Investigation into the death of a man in June 2011, at St Rocco's Hospice, Warrington, whilst in the custody of HMP Risley

Report by the Prisons and Probation Ombudsman for England and Wales

December 2011

This is the report of an investigation into the death of the man, a prisoner at HMP Risley. The man died at St Rocco's Hospice, Warrington. The man had been diagnosed with lung cancer in 2009, which was initially treated by surgery. The cancer recurred around four months before he died. I offer my condolences to his family and friends.

The investigation was carried out by one of my investigators. A review of the man's clinical care in custody was carried out by a clinical reviewer on behalf of Warrington Primary Care Trust. I am grateful to the clinical reviewer for his assistance. As the man died from natural causes the findings of the clinical review were essential to my own conclusions. The review concludes that the standard of care the man received was equitable to that which he could have expected in the community. The clinical reviewer's clinical review is the first annex to this investigation report.

I would also like to thank the Governor and staff of HMPs Risley and Preston for their co-operation during the course of the investigation.

The principal finding of this investigation is that the man received appropriate healthcare generally commensurate with that which he would have received in the community. However, there is scope for learning from the man's case and we therefore make two recommendations. In particular, we are concerned by the insistence of Prison Service managers' on the use of restraints on the man in the hospice, at a time when it was clear to clinicians, and even supervising staff, that this was disproportionate and undignified.

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 & Probation Ombudsman **December 2011**

CONTENTS

Summary

The investigation process

HMP Risley

HMP Preston

Issues

Conclusion

Recommendations

SUMMARY

1. The man was sentenced to a minimum of 18 months on 1 June 2006. He had a history of ischaemic heart disease, was prescribed multiple medications and was subsequently diagnosed with chronic obstructive pulmonary disease (COPD).

2. In December 2009, the man was diagnosed with lung cancer, he underwent surgery to remove a tumour in March 2010, but his cancer returned and spread to other areas of his body. By February 2011, his condition was considered terminal.

3. The man was located in Risley, but spent sometime at HMP Preston, where there is an inpatients' unit with 24 hour healthcare. His condition deteriorated and his life expectancy was estimated as three months. The man was moved to St Rocco's Hospice on 21 February, and was subject to restraints. Following treatment his condition improved and he was well enough to return to the inpatient unit at Preston on 16 March. When his condition deteriorated for a second time, he returned to St Rocco's on 29 May, again subject to restraints. He remained at the hospice until his death on 1 June.

4. A family liaison officer (FLO) was appointed by Risley when the man's condition was first diagnosed as terminal and he was first admitted to St Rocco's Hospice. The prison FLO met with the man's cousin, his nominated next of kin and made regular visits to the hospice, including the night before the man's death. The man's cousin was advised at the earliest opportunity of his death and funeral expenses were offered.

5. We are generally satisfied that the care the man received at Risley and Preston was comparable to that which would be expected in the community. However, we still find it necessary to make two recommendations: the first, regarding the need for better communications between prison healthcare departments in certain circumstances and, the second, arising from the disproportionate and undignified use of restraints on him when he was in the hospice.

THE INVESTIGATION PROCESS

6. The investigation was opened on 2 June 2011, when my investigator issued notices announcing the investigation to staff and prisoners. The notices invited those who wished to submit information relating to the man's death to make themselves known to the investigator. One prisoner came forward in response to these notices.

7. The investigator visited Risley on 6 June. During the visit he met the duty governor, healthcare manager and a representative of the prison's Independent Monitoring Board. My investigator was provided with copies of the man's prison records, including the medical record.

8. On the same day, my investigator visited Preston. He met the lead clinician for chronic disease and visited the dormitory in the healthcare inpatient unit in which the man lived. The investigator spoke to two men who lived in the room with the man, both of whom shared their recollection of him.

9. My investigator returned to Risley on 13 and 14 July. During the course of this visit he interviewed five members of staff and spoke to one prisoner who responded to the notice of this investigation. At the conclusion of the visit, he met the Head of Safer Custody to feed back the initial findings of the investigation. This was subsequently followed up in writing to the Governor on 15 July. My investigator also spoke with the Head of Reducing Re-offending at Risley on 18 July. A notes of this conversation and transcripts of all interviews are attached as annexes to this report.

10. A review of the man's clinical care in custody was undertaken by the clinical reviewer, on behalf of Warrington Primary Care Trust (PCT). We are grateful to the clinical reviewer for his assistance in this matter.

11. One of my family liaison officers contacted the man's cousin, his nominated next of kin, by telephone. She and my investigator subsequently visited the man's cousin on 11 July 2011. During the visit, my family liaison officer explained the purpose of the investigation and gave the man's cousin the opportunity to ask questions or raise any concerns she might have about the care he received in prison. The man's cousin said that she was concerned that he was handcuffed to a prison officer when she visited him in St Rocco's hospice.

12. The man's cousin chose not to receive or comment on the draft report. She has requested a copy of this final report. We hope this report clarifies any issues that remain unclear for the man's cousin and helps her better understand what happened in the time leading to his death.

13. The investigation assesses the following aspects of the man's care and treatment:

- Whether his diagnosis was made in a timely fashion?
- Whether the man was told about his condition and the treatment which followed?
- Whether he was treated properly and attended hospital appointments as necessary?
- Whether the liaison with the man's family was appropriate?
- Whether the man was accommodated in the most appropriate part of the prison?
- Whether consideration was given to compassionate release from prison?
- Whether appropriate palliative care was provided?

HMP RISLEY

14. Risley is a modern, purpose built prison that opened in 1964. It is a category C training prison (one which offers courses and training to help a prisoner stop committing more crime after they're released). Since the opening of a new wing in 2003, it has a capacity of 1,085.

15. Healthcare staff are available in Risley 24 hours a day. By day, there is a doctor in the prison; at night, cover is provided by nursing staff. There is no inpatient facility at Risley. Prisoners who require inpatient treatment are referred to other prisons (including Preston) or to outside hospital.

16. Healthcare services at Risley are commissioned by the National Health Service (NHS), through Warrington Primary Care NHS Trust (PCT).

Her Majesty's Chief Inspector of Prisons (HMCIP)

17. HM Chief Inspector of Prisons last conducted an announced inspection of the prison between 7 and 11 February 2011. The Chief Inspector noted that:

> "There is still much to be done to ensure that the prison becomes a fully effective establishment that meets the range of prisoners' diverse needs and prepares them appropriately for release through useful work and effective interventions. Nevertheless, Risley is a much safer, cleaner and more decent prison than before – a better and more purposeful place for prisoners (and as they often told us, a better place for the prison staff to work). The governor and the prison staff are to be commended on the improvements."

In respect to healthcare services:

> "There was good access to external health care appointments at local hospitals and specialist centres and these were well managed. Cancellations for security reasons were rare."

Independent Monitoring Board report (IMB)

18. Each prison has an Independent Monitoring Board (IMB), whose members are appointed by the Secretary of State for Justice from members of the community. Their role is to satisfy themselves that the prisoners are treated humanely and justly. The IMB report directly to the Secretary of State if they have any concerns. They also submit annual reports on how the prison has met the standards and requirements placed on it. Members of the IMB have access to every prisoner, every part of the prison and every prison record.

19. In their annual report for the period April 2009 to March 2010, the IMB made the following comments specifically about the healthcare provision:

> "Warrington PCT finances 3 beds for HMP Risley prisoners at HMP Preston. The beds at HMP Preston cater for both mentally and

physically ill prisoners who require care in an “inpatient” facility. Following a review of the criteria for acceptance by HMP Preston, the referral process has been speeded up and the whole process has run much more smoothly with no disagreements between health care professionals at the two centres... There are major discrepancies between amounts of money received from PCTs across the North West to fund healthcare in prisons. The funding at Risley is one of the lowest amounts per prisoner, resulting in delays for prisoner appointments and over stretching of staff resources.”

Previous deaths at Risley

20. There have been four previous deaths at Risley in the past year. My investigator reviewed the Ombudsman’s reports into these deaths and he found no issues in common between the earlier deaths and that of the man. There have been twelve previous deaths in total since the Ombudsman was given responsibility for investigating deaths in custody in England and Wales in April 2004, five due to natural causes, five self-inflicted, one due to an illicit drugs overdose and one murder. There are no similarities between these previous deaths and that of the man.

HMP PRESTON

21. Preston is a large Victorian prison, situated near the town centre. It operates as a category B male local Prison, serving the courts of Lancashire, holding male offenders aged over 21 years who have been remanded in custody, are awaiting trial, or allocation to another prison after sentencing.

22. Preston contains one of the few inpatients' facilities in the North West region, with health services provided by NHS Central Lancashire Provider Services. The inpatient facility holds prisoners who are too ill for normal location but do not require admission to hospital. Admission is arranged by referral from the original establishment, followed by an assessment from the team at Preston. There are separate landings for patients with mental and physical needs, with a total of 30 beds. On the physical needs landing, six staff are on duty during the day, and two at night. This includes healthcare officers. There is a full-time doctor between the hours of 9.00am to 5.00pm Monday to Friday. Between 5.00pm and 8.00pm there is a doctor in the prison's reception area. At night, on-call cover was, at the time of this investigation, available through a contract with Care UK

Person Escort Record (PER)

23. This is a form that accompanies prisoners on all journeys from and between prisons. It serves as a communication tool about risks a prisoner poses on escort or transfer.

Categorisation

24. Prisoners are risk assessed when they come into prison and given a category based on their offence and the risk that they pose to the public should they escape. There are four levels of category: A, B, C and D, with category A prisoners being the most dangerous. The man was assessed as category C. A category C prisoner is one who cannot be trusted in open conditions, but does not have the resources and will to make a determined escape attempt. Prison Service Order (PSO) 0900, gives guidance on appropriate assessment to determine a prisoner's category.

Incentives and Earned Privileges (IEP) Scheme

25. The Incentives and Earned Privileges (IEP) scheme was introduced in 1996 to encourage and reward good behaviour in prisons. Governors have responsibility to develop their own schemes although the scheme must operate on at least three tiers: Basic, Standard and Enhanced. Prisoners move between levels according to their behaviour and performance. The key earnable privileges and incentives are: extra and improved visits, eligibility to earn higher rates of pay, access to in-cell television, opportunity to wear own clothes, more private cash to spend and time out of cell for association.

Prison Service Orders

26. Prison Service Orders were long-term instructions intended to last for an indefinite period. They were introduced to replace Standing Orders, Advice to Governors and Instructions to Governors and were updated by the issue of Prison Service Instructions (PSIs). Guidelines written in italics within the PSO are mandatory instructions

ISSUES

The diagnosis of the man's terminal illness

27. The man entered custody in June 2006. Following his initial health screen and reported chest pains in August 2006, he was referred to the cardiology department at the Royal Devon and Exeter Hospital and a heart disease care plan was formulated.

28. On 17 January 2007, the man was assessed by a cardiologist and he was subsequently diagnosed with chronic obstructive pulmonary disease (COPD is a term used for a number of conditions; including chronic bronchitis and emphysema. COPD leads to damaged airways in the lungs, causing them to become narrower and making it harder for air to get in and out of the lungs).

29. In August 2008, the man reported more frequent chest pain and was experiencing increasing shortness of breath. The following month, the man continued to experience shortness of breath and was prescribed amoxicillin (used to treat bacterial infections of the chest) and a salbutamol inhaler (to treat asthma).

30. On 6 January 2009, the man's chest had improved, but he had lost a significant amount of weight and was urgently referred for review. He had a chest x-ray two days later at St Mary's Hospital, Isle of Wight, and his lungs were consistent with emphysematous change (irreversible damage to the lungs), but there were no lesions on his lungs (abnormal tissue).

31. Following his transfer to Risley on 1 July 2009, the man was regularly reviewed. There were no further concerns until, on 12 November, he experienced severe chest pains when walking and felt unwell. Following examination by prison Dr A, there were concerns the man might be experiencing a heart attack and he was admitted to Warrington Hospital by ambulance. He was diagnosed with an angina attack, but he was referred for a CT scan (computerised tomography (CT) is a test that uses X-ray equipment and computer software to create a picture of the inside of the body) as it was suspected that he had a mass in the right middle lobe of his lung. This scan was undertaken on 25 November. The results were received at Risley on 2 December and stated that the man had a malignant (cancerous) tumour. In March 2010, the man underwent surgery to remove the cancerous tumour.

32. The clinical reviewer comments that '[the man] was seen in a timely manner by healthcare staff and also referred for specialist care in a timely manner'. The man's illness was diagnosed at the earliest opportunity.

Informing the man about his condition and treatment

33. On 4 December 2009, following the results of a CT scan, the man was advised by the doctor that he had a malignant tumour in the right middle lobe of his lung. The man was encouraged to stop smoking, but failed to attend for

his ‘stop smoking’ appointment on 10 December. He did ultimately manage to reduce the number of cigarettes he smoked prior to his death, but nevertheless continued to smoke.

34. A multi-disciplinary team (MDT) discussed his case and agreed that surgery to remove the tumour was appropriate, if the man was fit enough, as they had concerns about his heart condition. On 2 February 2010, he went to Warrington Hospital and underwent a coronary angiogram. This was normal and he was declared fit enough to undergo surgery, to which he agreed.

35. Following a decline of his health in February 2011, the man was advised that his condition was terminal. He was told that he would receive palliative care and that he would be transferred to a hospice.

36. Hospital and healthcare staff ensured that the man was fully informed at all times about his condition, from the initial diagnosis and throughout his ongoing treatment and care.

The man’s medical appointments and treatment of the prisoner

37. According to his prison medical records, the man had 388 healthcare interventions from diagnosis in December 2009, until his death in June 2011. The man attended all outside hospital appointments, although on at least one occasion (13 April 2011) the hospital failed to notify Risley that an appointment had been cancelled and re-scheduled.

38. The man was transferred to Preston because they had a 24 hour inpatients’ unit and could provide him with the level of care necessary following his surgery. He was still considered to be in the custody of Risley, who remained responsible for staffing any escort or transfer. Following his discharge from the hospice to Preston in March 2010, the man was regularly monitored and it is recorded that his chest was clear and that he appeared well. He was fit to return to Risley on 1 April.

39. On 26 May, the man was assessed at Warrington Hospital and reported that he felt well, was fully mobile following surgery and had reduced the number of cigarettes he smoked. The hospital advised the man that a chest x-ray had not indicated an obvious sign of recurrence, and that he would be reviewed in September.

40. The man was reviewed at Warrington Hospital on 29 September. He was still experiencing mild breathlessness, but had maintained a reduction in his smoking and was to be reviewed in a further three months. The following day, the man was reviewed by the prison doctor as he was experiencing increasing breathlessness and was coughing. He was diagnosed with a lower respiratory tract infection and prescribed clarithromycin (an anti-biotic).

41. On 18 October, prison Dr B examined the man who was experiencing chest pain and shortness of breath. Initially, he was treated with a salbutamol nebuliser (most commonly used by people with asthma or COPD to take

relievers such as salbutamol, at a high dose). However, upon review his condition had not improved and he was admitted to hospital by emergency ambulance. The man used a nebuliser four times a day in hospital, where he remained until 25 October when he returned to Risley.

42. Over the next few months, the man continued to be monitored by healthcare staff and experienced shortness of breath. On 23 December, he had a fall as a result of becoming dizzy when he bent down, and he was advised to rest in bed. The next day Dr A examined him, and an electrocardiogram (ECG) was completed which was normal. The man's condition was recorded as 'systemically well', and he was advised to seek medical assistance if any of his symptoms got worse.

43. The man was examined in his cell by Nurse A on 30 December, as he was short of breath. The man explained that due to the cold weather his COPD had got worse and that his inhalers and nebuliser were not relieving his symptoms. He also reported that he had fallen twice in the previous 24 hours. The nurse observed that the man was unsteady on his feet, his medication was reviewed and consideration was to be given to transferring him to another establishment with more appropriate healthcare facilities. The next day, Dr A completed a referral for a wheelchair, due to the man's limited mobility. Nurse A examined him on 5 January, when the man was observed to be 'much better, less breathless'.

44. The man was due to attend a hospital appointment on 5 January. However this was rescheduled until 19 January, at the man's request, as he was attending a parole hearing.

45. On 10 January, Dr A examined the man as he was very short of breath on minimal exertion and was unable to walk more then three metres. Due to this deterioration, he was admitted to Warrington Hospital for review by the respiratory team. Prison Dr A wrote to a respiratory consultant, expressing his concerns, requesting a prognosis and asking whether the man should be given palliative care. The man returned to Risley the following day.

46. On 12 January, a referral was made to Preston requesting transfer for the man to their healthcare in patient unit. Preston responded informing Risley that as the lift was broken they were unable to accept wheelchair users at the time. The following day, prison Dr A contacted Warrington Hospital for a letter confirming the prognosis, which was given as two years.

47. The man attended for a routine review at Warrington Hospital on 19 January. His chest x-ray was satisfactory and he was to be reviewed in three months. Over the next few days, the man became increasingly frail.

48. On 24 January, following examination by prison Dr A, the man was taken by emergency ambulance and admitted to Warrington Hospital as his condition had deteriorated. The doctor recorded that the man had weakness in his limbs and a reduced appetite. He wrote 'in my opinion gradually dying and needs urgent release'. Confirmation was received on 27 January, that his

condition was terminal and that he was suffering, in addition to COPD, with brain metastasis (when cancer cells from a primary tumour in the body move through the blood stream to the brain and start to grow, producing a secondary tumour). The consultant concluded that surgery or radiotherapy were not options and palliative care was the most appropriate method of managing the man's symptoms.

49. The man was discharged to Preston on 1 February, he was in a frail physical state but mentally alert. He did not want to be at Preston and wanted to return to Risley, but they did not have sufficient healthcare cover for his needs. The man received support form nurses at Preston to mobilise and attend to his hygiene needs and a care plan was completed. A referral to St Rocco's hospice was completed by Risley. The man was accepted and due to move to the hospice on 14 February. Staff from Risley arrived to escort him to the hospice, but Preston were unaware of the arrangement and the necessary risk assessments had not been completed. The man eventually moved to the hospice on 21 February.

50. During his stay in the hospice, Risley staff provided the bed watch escort. A daily contact log was maintained and there is significant evidence that staff on these escorts were sensitive and respectful of his situation. The use of restraints at the hospice is discussed further in paragraphs 67-76.

The man's pain relief and medication

51. The man received all the appropriate medication as directed by prison doctors and hospital consultants. At the time of his death the man was prescribed the following medication:

- diamorphine (via a syringe driver for pain relief)
- midazelam (a sedative)
- furosemide (used in the treatment of congestive heart failure)

The clinical reviewer concludes in the clinical review:

> "[The man] received care of an adequate standard. He was looked after by the healthcare staff with adequate input from consultant staff at the relevant hospitals. He also received adequate and compassionate care in relation to pain and other symptoms"

The man's location

52. On 9 November 2010, prison Dr A wrote to OMU – Offender Management Unit to advise that the man was struggling to cope with the regime at Risley because of his medical condition. The doctor asked that consideration be given to transferring him to another prison that could better manage his needs. A letter from Warrington Hospital dated 21 December, supported such a move. However, a suitable bed at another prison was not found and the man returned to Preston on 1 February, with the same arrangement of Risley staff being responsible for staffing any escorts.

53. On 4 February, the Head of Healthcare at Risley referred the man to St Rocco's Hospice. He was advised that there were no beds, but there would potentially be a space in one or two weeks. A bed became available and staff from Risley were due to escort the man to St Rocco's on 14 February. However, when they arrived at Preston, staff were unaware of this move and the appropriate assessments had not been completed. The healthcare manager from Risley visited the man at Preston the following day, and advised that he would continue to telephone the hospice daily to check bed availability.

54. The man was told that there was a bed available on 21 February, and pre-discharge risk assessments were completed on 20 February, authorising a two officer escort and that single cuffs were to be used. The man remained at St Rocco's until he was discharged back to Preston on 16 March, as his condition was stable and he was fit to return to prison. St Rocco's confirmed that should the man's condition deteriorate, they would consider re-admission.

55. The man returned to the inpatient ward at Preston, and shared a room with two other men. During a discussion with my investigator, both his room mates were positive about the healthcare at Preston, and told my investigator that they thought the man was happy with his care and were not aware that he ever made any complaints.

56. The flexible arrangements between Risley and Preston to ensure that 24 hour healthcare cover is provided for prisoners is a good example of maximising the use of local resources. However, in the man's case he had an opportunity to move to St Rocco's earlier than he did in February, and whilst in this case it did not significantly affect his care or treatment, better communication between the establishments would have avoided this unnecessary delay.

The heads of healthcare at Risley and Preston should ensure that the process for communicating information relating to the transfer of prisoners (located at Preston but for who Risley have escorting responsibility) to a hospice is made at the earliest opportunity.

Compassionate release

57. Prisoners who are suffering from a terminal illness and for whom death is thought likely to be imminent can be released from prison early on compassionate grounds. An application must be sent to the Public Protection Unit (PPU) in National Offender Management Service headquarters in London. The application form includes sections to be completed by the Governor, a prison doctor and an offender manager. A full prognosis must also be provided. Once the form is submitted, caseworkers in the Public Protection Casework Section (PPCS) determine whether the application meets the criteria set out in Prison Service Order (PSO) 6000 (the instruction that deals with the release and recall of prisoners). In making this decision, they consult with the Parole Board and specialist medical advisors in the Department of Health. PSO 6000 states:

- "The criteria applied in medical and tragic family circumstances cases are as follows:

Medical

- the prisoner is suffering from a terminal illness and death is likely to occur soon; or the prisoner is bedridden or similarly incapacitated; and
- the risk of re-offending is past; and
- there are adequate arrangements for the prisoner's care and treatment outside prison; and
- early release will bring some significant benefit to the prisoner or his/her family."

58. Prison Dr A completed a referral for early release on 21 January 2011, which said that the life expectancy of the man was 'expected approx two years dependent upon care and environment but continues to smoke'. The guidelines for early release suggest that if a prisoner's life expectancy is longer than three months, they will not be considered for compassionate release. Therefore, the man did not meet the criteria at this stage. On 28 January, the doctor requested that Warrington Hospital send a letter to the Ministry of Justice in support of the early release application and with a detailed prognosis of his condition. On 3 February, a letter from his consultant was received which noted that the man's life expectancy was 'difficult to predict accurately, but average survival for a patient is 3 months' and that his mobility was unlikely to improve. This communication was faxed to PPCS the same day. The following day, the PPCS requested further information relating to the man's discharge plan.

59. The decision regarding release was protracted due to the difficulties of finding suitable and appropriate release accommodation for the man. He lived in the Truro area prior to his imprisonment, but wanted to live in the Warrington area, although changed his mind occasionally. His physical health deteriorated rapidly and so the level of care he would require at the point of release was changing. The man ultimately said that he wanted to be released to his home area. The man's probation officer, had been in regular contact as she was trying to find availability at a nursing home that provided 24 hour medical care. Due to the quick decline in the man's health, no release address was secured prior to his death and the man was not granted compassionate release.

60. The man was not eligible for ERCG, but Risley considered release on temporary licence (ROTL - in certain circumstances, a prisoner may be allowed to leave prison on a temporary licence). On 15 March whilst at St Rocco's, the man was advised that the application for ROTL had been unsuccessful as he did not meet the criteria. His application had been considered but on account of new rules covering IPP and ROTL (PSO 4700 - Chapter 4 Temporary Release for Life Sentence Prisoners) he was not eligible as he had not served a minimum of ten years (from conviction) in

custody. The Governor explained to my investigator that he enquired whether there was flexibility for IPP prisoners to be released for hospital or hospice stays on compassionate medical grounds but was told that there were no criteria to allow this.

61. It is evident that the prison assisted the man in his attempts to achieve compassionate early release and ensured he was kept informed of the efforts to secure accommodation in the area of his choice. We find no fault in this regard and welcome the support offered by prison and healthcare staff to the man.

Palliative care plans

62. By February 2011, the man's lung cancer had recurred and he was diagnosed with brain and liver metastases (cancer that has spread to other parts of the body). His condition was terminal. The man's, Consultant Respiratory Physician at Warrington Hospital, wrote to Risley on 2 February:

> "The outcome of the lung cancer MDT [multi-disciplinary team] was for palliative care only given the extent of his disease and poor performance status. Life expectancy for the man's difficult to predict accurately, but average survival for a patient with this level of disease is three months".

63. Palliative care is defined by National Institute for Clinical Excellence (NICE) and National Council for Palliative Care (NCPC) as:

> "Palliative care is the active holistic care of patients with advanced progressive illness. Management of pain and other symptoms and provision of psychological, social and spiritual support is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families. Many aspects of palliative care are also applicable earlier in the course of the illness in conjunction with other treatments."

64. Once it was established that the man's condition was not curable, a care plan was completed by Preston on 2 February. This care plan outlined the assistance the man would receive with his 'activities of daily living' (ADLs).

65. The lead clinician for chronic disease management at Preston. She told the investigator that the man was very compliant with his treatment (although he continued to smoke) and appeared happy at Preston, but that he wanted to move to a hospice to spend some quality time with his family. During interview prison Dr A said:

> "I think he [the man] received excellent care, I really do. I think from his diagnosis to his treatment, from referrals, trying to obtain early release on compassionate grounds, we were prepared, we were planning ahead. We communicated with the hospice at Warrington, they were

aware of the situation, this was all beforehand, and I thought his care was excellent…I don't think it could have gone any better"

66. However, there is no evidence that a Macmillan nurse was contacted (specialist cancer nurse) to have an input into the care plan, although there was good contact with the hospice throughout. Consideration of a referral to a Macmillan nurse should be made in all cancer cases. Whilst this was not done in he man's case, his care plan was comprehensive and no different to the man that which a Macmillan nurse would have advised, therefore we do not make a specific recommendation.

Restraints, security and bedwatch

67. When my family liaison officer and my investigator visited the man's cousin, she raised her concerns that restraints were used whilst he was in St Rocco's Hospice, stating that she thought it was unnecessary.

68. The man was first admitted to St Rocco's Hospice on 21 February. A risk assessment was completed that stipulated that a single cuff with closet chain should be applied, and that the man was to be escorted by two prison officers. On 23 February, the Head of Reducing Re-offending visited the man at St Rocco's as part of a routine management check. He authorised the immediate removal of the restraints. However, the following day during the management check, the junior prison manager instructed that the restraints were to be reapplied as there was no requirement for them to be adjusted. In his opinion, the Head of Reducing Re-offending had not given the proper authority for removal.

69. Two days later, the junior prison manager was approached by nursing staff during his management check at St Rocco's, where a request was made to remove the restraints whilst the man was being bathed. This request was later granted, with the proviso that prison staff sought permission prior to removal and that one of the escort staff must remain in the room at all times, and restraints applied again to the man before he left the bathroom.

70. On 7 March, staff at St Rocco's requested that the restraints were applied alternately to the man's wrists, as they were causing bruising (his wrists were bandaged to minimise chaffing). The same day, a letter was sent by the doctor from St Rocco's, to the Head of Healthcare, Risley requesting that the restraints were removed from the man. She noted that he was in very frail physical health, he had very limited mobility and his situation was distressing other patients and visitors. The Head of Healthcare responded by e-mail the same day, advising the doctor from St Rocco's that prison officers had also raised concerns about the use of restraints and that he would pass her letter to the Governor for consideration. The doctor from St Rocco's told my investigator that she had not received a response to this letter. During his management check on 11 March, the junior prison manager noted in the bed watch log that there was no requirement to adjust the level of restraint and there were no subsequent amendments made.

71. The man was transferred back to Preston inpatients' unit on 16 March, as his condition had improved following treatment. However, when he returned to St Rocco's Hospice in May, the risk assessment again indicated that the man should be subject to restraint by a single cuff closet chain, and escorted by two officers. Following examination after his arrival by a second doctor from St Rocco's it was noted that there was 'extensive bruising' to the man's wrists, and a request to Risley was made for the restraints to be removed. The Head of Security, Risley was contacted and gave permission for the removal of the restraints, but instructed that the risk assessment should be reviewed daily.

72. In a letter dated 26 July, sent in response to questions asked of her by my investigator, the first doctor at St Rocco's wrote:

> "During the first admission I do not feel that the handcuffs caused the man any great injury and, in fact, the staff were very good. For example, when he required personal care such as washing or a private one to one conversation with our counsellors the officers would leave and allow the man his dignity. I did feel, however, that he under the close watchful eye of two guards would have been incapable of moving such that he would be out of their sight or control at any point in time".

In respect to the man's second admission, the first doctor from St Rocco's wrote:

> "…it was noted that there was bruising to both forearms and that he was bedridden and incapable of moving himself… a conversation was had with the Head of Security, Risley requesting the cuffs to be removed and that this was agreed…The man remained bedbound and uncuffed for the duration of the second admission".

73. The first doctor from St Rocco's confirmed that she received no response (other than an acknowledgement of her contact from the Head of Healthcare) from the prison to her letter submitted on 7 March, requesting a review of the level of restraint used.

74. In my opinion there is significant evidence from healthcare professional involved in his care that the man did not pose a risk that necessitated the use of restraints due to his condition. He was escorted by two officers and observed at all times, and would not have had the physical capability to move out of their control. The first doctor from St Rocco's confirmed that the man was usually transferred around the hospice in a wheelchair. Further, the Head of Reducing Re-offending and a number of escorting staff also raised concerns about the level of restraint used.

75. During a telephone conversation with my investigator, the Head of Reducing Re-offending told him that he was not advocating the removal of the escorting staff when he ordered restraints to be removed on 23 February, and thought that the escort presence was sufficient to manage any potential risk. He added that the man was in a private room, could walk little more than 20 yards and the cuff was cutting his wrist. He did not think that the man posed a risk

to the public in these circumstances, that the prison were in support of him being released on compassionate release and that he considered it would be embarrassing to the service that restraints were used on such a frail terminally ill man. In interview, Officer A said:

> "to find him [the man] on the cuffs was quite shocking really in that condition. And the Head of Reducing Re-offending came out and as soon as he saw it he said 'this is disgraceful' and straightaway took them off, which myself and my colleague both agreed with."

76. Assessing risk and protection of the public is a priority for any prison and the risk assessment for restraints in this case were regularly reviewed. Despite the man being terminally ill, physically frail and incapable of posing a risk to others while being escorted by officers, he remained in restraints that caused bruising to his wrists. The first doctor from St Rocco's Hospice raised her concerns by letter, but there is no evidence that those concerns were considered. Further, those staff providing the escort were upset by the level of restraint used and would have been affected by their ongoing use. We believe restraints were not necessary in this case and compromised the man's dignity.

The Governor of Risley should ensure that when restraints are used, the risk assessment accurately reflects the risk posed, to ensure restraints are proportionate and maintain human dignity.

Liaison with the man's family

77. A member of the prison chaplaincy team, was appointed as the prison family liaison officer when the man was first admitted to St Rocco's Hospice on 21 February. He regularly visited the man and met with his nominated next of kin, his cousin. The prison family liaison officer regularly visited the hospice, and was there the night before the man died.

78. The man's next of kin was not contactable at the time he died because she was on holiday. A message was left for her to ring Risley, which she did the following day. The prison family liaison officer told her that the man had died, and later visited her at home on 7 June. The man's cousin requested that the funeral was held in the prison chapel and funeral expenses were offered.

79. We are pleased that a prison FLO was appointed as soon as the man was diagnosed with a terminal illness. The prison family liaison officer was able to establish good communication with the next of kin, providing information and a support at a difficult time, which the family expressed their thanks.

CONCLUSION

80. During his time in the custody of Risley, the man had well documented and regular interventions with doctors and other healthcare staff. There was good liaison between healthcare staff and the hospice to ensure that the man received appropriate and timely treatment and medication. The care shown to him by prison staff was of a high standard, and he was supported in trying to find suitable accommodation to be released early on compassionate grounds, although this was not achieved prior to his death.

81. Despite the positive finding of this investigation, the man should not have been in restraints whilst at St Rocco's hospice against the advice given by those leading his clinical care at the time.

RECOMMENDATIONS

1. The heads of healthcare at Risley & Preston ensure that the process for communicating information relating to the transfer of prisoners (located at Preston but for who Risley have escorting responsibility) to a hospice is made at the earliest opportunity.

   Accepted by both HMP Risley and HMP Preston

   Response from HMP Risley – head of healthcare, or lead nurse if head of healthcare not present, will liaise with same at Preston and formally notify in writing (e-mail) to ensure that accurate and timely information is communicated prior to transfer.

   Response from HMP Preston – a protocol is now in place whereby all scheduled transfers of such prisoners is communicated directly to the head of healthcare at the 'sending' establishment prior to any transfer taking place. This information will be communicated by the healthcare administration department as part of the pre-transfer arrangements made via the admin department.

2. The Governor of Risley should ensure that when restraints are used, the risk assessment accurately reflects the risk posed, to ensure restraints are proportionate and maintain human dignity.

   Accepted – the risk assessment process takes account of accurately reflecting the risk posed and ensures restraints are proportionate and maintains human dignity. The healthcare department contribute fully to the assessment that will inform the decision regarding restraint. This process was put in place following the man's first period at the hospice and in fact resulted in the decision to remove restraints on the man's second visit to the hospice.