Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Orlando Baker a prisoner at HMP Rye Hill on 25 October 2016

A report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Orlando Baker died on 25 October 2016 from an obstructed blood vessel in the lungs, caused by deep vein thrombosis and a type of brain tumour, while a prisoner at HMP Rye Hill. Mr Baker was 50 years old. I offer my condolences to Mr Baker's family.

Mr Baker had been suffering with a range of symptoms for several months. He was diagnosed with sinus cancer just over a month before his death and given a terminal prognosis two weeks later. Although Mr Baker had a history of challenging behaviour, I am concerned about the standard of healthcare he received in Rye Hill. Mr Baker's conditions may have been diagnosed sooner if all his symptoms had been considered together. He was also in regular receipt of pain killers for over three months without a review by a member of healthcare. I am also concerned that he appears to have been restrained while unconscious.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **May 2017**

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Summary

Events

1. On 24 November 1995, Mr Orlando Baker was sentenced to nine years in prison, which was increased to life imprisonment after an appeal. Mr Baker spent time at a number of prisons before arriving at HMP Rye Hill on 2 December 2014.

2. Mr Baker's initial health screen revealed no medical concerns or outstanding health appointments. Mr Baker had no relevant health concerns until May 2016.

3. On 9 May 2016, Mr Baker reported having nose bleeds and trouble breathing through his nose for a few days. The prison GP referred Mr Baker to the ear, nose and throat (ENT) clinic at the hospital with a suspected septal haematoma (a condition affecting the nasal septum). Mr Baker was examined at the ENT clinic, given a prescription, and asked to attend a follow up appointment in the next two days. He was discharged the same day, but did not attend the follow up appointment.

4. Mr Baker was seen by healthcare staff and prison GPs throughout May for nose bleeds and other nasal problems, but was not referred to the ENT clinic again. Between 31 May and 29 August, Mr Baker was regularly given paracetamol and ibuprofen, but there is no record of any medical appointments during that time.

5. He was managed under suicide and self harm prevention (ACCT) procedures from 29 August after being found with a noose around his neck and with superficial cuts to his wrist.

6. In the evening of 5 September, Mr Baker swallowed four batteries and said it was so he could go to hospital. He was taken to hospital, reviewed and discharged shortly afterwards.

7. On 15 September, concerns over Mr Baker's deteriorating health and behaviour were discussed at a complex care case meeting. Later that day, a prison GP advised that he should be transferred to hospital after healthcare staff saw that Mr Baker was catatonic. At 4.45pm, a multi-disciplinary team meeting was held to discuss his condition, and he was moved to a cell in the inpatient unit. Mr Baker's condition deteriorated further, and an ambulance was called at 8.20pm to take him to hospital under restraint.

8. Mr Baker was diagnosed with sinus cancer shortly after arriving at hospital. He had surgery at 1.35am on 16 September, where a tumour was partly removed. He was moved to the intensive care unit and kept in an induced coma.

9. Mr Baker never regained consciousness, and a palliative care referral was made on 10 October. Mr Baker was transferred to a hospice on 24 October. Mr Baker died at 10.00am on 25 October at the hospice.

Findings

10. Overall, we are concerned that the clinical care Mr Baker received was unsatisfactory. Healthcare staff missed opportunities to diagnose his sinus cancer earlier because they did not consider his symptoms together, which may

have indicated a more serious illness. We are also concerned that Mr Baker regularly received pain relief for three months without a GP review, which also may have indicated something more serious. We accept that Mr Baker was a complex case and did not cooperate with healthcare, but we consider this may be partly due to him losing faith in the healthcare provisions at Rye Hill.

11. Mr Baker was restrained when he first went into hospital; the restraints were recorded as being removed several hours after he entered theatre for his operation. We are concerned that prison staff failed to follow or were not aware of the legal guidance for using restraints when a prisoner is clearly unconscious.

12. We consider that once Mr Baker was given a terminal prognosis and referred for palliative care on 10 October, the prison should have started an application for compassionate release.

Recommendations

- The Head of Healthcare should ensure that clinicians consider a prisoner's overall symptoms in a holistic manner, so that any indicators of disease progression are quickly acted upon.

- The Head of Healthcare should ensure that prisoners who frequently request pain relief for an undiagnosed condition are referred to a GP promptly.

- The Director and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Rye Hill informing them of the investigation and asking anyone with relevant information to contact him. Two prisoners contacted him by telephone and three prisoners sent in letters.

14. The investigator obtained copies of relevant extracts from Mr Baker's prison and medical records. He also conducted telephone interviews with two prisoners on 17 and 21 November 2016.

15. NHS England commissioned a clinical reviewer to review Mr Baker's clinical care at the prison.

16. We informed HM Coroner for Coventry and Warwickshire of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

17. The prison family liaison officer informed the investigator that Mr Baker's family did not want to be contacted about his death or the Ombudsman's investigation, and that they only wanted limited communication with her herself. After being notified of Mr Baker's death by the family liaison officer, Mr Baker's father stopped answering his telephone. Given these circumstances, we took the decision not to contact Mr Baker's family.

18. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Background Information

HMP Rye Hill

19. HMP Rye Hill is run by G4S and holds more than 600 men convicted largely of sex offences. G4S Forensic and Medical Services provide primary physical and mental health services, and Northamptonshire Healthcare NHS Foundation Trust (NHFT) provides secondary mental health services. The prison does not have an inpatient facility.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Rye Hill was in August 2015. Inspectors noted that the prison held a complex mix of serious offenders and some frail older men who needed significant levels of care. The inspection found that the quality of healthcare services was the weakest area of the prison. Services had not sufficiently adapted to meet the needs of the new population, when the prison had changed its role to take sex offenders in 2014. There were staff shortages and the available staff were not deployed efficiently. There were long waiting times for most clinics. A small group of regular GPs had run daily clinics since January 2015, which had improved consistency and prisoners' perceptions of service provision. However, prisoners waited up to three weeks for routine GP appointments. Prisoners had good access to pharmacy staff for advice.

Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to March 2016, the IMB reported that healthcare provision remained under pressure and was a cause for concern. They found that recruiting and retaining suitable healthcare staff was an ongoing problem, which led to staff shortages particularly on weekends. The IMB also found that the number of clinics had increased, which had decreased waiting times.

Previous deaths at HMP Rye Hill

22. Mr Baker was the fifth person to die from natural causes at Rye Hill since January 2015, and there have since been three further deaths. We have made previous recommendations regarding pain relief and the use of restraints.

Key Events

23. Mr Orlando Baker was sentenced to nine years imprisonment on 24 November 1995, for false imprisonment and rape. This was increased to life imprisonment at the Court of Appeal on 3 May 1996. Mr Baker spent time at a number of prisons before arriving at HMP Rye Hill on 2 December 2014. He was 48 years old when he first arrived at Rye Hill.

24. When he arrived at Rye Hill, a nurse reviewed Mr Baker at an initial health screen. He had no physical health concerns and no outstanding medical appointments at this stage. Mr Baker was assessed has having no thoughts of self harm or suicide at his reception screening.

25. Mr Baker had a long history of mental health problems during his time at other prisons, and was assessed and diagnosed with a personality disorder on 1 May 2009. Mr Baker had been subject to suicide and self harm prevention (ACCT - assessment, care in custody and teamwork) plans on numerous occasions due to self harming. On several occasions prior to arriving at Rye Hill, Mr Baker had swallowed batteries, and he was kept under observation and review until they passed naturally.

26. On 19 December 2014, Mr Baker was placed on an ACCT after he was observed chewing batteries and with superficial scratches on both wrists.

27. Mr Baker had no relevant physical or mental health issues during the next year.

28. On 22 March 2016, a nurse examined Mr Baker after he was reported to have swallowed six batteries. She could see no signs of burns or corrosion in his mouth, and Mr Baker did not report any feelings of nausea, vomiting or burning. Mr Baker was taken to the hospital but discharged the same day, with doctors explaining that the batteries would come out naturally. Following this episode, Mr Baker was monitored on an ACCT until 4 April.

29. On 3 April, Mr Baker was seen by a healthcare assistant, following reports he was coughing up blood. Mr Baker told her that this had been happening for a month and showed her a cloth which appeared to have blood on it. He was referred to see the GP the following day. The next day, a locum GP saw Mr Baker and noted that he was on hunger strike, although Mr Baker did not want to discuss why he was on a hunger strike. There was no mention about the concerns reported the day before.

30. On 9 May, Mr Baker reported having nose bleeds and trouble breathing through his nose for a few days. A locum GP examined Mr Baker and referred him to the ear, nose and mouth (ENT) clinic with a suspected septal haematoma (a condition affecting the nasal septum). Mr Baker was seen at the ENT clinic later that day, and discharged with a prescription for augmentin (a drug used to treat sinus problems) and nasal cream. The ENT clinic requested Mr Baker attend a drop in, follow up appointment within two days. The prescription was not collected from the pharmacy until the following day. There is no record of Mr Baker attending the follow up appointment at the ENT clinic.

31. In the early hours of 15 May, Mr Baker complained about his nose bleeding and breathing difficulties. He refused observations and demanded to be taken to hospital. A nurse observed Mr Baker through his viewing panel and noted he was not bleeding but had blood stains under his right nostril. She later examined Mr Baker in his cell, and observed his skin was normal in colour and condition, there was no cyanosis (bluish skin, nail beds and mucous membranes), and he had no dizziness or nausea. She advised him to apply a cold compress and to use the cream prescribed by the ENT clinic. Later that day, Mr Baker was still having issues with his nose but he appeared stable.

32. The next day, a nurse saw Mr Baker and saw blood on his face and nose. He stated that his nose bled every time he sneezed - he denied inserting foreign objects into his nostril.

33. On 17 May, a locum GP examined Mr Baker and noted he had been suffering with a bleeding, nasal obstruction for three weeks. He observed fresh blood in Mr Baker's right nostril, clear mucous and slightly inflamed mucosa (the thin skin that covers the inside surface of parts of the body such as the nose). He added beclometasone (a nasal steroid spray) to Mr Baker's prescription and sought a review in three to four weeks. He also made reference to an earlier visit to hospital by Mr Baker when he had a lollipop stick removed, though there is no record of this in his notes.

34. The following day, a nurse manager issued a reminder about the management of Mr Baker's nose bleeds. She noted that advice should be sought from a clinical lead or GP before advising on a transfer to hospital.

35. On 23 May, a locum GP said he observed Mr Baker collapse but suspected it was simulated. He also noted that Mr Baker's recent nasal problems were due to a foreign body which he had not reported. He further noted that staff said he had no further nose bleeds, but Mr Baker claimed to have had one that morning. All observations were recorded as being normal.

36. Between 31 May and 29 August, Mr Baker was regularly given pain killers, but there is no record of any medical appointments during that time. Mr Baker received on average 1g of paracetamol and 400mg of ibuprofen per day.

37. On 29 August, a nurse observed Mr Baker sat on his bed with blood over his nose and mouth. Mr Baker told her that he could not breathe and had been suffering with nose bleeds for five months, but denied putting anything up his nose. She examined Mr Baker and could not find any foreign objects in his nose. She offered to refer Mr Baker to the prison GP the next day, but he said not to bother because he did not trust them and wanted to go to an outside hospital.

38. Later that night, Mr Baker was seen in his cell with a noose around his neck and superficial cuts to his wrist. Mr Baker told officers he could not live any more due to the pain that he was suffering. Staff placed him on an ACCT, where he was initially subject to two observations per hour, but this was increased to five following a review on 6 September. The ACCT was not closed before he went to hospital on 15 September.

39. On 2 September, Mr Baker demanded paracetamol and ibuprofen for his sinus problems, dental pain, back trouble and aching joints. A nurse refused and advised Mr Baker to see a GP. An appointment was made for later that day, but Mr Baker did not attend.

40. On 5 September, a member of the community health service saw Mr Baker in his cell. She observed blister like lesions around his mouth and top lip, along with some swelling and redness. He denied taking any illicit or non prescribed substance, or swallowing anything toxic. A locum GP saw Mr Baker later that day and noted that he had a significant herpes outbreak on his face and a purulent discharge from his right nostril. He prescribed aciclovir (used to treat herpes) and amoxicillin (an antibiotic for his sinuses).

41. At 8.48pm, the member of the community health service noted that Mr Baker told staff he had taken an overdose of his medication and wanted to die because he was in pain and no one cared. She advised Mr Baker to rest and to drink plenty of water.

42. At 9.30pm, a member of the community mental health service saw Mr Baker after he reported to officers that he had swallowed four batteries. An officer confirmed he saw Mr Baker bite and swallow a battery. Mr Baker said he did this to get transferred to hospital as he was not being given adequate care for the herpes on his face and his sinus infection. Initially, the duty governor refused to send Mr Baker to hospital, because Mr Baker was known to self-harm to go to hospital, but after speaking with a locum GP he was sent to hospital at 12.30am on 6 September. Mr Baker was examined in hospital, where an X-ray revealed the batteries were clumped together in one place. The hospital discharged Mr Baker at 2.45am, with a follow up appointment scheduled for 2.30pm on 7 September. Mr Baker did not attend this appointment, though the reason was not recorded in his medical record. At 9.42am on 6 September, a nurse noted that Mr Baker had refused to go to hospital for his review.

43. On 8 September, a nurse saw Mr Baker in his cell and noted that the swelling to his face was now up to his left eye. Mr Baker said he felt nauseous and had diarrhoea. She explained to him that this might be the after effects of the medication overdose he had taken three days earlier.

44. On 9 September, Mr Baker threatened a prisoner and was placed on report. Mr Baker then threatened the officer who placed him on report. Over the weekend, Mr Baker appeared to settle down. His ACCT log recorded him as watching TV, listening to the radio and socialising with other prisoners.

45. Prison staff were becoming increasingly concerned about Mr Baker. On 12 September, the residential manager started a decision log. On that day, she recorded that Mr Baker was very tearful and told her he had not spoken to his family for years due to his current offence.

46. On 13 September, a mental health nurse referred Mr Baker to the mental health Inreach team due to his recent suicide attempt, poor personal hygiene and unusual behaviour.

47. On 14 September, Mr Baker was seen by the residential manager. Mr Baker told her he would not be attending his ACCT review as he felt too unwell. She noted in the decision log that he did not appear too unwell, spoke clearly and responded to her. She set the review for the following day.

Mr Baker's admission to hospital

48. In the morning of 15 September, the residential manager visited Mr Baker. Concerns had been raised by staff after he had urinated and defecated in his cell. She found that Mr Baker seemed very lethargic and did not appear to be himself. She raised her concerns at 2.00pm during a complex care case meeting. The meeting agreed that they would continue to monitor Mr Baker on the unit.

49. At 3.31pm, mental health nurses from the Inreach team visited Mr Baker in his cell. One nurse noted that Mr Baker appeared catatonic, was extremely unkempt and his cell smelt strongly. They requested a constant watch cell and scheduled a multi-disciplinary team meeting for later that day. Another nurse also emailed and spoke to a psychiatrist to request an urgent psychiatric review for the next day. The psychiatrist advised that Mr Baker should be transferred to hospital immediately, and noted that he lacked the capacity to refuse at that time. There was no evidence of a formal review of Mr Baker's capacity to consent at this stage and healthcare staff chose to observe Mr Baker rather than follow the psychiatrist's advice.

50. A nurse saw Mr Baker in his cell at 4.30pm, when he was able to follow instructions and drink water. Mr Baker told her that he had pain when passing urine and he had not eaten for three days. She examined Mr Baker and noted that his abdomen was soft but not tender and his pupils were equal and reacting. She recorded his temperature as 38.4C, and gave him paracetamol for pyrexia (a higher than normal body temperature).

51. At 4.45pm, a multi-disciplinary team meeting was held to discuss Mr Baker's condition. Mr Baker was moved to a cell in healthcare following this meeting and kept under observation. A nurse visited Mr Baker again at 6.25pm and recorded his temperature as 36.7C. She noted that Mr Baker was drinking water, when encouraged, and was able to sit up on the side of his bed.

52. At 8.00pm, a mental health nurse saw Mr Baker dribbling from the left side of his mouth. A grip examination showed some strength on his left side but weakness on his right side. Mr Baker was confused following commands and appeared lethargic, but his eyes were able to follow the nurse's finger. The nurse asked for a non-emergency ambulance to take Mr Baker to hospital at 8.20pm.

53. At 8.50pm, a nurse saw Mr Baker and noted his speech was delayed and slurred, he had weakness on the right side of his body, and his oxygen saturation had dropped. She started oxygen therapy and observed Mr Baker at 15 minute intervals, while waiting for the ambulance.

54. The ambulance crew arrived at 9.40pm, and took over the care for Mr Baker. Mr Baker left for the hospital at 9.58pm, accompanied by two officers and restrained with an escort chain.

55. In hospital, Mr Baker had a CT scan at 10.55pm and was diagnosed with a sinus tumour. Mr Baker had surgery at 1.35am on 16 September, where the tumour was partly removed. He was moved to the intensive care unit and kept in an induced coma. At 8.05am, a note in the bed watch log stated that the escort chain was removed.

56. Mr Baker was also diagnosed as suffering with hydrocephalus (a build up of fluid on the brain) and viral meningitis. He underwent a number of other tests and had emergency surgery on 22 September. Mr Baker never regained consciousness and a palliative referral was made on 10 October. Mr Baker was transferred to a hospice on 24 October. Mr Baker passed away at 10.00am on 25 October at the hospice.

Contact with Mr Baker's family

57. Mr Baker had no next of kin listed on his prison record and was estranged from his family. The prison appointed the residential manager as a family liaison officer on 16 September, and she found a number on Mr Baker's records for his father in Barbados.

58. On 16 September, the residential manager spoke to Mr Baker's second cousin, who said the family wanted nothing to do with him. Six days later, she spoke to Mr Baker's father, who initially said the family did not want to have anything to do with Mr Baker, but agreed to receive updates at prearranged times and only from her.

59. The residential manager continued to keep Mr Baker's father updated over the next few weeks. On 25 October, she called Mr Baker's father to inform him of Mr Baker's death. Following this contact, several attempts were made to call Mr Baker's father again, but the phone was never answered.

60. Mr Baker's funeral was held on 18 November. The prison arranged and paid for the funeral, in line with national instructions.

Support for prisoners and staff

61. The prison posted notices informing staff of Mr Baker's death, and offering support. The staff care team also offered support.

62. The prison posted notices informing other prisoners of Mr Baker's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Baker's death.

Post-mortem report

63. The Coroner found that Mr Baker died from a pulmonary thromboembolus (an obstruction of a blood vessel in the lungs, usually due to a blood clot) caused by deep vein thrombosis and craniopharyngioma (a type of brain tumour derived from the pituitary gland, which is a tiny organ found at the base of the brain).

Findings

Clinical care

64. The clinical reviewer accepted that Mr Baker's case was complex; his mental health problems and personality disorder made it difficult to communicate effectively with him. Mr Baker had a history of not cooperating with healthcare, and of not attending appointments. The clinical reviewer found that his refusal to attend the follow up appointment at the ENT clinic might have been critical.

65. Mr Baker showed many of the signs and symptoms attributable to sinus cancer, but the clinical reviewer acknowledged these are also similar to a number of other conditions. When Mr Baker was reviewed in isolation, these symptoms appear to have been misdiagnosed. The clinical reviewer suggested that Mr Baker may have been correctly diagnosed sooner in the community if his symptoms were collated by a smaller team of clinicians.

66. The prison referred Mr Baker to the ENT clinic in May, although a locum GP suspected a septal haematoma, so they may not have investigated this possibility in detail. The clinical reviewer observed that sinus cancer is rare in the UK, with an average of only 440 cases each year, and that while the ENT clinic would have experience of it, they would need a clear referral and information to enable them to make a diagnosis.

67. Between May and September, Mr Baker made repeated requests for pain relief; averaging 1g of paracetamol and 400mg of ibuprofen per day. He was not reviewed by a GP or member of healthcare staff until 2 September when his pain relief was refused. Mr Baker self harmed and threatened suicide during the summer in order to attract attention to his suffering, and it appears that he had little faith in the healthcare at Rye Hill during his last few months there. Several prisoners have expressed their concerns about the amount of pain Mr Baker was in, and that he was not receiving appropriate care while he was at Rye Hill.

68. We consider that Mr Baker should have been reviewed by a GP more promptly during this three month period when he was in regular receipt of pain killers. This might have led to an earlier diagnosis which could have made his condition treatable or at least minimised the suffering he endured. We make the following recommendations:

    The Head of Healthcare should ensure that clinicians consider a prisoner's overall symptoms in a holistic manner, so that any indicators of disease progression are quickly acted upon.

    The Head of Healthcare should ensure that prisoners who frequently request pain relief for an undiagnosed condition are referred to a GP promptly.

Restraints, security and escorts

69. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be

necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

70. A risk assessment was completed on 15 September prior to Mr Baker being taken to hospital. He was deemed to be violent and had threatened another prisoner and prison officer within the previous week. There was also intelligence dating from 2008 where he planned to take a nurse hostage to enable his escape. Healthcare staff made no observations at this point. A prison manager authorised two officers to accompany Mr Baker and restrain him with an escort chain (an escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer).

71. Mr Baker went into theatre at 1.35am on 16 September. There is no note on the escort or bedwatch log about his restraints being removed at this stage, but there is a note on his ACCT log stating that the restraints were removed at about 1.50am once Mr Baker was unconscious.

72. It is unclear from the log when Mr Baker was restrained after his operation, but there is a note on the ACCT log at 8.06am, stating that an officer authorised their removal after hospital doctors objected on medical grounds to their use.

73. A risk assessment was completed on 16 September which concluded that restraints were not required. Restraints were not used again.

74. We accept that Mr Baker presented a risk of violence and of escape, and we agree that the initial decision to use restraints was justifiable, notwithstanding Mr Baker's clearly deteriorating condition. However, we are concerned at the absence of meaningful input from healthcare into the initial risk assessment and that it appears that officers kept Mr Baker in restraints during the operation to remove his sinus tumour and when he was unconscious. The risk assessment appears to have been largely based on Mr Baker's historic risks, with little consideration of how his deteriorating health affected this risk, as the 2007 High Court judgment requires. Whenever restraints are used, the risk assessments must accurately reflect the risk posed at that time to ensure proportionality and to maintain human dignity. We make the following recommendation:

The Director and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

Compassionate release

75. Release on compassionate grounds is a means by which prisoners who are seriously ill, usually with a life expectancy of less than three months can be

permanently released from custody before their sentence has expired. A clear medical opinion of life expectancy is required. The criteria for early release for determinate sentenced prisoners are set out in Prison Service Order (PSO) 6000. Among the criteria is that the risk of re-offending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of the National Offender Management Service (NOMS).

76. Mr Baker was referred to palliative care on 10 October when he was considered to be terminally ill. Compassionate release was discussed at a multi-disciplinary meeting on 12 October. It was argued that Mr Baker had only been given 72 hours to live (though he lived for 13 days), but the compassionate release process would take three months. It was also pointed out that Mr Baker's family wanted nothing to do with him. Accordingly, the prison concluded that it would not be appropriate to consider compassionate release. While we understand the prison's position and recognise that an application would have been unlikely to succeed, we would still normally expect the process to have been commenced. However, in the circumstances we make no recommendation.

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PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141