PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the circumstances surrounding the death of a man in February 2012 at hospital while in the custody of HMP Standford Hill

Report by the Prisons and Probation Ombudsman for England and Wales

September 2012

This is the report of an investigation into the death of a man. He died in February 2012 at hospital following his release on temporary licence from HMP Standford Hill. He was 47 years old. The man died from cancer of the lung, which was diagnosed nine months previously. I offer my condolences to his family.

The investigation was carried out by an investigator. A review of the man's clinical care in custody was carried out by a clinical reviewer on behalf of the local Primary Care Trust. Standford Hill co-operated fully with the investigation.

The man was diagnosed appropriately and given relevant information in a timely manner. However, during the early stages of his illness, when he was undergoing chemotherapy and radiotherapy, he received surprisingly little support from healthcare staff at Standford Hill, with few checks on his physical and mental wellbeing at this crucial time.

In contrast, when he entered the terminal phase of his illness in January 2012, the man was appropriately supported. While there were no significant omissions in his care at this stage I consider that this could have been managed better through a formal end of life pathway, which would also have encouraged appropriate family liaison with his family before his death.

Finally, it is understood that compassionate release for the man was not supported by the National Offender Management Service (NOMS), even for someone so near to death and unable to move to a hospice, because hospital was not considered suitable release accommodation. It seems unfortunate that this technicality may have prevented him from dying with the additional dignity accorded to a free man. I recommend that NOMS amend their approach.

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

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

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SUMMARY

1. The man was admitted to hospital from HMP Standford Hill on 2 May 2011, having reported chest pain, shortness of breath and vomiting. Tests undertaken at hospital identified a lesion in his lung and a biopsy was taken. The results of the biopsy showed that the man had lung cancer. The investigation found that he was diagnosed and told of his illness in a timely manner.

2. Over the following seven months, the man completed courses of chemotherapy and radiotherapy, although there is little evidence that he received significant support from healthcare staff at Standford Hill during this period. The clinical reviewer concludes that this might have affected him both physically, as necessary observations were not taken, and psychologically, to help with the worries that a patient undergoing such treatment would usually experience. We recommend that patients undergoing treatment for cancer receive support from healthcare staff, with input where appropriate from other agencies.

3. Palliative care specialists at a local hospice were asked to visit and review the man in January 2012, when the man became more unwell. They gave advice on pain relief and symptom control. The man's condition fluctuated through the month. On one occasion, he was admitted to hospital in an emergency but he was later well enough to visit his family on home leave. The clinical reviewer concludes that the man received care in this period equivalent to that he might expect to receive in the community. However, we recommend that a formal end of life pathway is followed in future to ensure that none of the key principles of end of life care are overlooked.

4. The man's condition deteriorated significantly in early February and he was admitted to hospital on 3 February. He had now reached the stage where hospice care was appropriate but, unfortunately, there was no bed available. An application for early release on compassionate grounds was submitted but turned down, on the grounds that there was no suitable release accommodation. On 9 February, a hospice bed became available but the man was now very close to death and too unwell to move from hospital. He had been released on temporary licence but formal early release on compassionate grounds was again refused, as the hospital was not considered suitable accommodation. We consider that a hospital should be viewed as suitable release accommodation when a prisoner is very close to death and too unwell to move to alternative accommodation.

5. The man died with family members at his side. It was disappointing to find that the first contact between his sister, his next of kin, and the prison was initiated later that morning by the man's sister. We recommend that a family liaison officer is appointed at an earlier stage when a prisoner is diagnosed with a terminal illness.

THE INVESTIGATION PROCESS

6. On 13 February 2012, the investigator issued notices announcing the investigation to staff and prisoners and invited those who wished to submit information to make themselves known. No one came forward as a result.

7. The investigator visited Standford Hill on 14 February. During the visit he saw the room on C wing in which the man had lived and spoke to staff on the wing. He spoke to the deputy governor, the Head of Healthcare and the prison's family liaison officer. He was provided with copies of the man's prison records, including his medical record.

8. The investigator returned to Standford Hill on 24 April and interviewed two members of staff. A review of the man's clinical care in custody was undertaken by a clinical reviewer on behalf of the local Primary Care Trust.

9. One of the Ombudsman's family liaison officers telephoned the man's sister, his nominated next of kin, on 5 March. She explained the purpose of the investigation. The man's sister raised the following questions that she wished the investigation to address:

    - Whether prison doctors could have done more for her brother and whether he should have been sent to hospital sooner?
    - Why she was not contacted by the prison when her brother was seriously ill? The man's sister said she found out he was in hospital through her son, who went with him in the ambulance. (Her son is also a prisoner at Standford Hill.)

10. The investigation has assessed the main issues involved in the man's care including his diagnosis and treatment, liaison with his family, his location, whether compassionate release was considered and whether appropriate palliative care was provided.

11. The family received a copy of the draft report as part of the consultation process. We received feedback from the man's sister, and are grateful for the time she and her family have taken to consider the report. Her comments have been included as appropriate in the report and a further response is included.

12. The report was also sent in draft to the Prison Service. Their response to our recommendations is also included.

HMP STANDFORD HILL

13. Standford Hill is an open prison on the Isle of Sheppey, holding up to 462 sentenced male prisoners. It is managed as part of a group of three prisons, along with Elmley and Swaleside. Some prisoners at Standford Hill are employed in workshops in the prison, while others work in the community. Prisoners, such as the man, who are assessed as suitable are able to visit their family at weekends around once a month. C wing, where he lived, is for prisoners who work in or visit the community. Prisoners on this wing have their own keys to their rooms.

14. Health services at Standford Hill are commissioned by the local NHS Primary Care Trust and are provided by the prison. The healthcare centre is open from 8.30am to 4.30pm on Monday to Friday. There are no healthcare staff on duty during the evening, overnight or at weekends, although an out of hours service is available. A part time doctor works on Mondays, Wednesdays and Fridays.

15. HM Chief Inspector of Prisons conducted an announced inspection of Standford Hill in December 2011. The Chief Inspector found several areas where improvement was needed, most notably in resettlement work, the core function of such a prison. Some concerns were raised about the wing environments and staff-prisoner relationships, although C wing was reported to be better than others. Health care provision was found to have improved from the previous inspection with a reasonable range of primary care clinics. Secondary care provision was judged as sound, with good access to hospital appointments. Inspectors noted that there was an end-of-life care policy, based on the Liverpool end-of-life pathway, and access to the primary care trust palliative care link nurse for those needing more specialist support. The Sheppey group of prisons had produced a pain control management guide. (This investigation did not find that all aspects of the end-of- life pathway were followed in the man's case).

16. The prison's Independent Monitoring Board (IMB, a body of unpaid volunteers from the local community whose role is to monitor the prison to see that proper standards of care and decency are maintained.) The IMB report for 2010-11 commented on the difficulties caused by a number of recent changes to the senior management team at Standford Hill. However, they considered that healthcare staff at the prison provided "a good and efficient service".

17. The man was the first prisoner to die at Standford Hill since 2007. Another prisoner died a week after. While this second prisoner also died as a result of apparent natural causes, there are no significant similarities between the deaths.

ISSUES

The diagnosis of the man's terminal illness

18. On 31 May 2007, the man was remanded in custody to HMP Elmley and later sentenced to an indeterminate sentence for public protection (IPP) with a minimum term of 42 months. (This means that the earliest point he could be released from prison was three and a half years after he was remanded, but that he could be held indefinitely if the Parole Board believed he was still a risk to the public.) The man moved to Standford Hill on 13 October 2010.

19. The man was admitted to hospital on 1 April 2011, after reporting difficulty breathing. A chest x-ray and electrocardiogram (ECG, a test of the electrical activity of the heart in order to detect abnormal heart rhythms) were taken and he was diagnosed with pneumonia. The man was prescribed a course of antibiotics and discharged the same day.

20. Over the following five days, the man did not improve. He returned to hospital on 6 April and stayed in overnight for investigations. His antibiotic was changed. On 8 April, the man was taken to hospital again as he was still very unwell, but he returned to prison the same day.

21. On his return, it was decided that the man should spend the weekend in the inpatient unit at the neighbouring HMP Swaleside so that healthcare staff could keep him under observation. He returned to Standford Hill on 11 April, reportedly feeling a lot better. Over the following three weeks he experienced intermittent stomach pain.

22. On 2 May, the man was admitted to hospital after reporting chest pain, shortness of breath and vomiting. During his four night stay in hospital he underwent various tests, including a bronchoscopy (an examination of the lungs using a fibre optic camera). This identified a lesion in his lung. (A lesion is an area of abnormal tissue which, in the lung, can be the result of an illness or infection. The presence of a lesion can also indicate that the patient has lung cancer.) A biopsy was taken and the man was discharged to await the results. The results of the biopsy showed that he had lung cancer.

23. The clinical reviewer concludes that the man's diagnosis was made appropriately and without any delay. We agree.

Informing the man about his condition and treatment

24. The man went to an outpatient appointment at hospital on 16 May, at which the consultant oncologist (cancer specialist) explained the results of the biopsy, which indicated that he had lung cancer. The consultant set out his treatment plan, which initially involved chemotherapy and, depending on the outcome, radiotherapy to follow.

25. Following this outpatient appointment, the man had a period of home leave until 19 May. An appointment was booked for him to see a prison doctor on 20 May.

They discussed the diagnosis and treatment plan, and the doctor reminded him that he could see him if he had any concerns.

26. The man saw an oncologist at hospital on 27 May for further discussion of his treatment plan. The consultant recorded that he understood his diagnosis, but that it had made him stressed.

27. The clinical reviewer concludes that the man was given information about his diagnosis and treatment plan in a "timely and constructive manner". We note that an appointment was made with the prison doctor at the earliest opportunity following the results of his biopsy, at which he was able to talk through the implications of his diagnosis and treatment. We agree with the clinical reviewer's view that the man was given information in a timely and appropriate manner.

The man's medical appointments and treatment

28. Following an induction session at hospital on 14 June, the man completed four cycles of chemotherapy as an outpatient from mid June to mid August. At a review appointment on 23 September, additional radiotherapy to the chest and brain was recommended. This began on 24 October and involved outpatient sessions each weekday until 10 November. The man was able to attend all of his scheduled treatment and consultation sessions.

29. Other than on 16 June, when he was reviewed by a nurse, there is no indication that a member of healthcare staff saw the man following his return from any of his chemotherapy or radiotherapy sessions. The Head of Healthcare told the investigator that this is not something that would happen routinely at the prison, as their remit is to provide a service equitable to that available in the community. She added that there was no request from the hospital to review him.

30. The clinical reviewer comments:

> "[If the man was not reviewed following chemotherapy] I believe this to be a serious omission, as patients following chemotherapy should be regularly reviewed to make sure they do not have complications whilst having chemotherapy, such as developing septicaemia [blood poisoning] … [A patient's] temperature should be recorded on a regular basis as a rise in temperature is a sign that septicaemia may be developing."

31. It is also important to provide the appropriate psychological support to a patient undergoing treatment for a terminal illness. Unsurprisingly, the man was stressed and worried by his diagnosis. Other than the consultations immediately following diagnosis (described in the previous section) healthcare staff at the prison do not appear to have talked through these worries with him. The clinical reviewer concludes that he "received very little support" both physically and psychologically during the early stage of his illness. He adds that the involvement of community nursing staff at a local hospice and specialist chemotherapy nurses at the Oncology Centre might have aided him. Involvement from outside agencies in the care and support of prisoners with terminal illnesses is usual in other prisons.

The Head of Healthcare should ensure that patients undergoing treatment for serious conditions should receive appropriate support from healthcare staff, including specialist help from relevant outside agencies.

Palliative care plans and end of life pathways

32. On 6 January 2012, the man went to an outpatient appointment to review his progress following radiotherapy. He was reported to suffer the usual side effects of the treatment, including nausea and tiredness. Over the following week, he became more unwell, and on 12 January, a referral was made by a prison doctor to specialist palliative care services at the hospice.

33. The following day a specialist palliative care nurse from the hospice visited the man with a palliative care link nurse from the neighbouring HMP Swaleside. They discussed with him a number of symptoms that were affecting him, including his pain control and a lack of appetite. The palliative care nurse gave advice on how these could be addressed. They also discussed his prognosis and how he might be cared for in the future. The man said he would like to move to a hospice at the appropriate time. As is standard, the nurses discussed with the man whether he would like to be resuscitated were his heart to stop. He said that he did not, and the appropriate forms were completed. On the same day, staff working on the man's wing were given a pack with details of who to contact in an emergency outside healthcare opening hours. They were asked to check on him at least every four hours and record their observations.

34. The man said he felt better over the following week due to his change in medication and, on 17 January, asked that the 'do not attempt to resuscitate' forms he had signed be withdrawn. On the same day, a multi disciplinary team meeting was held to discuss his future management, including the process for applying for early release on compassionate grounds (the application is discussed further in a later section).

35. During the night of 18 January, he told night staff on his wing that he had diarrhoea and had vomited. An ambulance was called and he was admitted to hospital. He returned to Standford Hill the following morning, having been given fluids in hospital. The man spent the following four nights on home leave at his sister's house and, on his return, said he had been well during his time away.

36. The man remained reasonably well over the remainder of the month. On 30 January, he asked that healthcare staff did not visit him every day (as they had been doing throughout the month) as he found this unnecessarily intrusive. It was agreed that healthcare staff would visit every other day, with wing staff asked to contact them if required.

37. On 1 February, the man's condition appeared to have deteriorated and the palliative care nurses visited him that afternoon. He explained that he had had a busy day the previous day and was therefore tired. (The man had an outpatient appointment at hospital and had also viewed a flat that it was proposed he move

to should he be granted early release on compassionate grounds.) The nurses advised him to rest.

38. By 3 February, the man's condition deteriorated further and he was reported to be confused and dehydrated. Following review by a doctor, the Head of Healthcare spoke to the palliative care nurse, who advised that he be admitted to hospital. He stayed in hospital for the remaining week of his life and was initially treated for gastroenteritis (stomach infection).

39. Although we have been critical about the support that the man received when he was when first diagnosed and undergoing treatment, it is apparent that he received considerable support from January 2012 when he began to enter the final stages of his life. We agree with the clinical reviewer's view that the care he received at this time of his life was equivalent to that he could expect to receive in the community.

40. We have noted earlier that HM Chief Inspector of Prisons found in his inspection of December 2011 that an end-of-life care policy, based on the Liverpool end-of-life pathway, was in place at Standford Hill. However, as the clinical reviewer notes, there is no evidence that the man was managed using a formal care plan or end of life pathway. The Head of Healthcare confirmed that he was not formally managed under the end-of-life care policy.

41. The NHS document 'The route to success in end of life care – achieving quality in prisons and for prisoners' sets out how an end of life care pathway might be implemented in prisons. Among the benefits of an end of life pathway are that it helps carers to plan when and how care will be delivered, and helps patients make choices about how they are cared for towards the end of their lives. We acknowledge that many of the principles of an end of life pathway, including several discussions with the man about his wishes, took place at Standford Hill. However, best practice would be to incorporate these principles in a formal documented pathway to ensure that none of the principles are overlooked.

    The Head of Healthcare should ensure that an appropriate end of life pathway is implemented when a prisoner nears the end of life.

The man's pain relief and medication

42. For a number of years before his cancer diagnosis, the man had taken painkillers for recurrent back pain. At the time of diagnosis he was prescribed codeine (for mild to moderate pain), and continued with this throughout his chemotherapy and radiotherapy treatment. He also took medication to counter the side effects, such as nausea, associated with these treatments.

43. On 14 November 2011, shortly after completing radiotherapy, the man saw the prison doctor for a review. He said he was experiencing severe headaches, and the doctor changed his painkiller to dihydrocodeine (a stronger form of codeine). Two weeks later, the man said he was still experiencing headaches and the doctor prescribed tramadol rather than dihydrocodeine. (Tramadol is a stronger painkiller for moderate to severe pain.) Following a risk assessment, the man

was permitted to keep this stronger medication in a locked cabinet in his room (known as 'in possession' medication). He was given the medication in dosette boxes (a box in which medications are organised into compartments by day and time) to help him take it at the correct time.

44. At his next review, on 28 December, the man reported no further headaches and no changes were made to his medication. At an outpatient appointment with an oncologist on 6 January, the man was prescribed an additional drug, dexamethasone, for the side effects of radiotherapy after experiencing nausea and loss of appetite.

45. The palliative care nurse visited the man at the prison on 13 January. The man was still experiencing nausea and associated symptoms, and the palliative care nurse made several changes to his medication. This included replacing tramadol with zomorph (a morphine based painkiller for severe pain which is designed to release the morphine slowly over a 12 hour period) and oromorph (also a morphine based painkiller, which the man was given to take as needed when he experienced additional pain). Again, the man was permitted to keep these medications in the cabinet in his room.

46. Over the following three weeks, the man's pain control was reviewed regularly. On each occasion, he said that the painkillers were working well and his pain was under control. As we have previously noted, his condition deteriorated rapidly and he was admitted to hospital on 3 February. A letter from the oncologist, dated 9 February, reported that the man's pain continued to be controlled by zomorph.

47. The clinical reviewer comments that pain control was not a major feature of the man's illness until he entered the terminal stage in January 2012. Changes to his medication were made promptly when he complained of additional pain and he was reviewed regularly following changes to ensure that his pain was under control. The man was able to keep his medication, including stronger morphine based painkillers, in possession and there is no indication that he did not take the medication at the correct times. We are satisfied that the man's pain control was monitored appropriately at Standford Hill.

The man's location

48. The man transferred to Standford Hill in October 2010, seven months before he was diagnosed with cancer. He lived on C wing, which is for those who work in or visit the local community.

49. When the man became more unwell in January 2012, nursing staff at Standford Hill began to visit him on C wing daily (except weekends, when the healthcare centre is shut). Consideration was given to transferring the man back to a closed prison, where he could live in an inpatient unit with 24 hour nursing cover. In correspondence with the Ombudsman following the man's death, his sister said she thought this would have been the best option. However, a move was rejected following discussion between the Head of Healthcare and deputy governor, who concluded that it was better for the man to remain in open

conditions. We agree with this conclusion. The benefits of remaining at Standford Hill included more freedom of movement, both inside and outside the prison, and the presence at the prison of the man's nephew and friends who could see him each day.

50. At the same time it was recognised that Standford Hill would not be an appropriate environment for the man's care in the latter stages of his life, as there was no healthcare cover at night and at weekends. A local hospice had been contacted with a view to the man moving to the hospice at the appropriate time. Consideration had also been given to alternative release accommodation should an application for early release on compassionate grounds be successful (discussed further in the 'compassionate release' section of this report).

51. The man continued to live in his ground floor room on C wing. He was offered a room closer to the staff office, but chose to remain in his existing room. On 3 February, the Head of Healthcare contacted the hospice palliative care nurse, who concluded that the man had now reached the stage where he needed hospice care. However, there were no beds available in the hospice at that time, and it was agreed that the man should be admitted to hospital instead.

52. The man's sister thought that he should have been admitted to hospital at an earlier stage. She also commented that the Medway hospital should have kept her brother in as an inpatient for monitoring rather than sending him back to Channings Wood after each of his outpatient appointments. We have considered whether the man ought to have been admitted to a hospice or hospital at an earlier stage. We note that three days before admission, on 31 January, the man was well enough to visit a flat where he might potentially have lived were he to be released. On the same day, he attended an outpatient appointment with the hospice palliative care consultant. He was also reviewed by the palliative care nurse at Standford Hill on 1 February.

53. The clinical reviewer comments that it is "always difficult to judge when it is appropriate to transfer a patient to a hospice". The man saw different palliative care specialists in the days before he went to hospital. Neither recommended his admission at this earlier stage. We are satisfied that staff at Standford Hill took appropriate action at this time.

Liaison with the man's family

54. The man went on his first period of home leave from 16 May to 19 May 2011, shortly after he was diagnosed with cancer. This continued with visits for four nights at a time around once a month throughout his illness. On each occasion he stayed with his sister. The man's last two home visits were over Christmas 2011 and from 20 January to 24 January 2012.

55. The man's nephew transferred from another prison to Standford Hill in early January 2012. (He is the son of the man's sister, his next of kin.) The man's nephew was able to visit his uncle on C wing every day, although he told the investigator that this was not arranged until a week after his arrival at the prison.

56. When the man was admitted to hospital on 3 February, his nephew was permitted to accompany him in the ambulance and was able to visit him in hospital later in the week. The man's nephew was released on temporary licence for these visits. (Release on temporary licence [ROTL] is a form of release usually used to enable prisoners to participate in activities outside the establishment that directly contribute to their resettlement into the community. For example, the man was released on temporary licence to stay with his family on home leave.) We consider this was an appropriate and thoughtful decision, in keeping with the man's nephew's status as a category D prisoner (meaning that he was in an open prison and could be reasonably trusted not to try to escape).

57. The man's sister asked why she was not contacted by the prison when her brother was seriously ill. She said she was told of his hospital admission by her son rather than someone from the prison. In response to our draft report, the man's sister reiterated her disappointment not to have been told formally by the prison that her brother had been admitted to hospital. She said that this meant she could not arrange for the man's mother or daughter to visit him before he died.

58. An officer at Standford Hill wrote in the man's records on 3 February that his nephew would inform the man's sister that he had been admitted to hospital. The man's nephew, however, told the investigator that no one from the prison ever spoke to him about contacting and updating his family. He said that the man wanted his sister to know he was in hospital. The man's nephew added that he would tell his family a matter of course.

59. The prison's family liaison officer visited the man in hospital on 7 February. She recorded, and later told the investigator, that her impression from speaking to the man was that he did not understand how seriously ill he was at the time. She recalled that he was quite confused and struggled to hold a conversation. The man told the family liaison officer that he did not want to bother his family and asked that they were not contacted. The family liaison officer concluded that it was likely the man did not understand that his condition was so serious that his family needed to know and spend time with him. On returning to the prison the following day, she discussed her concerns with the Governor. They agreed that the family liaison officer should contact the man's sister. However, the same afternoon a palliative care nurse at the hospital telephoned the man's sister, who was able to visit the following day. It is not clear whether the man asked the nurse to contact his family on his behalf. Prison Rule 22 requires the governor to inform the prisoner's next of kin when a prisoner becomes seriously ill and we consider, irrespective of whether his nephew had been in contact, that the prison should have informed his sister when the man was taken to hospital on 3 February.

60. The man died in the presence of his family at around 4.10am on 10 February. His sister telephoned the prison a few hours later and asked that her son be allowed to bring her the man's property on his next period of home leave. This was agreed. The family liaison officer was formally appointed later that morning, and telephoned the man's sister to explain how the prison could help with the funeral costs and arrangements. The man's funeral was held on 23 February

and the prison contributed to the costs in line with national guidance. The man's nephew was given three days home leave to attend. A memorial service was held at Standford Hill for staff and prisoners.

61. We do not consider it satisfactory that the first contact between the prison and the man's next of kin was initiated by his sister after his death. We accept there is some mitigation, as the man was able to see his family on home visits and his nephew was present in the prison and able to accompany him to hospital. There is also some doubt about whether the man wanted his family to be contacted on 7 February as he was described as confused at that time. His nephew told the investigator that the man wanted his sister to know he was in hospital and had already told her he had terminal cancer. If there was any doubt over this matter it should have been clarified at an earlier stage. This is a subject that could have been formally addressed and discussed through the use of an end of life pathway, as we have recommended.

62. Good practice would be to appoint a family liaison officer at an early stage when a prisoner is diagnosed with a terminal illness. This is beneficial for the family as they have a point of contact should they have any concerns about their relative. It would also benefit the prison to have established a relationship should they need to contact the family in the event of a sudden deterioration and hospitalisation, as they are required to do under Prison Rule 22.

The Governor should appoint a family liaison officer when a prisoner is diagnosed with a terminal illness who should keep the family informed of important changes such as when the prisoner is admitted to hospital.

Compassionate release

63. Early release on compassionate grounds is a means by which prisoners who are seriously ill can be permanently released from custody before their sentence has expired. The criteria for early release for indeterminate sentenced prisoners are set out as follows in Prison Service Order (PSO) 4700:

- the prisoner is suffering from a terminal illness and death is likely to occur very shortly (although there are no set time limits, three months may be considered an appropriate period for an application), or the prisoner is bedridden or similarly incapacitated, for example, those paralysed or suffering from a severe stroke; and

- the risk of re-offending (particularly of a violent or sexual nature) is minimal; and

- further imprisonment would reduce the prisoner's life expectancy; 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.

64. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) within the National Offender Management Service (NOMS). Caseworkers in the unit consider the application and have a target of advising the prison of the outcome within two weeks of receipt (or sooner if the application is very urgent). Various reports are required to make up the application, including reports by the prison doctor (usually supported by further information from the hospital consultant or equivalent expert), the prison's probation officer and the Governor.

65. The process of compiling reports for an application for the man's early release began on 17 January 2012. The medical section of the report was completed by the prison doctor. He outlined the man's diagnosis and gave the opinion that the prison was not a suitable place for the man to live in the latter stages of his life as there is no healthcare cover overnight and at weekends.

66. A meeting was held on 26 January involving the prison cluster's palliative link nurse, and representatives from social services and a local housing association. They discussed the type of discharge accommodation that would be suitable for the man were his release to be approved. He subsequently viewed and accepted a ground floor housing association flat in Kent on 31 January. Arrangements were made for the man to receive a daily visit from the local social services plus additional support from the local Macmillan team. The man's probation officer and offender supervisor concluded that his risk to the public and risk of reoffending was minimal if he were to be released to this accommodation.

67. A letter in support of the application was submitted by the medical director of the Wisdom Hospice, on 1 February. He gave a prognosis of "probably less than three months and certainly less than six months".

68. The application was subsequently faxed to PPCS on 2 February. The following day, the man was admitted to hospital following a deterioration in his health. Before being admitted, the Head of Healthcare spoke to staff at the hospice, who said that the man probably now needed a hospice bed but that there was not one available at the time. They suggested he be admitted to hospital as an alternative.

69. On 6 February, PPCS refused the application for early release. They considered that the man's prognosis and reduced risk of reoffending were sufficient to meet the criteria for release. However, the application was refused as the accommodation arranged was not considered suitable. This was, firstly, because it was initially available for one month only and, secondly, the support available to the man in this accommodation was no longer sufficient given his deterioration and hospital admission. They also noted the prison doctor's comment about the lack of healthcare cover in the prison and that this also applied were he to move into the accommodation proposed. Nevertheless, PPCS highlighted that they would reconsider the application were the man to be allocated a place in a hospice.

70. Over the following days, it was noted that the man was still awaiting a bed at the hospice. A revised letter was submitted by a consultant in palliative medicine at the local hospital, on 9 February. The consultant explained that the man had "rapidly deteriorated" since hospital admission and was now "likely to die within hours to days". On the same day, a place became available at the hospice but the man was now assessed as too ill to undertake the ambulance journey to the hospice. The consultant's letter was faxed to PPCS and the Governor spoke to the unit to update them on the availability of a hospice bed. However, the hospital was not considered to be a suitable release address and the refusal stood.

71. We consider that the application for early release on compassionate grounds was submitted at the appropriate time from a clinical perspective. It is apparent that the man's release would have been approved on the grounds of prognosis and risk to the public, but that the difficulty was the provision of suitable accommodation. We agree with the PPCS caseworker that the proposed housing association flat appeared inappropriate for the man's needs, which were inevitably going to increase. It is unfortunate that a hospice bed did not become available until the man was too ill to move. But if, as indicated, compassionate release would have been agreed if the man had been able to get a hospice place it is hard to see why he could not have been released to the hospital address on 9 February, when it became apparent that the man was going to die very soon. We accept that a hospital bed would not normally be considered as suitable permanent release accommodation. However, as the man was too unwell to move from hospital to the hospice then it is apparent that this was the only accommodation in which he could spend the remainder of his life.

    Public Protection Casework Section at NOMS headquarters should view a hospital as suitable release accommodation when a prisoner is close to death and too unwell to move.

72. Nevertheless, we note that the man was released on temporary licence for the duration of his stay in hospital, which meant that he could be treated without a prison officer accompanying him. This was appropriate in the circumstances.

Restraints, security and bedwatch

73. As he was a category D prisoner, the man was released on temporary licence for each of his medical appointments, including chemotherapy sessions and inpatient stays. This meant that he was unaccompanied, and no restraints were used.

FAMILY RESPONSE TO THE DRAFT REPORT

74. We received a number of comments from the man's sister on the draft report, and have incorporated these into the final report at the appropriate point. In addition, she queried the account of the events of 3 February 2012 given by the Head of Healthcare. At interview, the Head of Healthcare described visiting the man at around 8.30am to 8.40am on 3 February. She described the man as confused and disoriented, and said there was faeces on the back of his legs and feet. She said her impression was that the man had been lying in that position for "quite some time". The man's sister queried how long he had been left like this and asked whether it was because he was not seen daily by healthcare staff.

75. Four days before these events (on 30 January), the man had asked that healthcare staff did not visit him every day, as they had been doing, as he found this intrusive. It was agreed that healthcare staff would visit him every second day, with wing staff asked to contact them if required. In addition wing staff had, since 12 January, been asked to see the man every four hours to check on his wellbeing, and record their observations in a log. Before the Head of Healthcare's visit on 3 February, the man was last checked at 6.00am when it was recorded that he was "asleep and breathing normally".

76. We appreciate how distressing it must be for the man's sister to learn that her brother was found in this condition. However, we consider it good practice that wing staff were asked to check the man every four hours and note that he was asleep and untroubled at the most recent observation. We note that the man was admitted to hospital on the morning of 3 February, and consider this appropriate.

CONCLUSION

77. The man was diagnosed with lung cancer in May 2011 in a timely manner, informed appropriately of his treatment options and received good pain management. Although he could have been better supported in the early months of his treatment, as his illness progressed the man received good support from healthcare staff in the prison, equivalent to that which he might expect to receive in the community. We consider liaison with his family should have started once he was diagnosed as terminally ill. Good efforts were made to arrange compassionate release but these were hampered by his sudden deterioration and the lack of a hospice place. We believe that compassionate release should have been allowed for his final days in the hospital.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that patients undergoing treatment for serious conditions should receive appropriate support from healthcare staff, including specialist help from relevant outside agencies.

   Accepted – we will review our end of life policy to incorporate appropriate referral and support at the point of diagnosis.

2. The Head of Healthcare should ensure that an appropriate end of life pathway is implemented when a prisoner nears the end of life.

   Accepted – we will review, update and publish the end of life policy in line with the recommendations.

3. The Governor should appoint a family liaison officer when a prisoner is diagnosed with a terminal illness who should keep the family informed of important changes such as when the prisoner is admitted to hospital.

   Accepted – when informed that a prisoner has been diagnosed with a terminal illness, the establishment will appoint a family liaison officer. Consent will be sought from the prisoner to disclose details of their condition and likely prognosis prior to the information being shared with their next of kin.

4. Public Protection Casework Section at NOMS Headquarters should view a hospital as suitable release accommodation when a prisoner is close to death and too unwell to move.

   Accepted – this recommendation is accepted based on the following criteria:
   - *There are no hospice spaces available*
   - *All early release on compassionate grounds criteria are met*
   - *An up to date prognosis from medical staff (at the relevant hospital) is available.*