, additional visits, in cell television and other facilities depending upon the resources available, with enhanced providing the most rewards.

Multi-Agency Public Protection Arrangements (MAPPA)

18. The MAPPA is a formal partnership between police, probation, prisons and other statutory and non-statutory agencies which assesses and manages offenders in order to minimise the risk of serious harm they may pose to the public. There are four core functions:

- identification of offenders with the potential to commit serious violent and sexual offences
- sharing relevant information between agencies
- assessing the risk of serious harm
- Managing that risk.

19. Offenders who come within the MAPPA remit are classified according to the nature of the risk and its management. The higher the risk, the higher the level at which they are managed. Level one offenders are managed by one agency, usually the police or probation service. Level two offenders are managed jointly by all the MAPPA agencies, and level three offenders are managed by the Multi-Agency Public Protection Panel (MAPPP), made up of senior managers from the MAPPA agencies.

Previous Deaths at Acklington

20. Since my office took over the responsibility for investigating all deaths in prison custody on 1 April 2004, there have been three apparently self inflicted deaths at Acklington and nine, including the man's, due to natural causes. I have not identified any common factors between my previous investigations and this one.

Sexual Offences Prevention Order (SOPO).

21. The Sexual Offences Act 2003 gives the courts the power to impose civil preventative orders against individuals convicted of sexual offences and whose behaviour suggests they may commit further similar offences. One of the orders is the Sexual Offences Prevention Order (SOPO), which is intended to protect the public from serious sexual harm. Offenders subject to the order are prohibited from engaging in specified activities, such as entering schools or swimming pools. Orders last for a minimum of five years. A breach of any of the conditions constitutes a criminal offence punishable by up to five years imprisonment.

KEY FINDINGS.

22. The man was convicted of a serious sexual offence and when he appeared at York Crown Court on 28 May 2005. He was bailed and told to return to court on 3 October, for sentencing. When he returned to court, he was sentenced to four years imprisonment and given a two year extended sentence, which meant that his actual term of imprisonment would take him to 2 October 2011. He was taken from court to HMP Hull to begin his sentence. Because of the length of his sentence, the man would not be eligible for release on licence until 3 October 2007.

23. Due to the nature of the man's offence, an order was made disqualifying him from working with children for life. He was also issued with a copy of the Sexual Offences Prevention Order and told that he would be required to sign the Sex Offender Register on his discharge from prison.

24. On 16 December 2005, the man was transferred from Hull to Acklington. Due to the nature of his offence, he was allocated to a vulnerable prisoner wing which provides a higher degree of safety from other prisoners. In addition, and because he was subject to MAPPA level two, arrangements were made by the prison's security department to routinely monitor his letters and telephone calls.

25. Six days later, the man attended a Well Man Clinic at the prison. The clinical reviewer notes there were no health problems identified. The man's weight was recorded as 58kg.

26. The man appears to have settled in well at Acklington. The clinical review notes that on 1 August 2006, the man was seen by a doctor at the prison. The doctor referred the man for an urgent appointment with a dermatologist at the Royal Victoria Infirmary (RVI) Newcastle, due to what was described as "a suspicious skin lesion". The urgent referral meant that the man should have been seen within 14 days.

27. On 26 September, the man saw a nurse at the prison as he had not received his dermatology appointment. Three days later, another prison doctor re-referred the man urgently to the dermatologist. On this occasion, the referral was acknowledged and an appointment made for 10 October at the RVI. However, at the man's request, the appointment was cancelled. He had signed a disclaimer showing that it was his decision.

28. The man was given a fresh date and, on 19 October 2006, he attended the dermatology department at the RVI as an outpatient. Arrangements were made for him to return to hospital on 16 November for tests and an operation.

29. Seven days later, on 24 November, the man returned to hospital and was given the result of the tests carried out the previous week. These showed that he had a malignant melanoma. The clinical reviewer notes that he was fully informed about the diagnosis and an appointment made for him to be seen on 1 December by a plastic surgeon.

30. On 11 December, the man underwent a second operation. The clinical reviewer notes that it is normal practice when a malignant melanoma is diagnosed for the patient to have a second operation shortly after the first.

31. Between 18 December and 26 January 2007, the man attended six RVI review appointments and according to his own diary, an MRI scan on 7 February. The clinical reviewer notes that the man's dressings were routinely changed and that he also had a CT scan.

32. In the meantime, the man made an application under the Prison Service's Incentives and Earned Privileges (IEP) Scheme asking to be considered for enhanced status. The IEP application was considered by a wing manager and rejected on the basis that the man was appealing against his sentence and therefore not engaging with his sentence plan.

33. On 17 April 2007, the man was due to go to hospital for a medical appointment with his plastic surgeon. Prison records show that he refused to go as he had a legal visit booked for the same day which he wanted to attend instead. As it was his choice, prison staff asked the man to sign a disclaimer acknowledging that it was his decision. This he did. A new appointment was scheduled for later in the year.

34. In preparation for his possible release on licence and on schedule, the prison parole clerk sent the man a parole application form at the beginning of April 2007, asking him to return it to her. The purpose of the form is to give any eligible prisoner the opportunity to either opt in or out of the parole process. In the man's case, he opted into the parole process, and six days later he returned the completed form to the parole clerk.

35. Once the prison's probation clerk received the completed form from the man, she began the formal process of obtaining up to date conduct reports which the Parole Board requires before considering an application. As well as asking for information from areas such as his workplace, specific requests were sent to the seconded probation officer based at Acklington, to the man's home probation officer and to his personal officer at the prison. The timescale for returning the completed forms to the parole clerk was two months. With the exception of the man's home probation officer, all the others returned them within this time.

36. On 18 September 2007, after rescheduling his earlier cancelled appointment, the man was due to go to hospital as an outpatient to see a plastic surgeon. However, as before, he cancelled the appointment and signed a disclaimer, as he had a social visit booked.

37. The clinical reviewer notes that from 16 October 2007 onwards, the man attended seven more appointments at the RVI. He also underwent a further operation to his arm glands and had his dressings changed regularly.

38. On 16 November, one of the prison chaplains, a reverend, made an entry in the man's prison record noting that he had received a call from the man's brother who was concerned about him missing a hospital appointment. The Reverend telephoned healthcare, who assured him that the matter was being dealt with and that a new appointment had been made, although no reason for the cancellation was given. The record shows that the Reverend telephoned the man's brother to tell him what was happening.

39. Later that same month (22 November), the man was interviewed by the prison race relations officer regarding something that the man had said to another prisoner on 4 November. The entry in the man's prison record notes that he acknowledged that he had caused offence to another prisoner. This is the first and only negative entry about his prison behaviour.

40. On 28 November, some seven months after making her first request for parole reports to be completed and returned, the prison's parole clerk finally received the report from the man's home probation officer. The prison's parole clerk told my investigator that she had previously made a number of requests to the home probation officer for the missing report to be completed and returned, but had had no success until then. I understand that the delay was as a result of the man's home probation officer being re-allocated, and not being given his files.

41. After receiving the report, the prison's parole clerk sent a copy of the parole file to the man that day so that he could read it and add any comments should he wish to do so. Six days later (4 December), the man returned the form to the clerk. In his submissions to the Parole Board he said he had had a malignant melanoma which had cleared. (I understand from his family that the man had received the all clear from the hospital.) He went on to say that something else had been found that would require radiotherapy, and he wanted to obtain the treatment from home rather than from prison.

42. Having received the completed form, the parole clerk sent the man's files to the Parole Board. She explained to my investigator that, once the file was received by the Parole Board, the Board then had 25 days to set a hearing date. However, prison records show that the files were returned by the Parole Board to the prison on 11 December. The reason for the Parole Board returning the files was that, with the exception of the home probation report, the remaining reports were over six months old and therefore not eligible for consideration. Unfortunately, despite the original reports being completed within the correct timeframe, the delay in obtaining the home probation report meant that the other reports had to be re-written before the Parole Board would consider them.

43. On 9 December, an entry was made into the man's prison record noting that, because he had had an operation, he was unable to work. The note said that the man was eager to work, but that this had not been authorised by healthcare.

44. Four days later, the man was seen by a nurse and referred to a prison doctor. The doctor, saw him on 17 December and took blood samples which he sent for analysis.

45. In the meantime, an entry was made in the man's prison record on 23 December that said he was stressed due to lack of progress with his parole application, his illness, and an unidentified issue. The entry did not say what, if anything, was done to assist him.

46. The next day, the prison doctor received the results of the man's blood test. The clinical reviewer notes that the results were inconclusive and arrangements were made to repeat the test three weeks later.

47. A week later on 2 January 2008, the man's consultant agreed that he could resume work. Prison records suggest that this decision made the man a lot happier.

48. Nine days later, at the request of a fellow prisoner who had said that the man was not well, a staff nurse went to see the man in his cell. She advised him to see a doctor, but he said he would do so as he was going for a scan. The nurse offered the man medication (paracetamol) for the relief of his symptoms, but he declined.

49. The nurse told my investigator that the man looked thin and pale, but was not in distress. She said he made it clear to her that he did not want to see her. The Nurse said she told the man that, if he wanted to change his mind, then she would refer him to a doctor immediately. When she returned to healthcare, she checked the man's records and saw that he had a hospital appointment for a scan a few days later.

50. On 15 January, one of the wing officers made an entry in the man's prison record noting that the man was depressed at the lack of action with his parole application and his illness. The officer also noted that the man appeared to be losing weight. (Prison records show that the man's weight was noted as 48kg, ten kilograms lighter that when he weighed in December 2005.)

51. The next day, a staff nurse made an entry in the man's prison record noting that wing staff had contacted healthcare about his declining health. She went to see him and told my investigator that he looked weak and frail, and was out of breath. She said she discussed with the man the option of moving him to a ground floor cell on another wing. This would have been easier for him as he would not have to climb stairs. However, the man declined the offer and told the nurse that his friends were on the wing where he lived and he wanted to remain with them.

52. On 18 January, at the request of a staff nurse, arrangements were made with the prison catering department for them to supply the man with a special diet. The diet supplied was yoghurt and milk.

53. Four days later, on 20 January 2008, the nurse was asked by wing staff to assess the man again as he was unwell. She went to his cell and found him confused, disorientated and vomiting. The nurse telephoned an on call doctor and he recommended that the man should be admitted to Wansbeck Hospital as an emergency patient. The nurse told my investigator that the man's medical condition deteriorated rapidly towards the end of his life.

54. In the meantime, the results of an earlier CT scan were received which showed that the man had "Advanced disseminated cancer disease". Once the full extent of the man's illness and prognosis was known, the prison doctor wrote to the Governor of Acklington asking him to consider early release or a transfer to a hospice.

55. Having received the doctor's letter, the Governor made the Head of Resettlement aware of its content, and asked him to look at the options for releasing the man early on compassionate grounds. When the head of resettlement checked the instructions contained in PSO 6000, he realised that he had to refer the case to the Parole Board for a decision, rather than follow the route for compassionate release which is a different process.

56. The Head of Resettlement asked the parole clerk to contact the Parole Board on his behalf and make them aware of the man's condition. In addition, a letter was sent by special delivery from healthcare to the Parole Board explaining the man's medical condition. The prison parole clerk said she followed up the healthcare letter by telephoning the Parole Board for a decision. She said she was unable to obtain an answer from the person whom she spoke to, other than being told the "file would be looked at".

57. At about the same time as this was taking place, the man was being prepared by medical staff for transfer from Wansbeck Hospital to Morpeth Cottage Hospital. A Senior Officer (SO) was in charge of the escort. He told my investigator that he had met the man previously in the prison, but when he saw him on this occasion the man was "a shadow of himself". He said the man was able to talk but only in short bursts and, because he was weak, could only manage to sit up in bed. The SO told my investigator that the security assessment, which has to be carried out on every prisoner taken out of prison, meant that the man was required to be handcuffed to an officer.

58. When they were ready to leave Wansbeck Hospital, the SO removed the handcuffs to allow nursing staff to place the man on a trolley. The SO said the man had to be assisted onto the trolley as he was unable to move unaided. Once he was on the trolley, the Ward Sister spoke to the SO and asked if the handcuffs needed to be reapplied as the man was dying. However, due to the security assessment, the SO had no option at that time but to reapply the handcuffs whilst the man was being transferred to the hospital by ambulance.

59. When they arrived at the hospital the SO telephoned the prison and spoke to someone (whose name he could not remember in interview), about the use of handcuffs. He said he told the person that nursing staff had told him that the man was dying. The SO was told that a member of staff would visit the hospital later that day to reassess the handcuff risk assessment.

60. Following concerns about the use of handcuffs, the Head of Security, spoke to the then Deputy Governor. Sadly, this Deputy Governor has himself since died and I am only able to give the head of security's and the Senior Officer's account of events.

61. The Head of Security said he agreed with the Deputy Head to reassess the situation and, as he was going to be travelling past the hospital later that day, he decided to carry out the assessment himself. His said his intention was to undertake a "dynamic risk assessment", which he described as being an assessment where he would give verbal feedback to the Deputy Head rather than in writing.

62. When he arrived at the hospital, the head of security was met by the SO who told him that the man's family were upset at him being handcuffed. The Head of Security told my investigator that the SO also told him that nursing staff had briefed him to say that the man was dying.

63. The Head of Security told my investigator that the man's room was on the third floor of the hospital. He said there was one door into the room and that the room had a window. He added that, although the window would open, there was no risk of escape as there were no stairs outside the window, only a sheer drop to the ground. The Head of Security said he went into the room where the man was. He described the man as looking very ill and drowsy. The only way he could communicate was by blinking his eyes or nodding his head.

64. After seeing the man, the Head of Security sat in on a handover meeting with a ward sister and a nurse. Between them, the nursing staff confirmed that the man was in the final stages of his life and that his death was expected imminently. Having received the latest prognosis, and being told that the man would not be required to leave the room, the Head of Security decided to remove the handcuffs.

65. When he returned to the prison, the Head of Security went to speak to the Deputy Head to tell him what he had done. However, he was not available and so the Head of Security spoke to the Governor instead. The Governor told the Head of Security that he did not have the authority to remove handcuffs and the decision could only be taken by him or, in his absence, the Deputy Governor.

66. The Governor spoke to the Deputy Governor about the situation and asked him to go to the hospital to undertake a further risk assessment. In the meantime, the Head of Security telephoned the SO to tell him that he had made a mistake in authorising the removal of the handcuffs. The SO told my investigator that the Head of Security asked if it would cause a problem if the

handcuffs were reapplied. He replied that it would be distressing to the man's family.

67. Unfortunately, due to the Deputy Governor's death, it is not certain what happened next but we do know that he gave instructions for the handcuffs to be re-applied. We also know from the SO's interview with my investigator that the Deputy Governor told the SO that he was reapplying the handcuffs because of a recent escape from a hospital escort. It is not known what escape the Deputy Governor had been referring to.

68. At some point, members of the man's family returned to the room and the SO explained to them why the handcuffs had been reapplied. He said a family member then produced a camera and tried to photograph the man. The SO told my investigator he did not know why the family member had attempted to take a photograph. The SO told the person concerned that photographs could not be taken and the camera was put away.

69. The following day (23 January 2008), another SO carried out a routine daily security check at the hospital. When he went to the man's room he was told by the escorting staffs (who by now were sitting outside the room) that the man was unable to move. The SO told my investigator he went into the room and that the man looked weak and frail. He confirmed that the man was not handcuffed, as the Governor had authorised their removal the day before. After completing the security check, the SO fed the information back to the Governor.

70. On 24 January, the prison parole clerk rang the Parole Board once again for an update, and was told that it would be at least one week and possibly two before a hearing would take place. The Parole Clerk told my investigator that she explained the urgency of the case to the person at the Parole Board, but said she was not given a review date and felt frustrated at the lack of assistance from the Parole Board office. (The actions of the Parole Board and its secretariat are outside my terms of reference. However, I will send a copy of this report to the Board for its consideration.)

71. In the meantime, the man's personal property had been gathered together for his family. The SO took the property to the hospital and handed it over to them. He said the family were upset at the treatment they had received from the Prison Service, but appeared happy with how the escorting staff had treated them and the man. The following day (25 January 2008), the man died.

After the man's death

72. The man's family told my investigator and FLO that, on the night of the man's death, they received a telephone call from the prison at 11:30pm, and the caller offered condolences. They felt it inappropriate to telephone at that time of night and said they would have preferred it if the call could have been made the following day.

73. At the meeting with my staff, the man's family said they wanted to pass on their thanks to two members of staff for their support, although they were unable to identify one of the people concerned. They mentioned that one woman in particular was always helpful and would call them back whenever they called to enquire how the man was. However, they compared this member of staff's actions to those of a healthcare nurse, who they said would not tell them anything and asked them to write to the Governor. The other person, whom they wished to recognise as being helpful, was an officer on bedwatch duty. The man's family described him as compassionate towards them and the man, and believe it was an officer. They asked me to pass on their thanks to the officer and the prison chaplains.

ISSUES

Incentives and Earned Privileges Scheme

74. My investigator asked the Prison Service for an explanation why an appellant could not be considered suitable for enhanced status. He was told that it should not be the case that a prisoner is denied access to enhanced status simply by being an appellant. However, because the Prison Service has to assume that someone is correctly sentenced and therefore guilty, the continued assertion of innocence ("denial") can be seen as refusing to take part in sentence planning.

75. In the man's case I understand that he had been advised by his solicitor not to take part in any offending behaviour courses as he was an appellant, and to do so could jeopardise his appeal. Because the man would not take part in addressing his offending behaviour, his decision effectively meant that he was not complying with his sentence plan, which in turn meant he could not be granted enhanced status.

76. The person advising my investigator added that in February 2008, the Prison Service Interventions Group issued new guidance to prisons in relation to this issue. The advice is that, "if a prisoner is denying their guilt and their case is being dealt with by the Criminal Cases Review Commission and they have a criminal appeal number then there may be a case for the prisoner to attain or retain enhanced status until their case has been heard". In the man's case my investigator could not find an appeal reference number and, as his application was made before February, it would appear that his IEP review was correctly assessed by the manager.

Parole Reports

77. The timescale for completing reports for submission to the Parole Board is two months. It was seven months after the initial request for the information that the home probation officer returned the documents to the parole clerk. I understand the reason for the delay was due to the probation officer being re-allocated. However, it is evident that the parole report was not tracked correctly by the home probation area, as they failed to pick up on the delay and deal with the application in a timely fashion. Whatever the reason, a delay of five months for such an important document is unacceptable and for this reason I make a recommendation to the Chief Officer for Durham Probation Area.

The Chief Officer for Durham Probation Area should review procedures to ensure that reports for the Parole Board are tracked correctly and submitted within the appropriate timescales.

Use of Handcuffs and other security matters

78. The man's family told my investigator and FLO that they were concerned that he was handcuffed until late in his illness and that the officers were in prison uniform. Additionally, they were unhappy that the officers would not leave them alone with the man.

79. In relation to prison staff being in uniform, this is a mandatory instruction and not something that I feel inclined to criticise. Additionally, due to the man's security category, prison staff were not authorised to leave him unattended at any stage, although they were allowed to sit outside the room at the final stages of his life.

80. The use of handcuffs, especially on a prisoner admitted into hospital, is a sensitive and difficult matter often considered in my fatal incident reports. The decision to use handcuffs in some cases is mandatory and cannot be overruled, for example in the case of a high risk prisoner. However, in other cases, the decision is devolved to the Governor or, in the Governor's absence, to the Deputy Governor.

81. In this case the decision to use handcuffs was devolved to the Governor and he had to balance security against decency. I have said in many reports that these decisions have become unduly risk averse, although I understand the culture within which this has become the case. I am satisfied that once a new risk assessment was carried out at the hospital, the Governor took the correct and proper decision to remove the handcuffs. Strictly speaking, the Governor was also entirely right to tell the Head of Security that he had no authority to instruct the earlier removal of handcuffs. However, the consequence was a macabre pantomime in which handcuffs were first removed, then re-applied, then removed again from a man who was frail and clearly dying.

82. In a recent report, I have called upon the Prison Service to look again at its guidance relating to the use of restraints on prisoner-patients. I therefore need make no further recommendation here. However, I do have a lot of sympathy with the family. The Governor will wish to consider if there are lessons to be learned, especially regarding the timing of risk assessments of those like the man who are in the terminal stages of disease and who are unable to move freely.

83. The clinical reviewer asked a representative from Wansbeck Hospital and Morpeth Cottage Hospital whether they had any concerns about the man's privacy and decency. He was told that hospital and staff believe the man was treated with all due privacy and decency. His report says that both hospitals felt unable to comment on the use of handcuffs.

Clinical Review

Referral to Royal Victoria Infirmary (RVI) Dermatology Department

84. The North of Tyne Primary Care Trust Doctor says in his review that there was reasonable evidence in the medical records and from interviews with healthcare staff that, after the man was seen on 1 August 2006, an urgent referral was completed by the prison GP. However, there is no record of this being received at the RVI. He adds that there is no formal system for logging and following up urgent referrals and that, on the balance of probability, the referral was not sent by the prison. He believes this to be an important finding, as the delay "may have had an adverse effect on the outcome for the man". My investigator fed the finding back to the Governor as an urgent issue and was told that it would be dealt with immediately.

Healthcare disclaimer

85. There is evidence in the medical records that on three occasions the man cancelled his medical appointments at the RVI. His family wondered if he was given sufficient notice about the appointments to allow him to re-schedule his legal visits, and my investigator has asked about this on their behalf. The family added that a senior manager at the prison told them it was common practice for the prison to book hospital appointments in the knowledge that a prisoner had other appointments booked, and the prisoner would then sign a disclaimer.

86. My investigator has examined this issue and was told that the reason for the man, or any other prisoner, not knowing an outpatient appointment date and time is because of the security risk that could be posed if they did. It would be all too easy for a determined prisoner to make an escape attempt if they knew the full escort details. The rule is applied across the board and not on an individual basis.

87. The Primary Care Trust Doctor has concluded that the main point to consider is whether a prisoner should be asked to sign a healthcare disclaimer only after receiving counselling from an appropriate member of healthcare staff. From his own investigations he found that, on occasions when healthcare staff are not in the prison, prison officers deal with disclaimers. He suggests that, wherever possible, healthcare staff should speak to the prisoner about the likely effects or outcomes if the appointment is cancelled. My investigator fed the finding back to the Governor and he agreed to deal with it.

88. The Primary Care Trust Doctor adds that, although the man missed three appointments, over the period of his illness he was taken on many occasions to hospital for reviews, operations and tests. For the majority of time, the system worked well. The Primary Care Trust Doctor commends healthcare and prison staff for their efforts to ensure the efficiency of the system.

Return to prison

89. Following the meeting between the man's family and my investigator and FLO, the investigator asked the Primary Care Trust Doctor if he could identify any occasion when the man had been returned to prison from hospital because the escorting officers' shifts ended before the appointment time. The Doctor says in his clinical review that there was no record in the prison medical files that this ever happened. Additionally, The Primary Care Trust Doctor says he asked the Medical Director for RVI, if there was any record in hospital files of this happening. The medical director for RVI wrote to the Primary Care Trust Doctor that, "there is nothing within the records at the hospital to indicate that this occurred". On the evidence of the Primary Care Trust Doctor and Doctor of Medical Director For RVI, I am satisfied that there is nothing to support the suggestion that prison officers returned to the prison before the man had been seen.

Dignity

90. The man's family also raised concern at him being handcuffed to a female prison officer when in hospital in October 2007. The Primary Care Trust Doctor asked the medical director for RVI if there was anything in the man's medical record to suggest medical staff were concerned about this. The Doctor for RVI confirmed there was not.

91. I appreciate that it is normal practice for the Prison Service to allow female prison officers to be handcuffed to male prisoners, and understand that female officers do not accompany male prisoners to the toilet. However, I have some sympathy with the family's view that the man may have felt uncomfortable in asking to use the toilet when a female was present in the room. Whilst I make no formal recommendation, the Governors may wish to give this matter further consideration.

Fitness to return to work

92. In his clinical review, the Primary Care Trust Doctor notes that it was the man who asked the doctor during his 20 November appointment whether he could return to his work as a cleaner. The doctor whom the man saw agreed to his request, and said he thought it would help improve the movement in his shoulder.

93. The Primary Care Trust Doctor discussed the issue with prison healthcare managers. He was told, "… this should be seen in context and is not equivalent to being advised fit to work outside of prison. In prison, fit to work is a privilege which allows the prisoners to get out of the cell and socialise with other inmates and even during illness this is usually preferred by most prisoners. There would not have been an expectation that the man would perform duties he was not fit to undertake."

Late stage illness

94. In relation to the family's question about the man's failing health in prison, the Primary Care Trust acknowledges in his review that in January 2008 the man's appearance was deteriorating, which must have been difficult for the family. However, he is satisfied that the man's health needs were being addressed appropriately. He is satisfied that the clinical assessment was appropriate and does not believe that the medical advice given would have been any different for anyone else.

95. Primary Care Trust Doctor adds that there is evidence to show that on 11 and 16 January 2008, the man declined some of the recommendations from healthcare which would have moderated some of the difficulties he was facing. Nursing staff to whom the Primary Care Trust Doctor spoke said that the man was able to express his own needs and they felt it appropriate to respect his wishes.

96. The Doctor says it appears that prisoners at Acklington have good access to medical assessment without undue delay. He adds that prisoners, where appropriate, are seen quickly and on the same day. He commends the prison healthcare department for providing timely and appropriately sensitive support to the man during the late stage of his illness.

CONCLUSION

97. It is clear that the man himself cancelled a number of appointments and, since he was fully aware of his diagnosis, it may be presumed he was aware of the consequences of his decision. However, the clinical review confirms that he attended the vast majority of appointments and was treated appropriately.

98. I have been concerned to learn that the first urgent appointment was not dealt with within correct timescales, despite the doctor's instructions for an appointment to be made. It would appear from the clinical review that the prison did not deal with the referral correctly. My investigator raised the issue as an urgent finding with the Governor, and was given an assurance that he would deal with the matter immediately to prevent further failure.

99. Although I do not know if the man would have been granted release on licence, I am not satisfied at the way the home probation service dealt with his application. The late response by the Durham Probation Area meant that his application was not seen or assessed at the earliest opportunity. This is manifestly not acceptable. However, I would like to acknowledge the efforts made by the prison's parole clerk and invite the Governor to share my comments with her.

100. I have been pleased to learn from my investigator that the Governor has dealt positively with all of the feedback given to him during the investigation process and made changes as necessary. This means that, with the exception of one recommendation for the Probation Area, I have no further formal recommendations to make. However, the Governor will wish to consider my comments on the risk assessment process governing the use of restraints on prisoner-patients, and the particular consequences this had for the man and his family. I also draw the attention of the NOMS Safer Custody and Offender Policy Group to my comments in paragraphs 82-83.

RECOMMENDATIONS

1. The Chief Officer for Durham Probation Area should review procedures to ensure that reports for the Parole Board are tracked correctly and submitted within the appropriate timescales.

   The Chief Officer for Durham Probation Area has not commented on the report and recommendation.