Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Barimore a prisoner at HMP Littlehey on 15 July 2017

A report by the Prisons and Probation Ombudsman

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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.

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

Mr Michael Barimore died on 15 July 2017 of lung cancer, while a prisoner at HMP Littlehey. He was 72 years old. We offer our condolences to Mr Barimore's family and friends.

Although a referral to secondary care should have been made sooner to investigate unexplained chest and shoulder pain, overall we are satisfied that Mr Barimore's care at Littlehey was equivalent to that which he could have expected to receive in the community.

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

Richard Pickering
Deputy Prisons and Probation Ombudsman **February 2018**

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Summary

Events

1. On 12 September 2014, Mr Michael Barimore was sentenced to nine years imprisonment for sexual offences. He was sent to HMP Peterborough. On 20 April 2015, he was transferred to HMP Littlehey.

2. On 2 December 2015, a prison doctor examined Mr Barimore after he reported left sided chest pain that had started six weeks earlier. His chest was clear with no tenderness. The doctor diagnosed musculoskeletal pain and prescribed painkillers.

3. Mr Barimore continued to experience chest pain. He saw several doctors over the next few months who prescribed different painkillers and arranged blood tests and a chest X-Ray. Nothing of concern was identified. Mr Barimore saw a physiotherapist in April 2016, who gave him a programme of exercises, but he found these too painful. In July, he had X-Rays taken of his neck and spine but they did not identify anything untoward.

4. In August, Mr Barimore had a range of blood tests and the results showed some abnormalities. A doctor referred him to an orthopaedic specialist who saw Mr Barimore on 8 September, and arranged a Magnetic Resonance Imaging scan (MRI uses strong magnetic fields and radio waves to produce a detailed image of the inside of the body). The next day a prison doctor prescribed stronger opioid-based pain medication.

5. On 26 September, Mr Barimore had the MRI scan. The results showed he had pleural effusion (an accumulation of fluid in the chest or lungs) and collapsed vertebra. This was later confirmed as spinal metastases (malignant cancer growth, which is at a distance to the original site of the cancer). A hospital doctor told him he probably had cancer. Mr Barimore was referred to oncology and palliative care specialists who discussed treatment options with him.

6. In October, Mr Barimore spent two weeks in a local hospice for pain relief. He had additional tests, which confirmed that the origin of his cancer was in his lungs. The test results also showed adenocarcinoma (a type of cancerous tumor that can occur in several parts of the body), pleural effusion, bone metastases and adrenal metastases. A doctor completed a ‘do not attempt resuscitation’ (DNAR) form.

7. After his diagnosis, healthcare staff at Littlehey cared for Mr Barimore, supported by hospital and hospice specialists. Staff developed and implemented appropriate care plans. Mr Barimore began radiotherapy treatment immediately and chemotherapy in December. He spent short periods of time in hospital and hospice to help control his pain and manage his risk of infection.

8. In March 2017, Mr Barimore developed a small painful lump on the side of his forehead and further tests confirmed his cancer had spread. He continued to have palliative radiotherapy for pain relief but no further active treatment. His prognosis was considered to be less than three months.

9. On 5 July, Mr Barimore was admitted to a hospice. Prison healthcare staff contacted the hospice regularly and visited him on a number of occasions. On 12 July, healthcare and hospice staff discussed plans for Mr Barimore's discharge back to Littlehey but his condition deteriorated and he remained at the hospice, where he died of lung cancer on 15 July.

Findings

10. Mr Barimore first reported chest pain in December 2015. The pain gradually worsened and spread to his back and shoulder. Doctors considered his pain as musculoskeletal but pain relief medication was ineffective. Initial blood tests and X-Rays showed no abnormalities, but the level of pain remained unexplained. In August 2016, after further blood tests, staff referred him to specialist secondary care. In September 2016, Mr Barimore was diagnosed with lung cancer.

11. Mr Barimore's symptoms of ongoing and unexplained chest and shoulder pain should have triggered consideration of other causes sooner. National Institute for Health and Care Guidance (NICE) suggests that a secondary care opinion would have been appropriate in June 2016, or possibly earlier.

12. The clinical reviewer did not consider that the delay in a secondary referral had an impact on Mr Barimore's prognosis, but makes a recommendation to the prison regarding the introduction of a care pathway to consider other causes of severe long standing pain that does not respond to conventional treatment.

13. After his diagnosis, Mr Barimore had chemotherapy to treat his tumour and to stop it spreading and radiotherapy to relieve his pain. Healthcare staff implemented appropriate treatment and care plans, and discussed this with him. He spent time in hospital and hospice as necessary. The healthcare team at Littlehey were responsive to changes in treatment plans and medication.

14. We agree with the clinical reviewer that, despite a delay in referral to secondary care, the overall care Mr Barimore received at Littlehey was equivalent to that which he could have expected to receive in the community and post diagnostic care was of a good standard.

The Investigation Process

15. The investigator issued notices to staff and prisoners at HMP Littlehey informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

16. The investigator obtained copies of relevant extracts from Mr Barimore's prison and medical records.

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

18. We informed HM Coroner for Cambridgeshire and Peterborough District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

19. The investigator wrote to Mr Barimore's son to explain the investigation and to ask if he had any matters he wanted the investigation to consider. When he replied to say that he did, one of the Ombudsman's family liaison officers contacted him. Mr Barimore's son expressed concerns about ineffective pain relief and the timeliness of his father's diagnosis.

20. The investigation has assessed the main issues involved in Mr Barimore's care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.

21. Mr Barimore's son received a copy of the initial report. He did not make any comments.

22. We shared the initial report with the Prison Service. They pointed out some factual inaccuracies in relation to healthcare centre opening times and this report has been amended accordingly.

Background Information

HM Prison Littlehey

23. HMP Littlehey in Cambridge is a medium security prison holding approximately 1,200 men. A large proportion of the population are convicted of sexual offences.

24. Northamptonshire Health Care Foundation NHS Trust commissions healthcare services. Prior to April 2015, Cambridgeshire and Peterborough NHS Trust provided healthcare services. The prison healthcare centre is open from 7.30am to 7.30pm, Monday to Friday, and from 8.00am to 5.30pm at weekends. A local practice provides GP services, and there is a range of nurse-led clinics. There are no inpatient beds at the prison.

HM Inspectorate of Prisons

25. The most recent inspection of HMP Littlehey was in March 2015. Inspectors reported that regular GPs had significantly improved patient care. Lifelong conditions were effectively identified and there was an appropriate range of clinics, led by specialist nurses. Hospital appointments were rarely cancelled. Risk assessments for keeping medications in-possession were not always appropriate.

Independent Monitoring Board

26. 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 January 2017, the IMB reported that healthcare provision and availability was broadly comparable with that in the community. The report recognised the significant demands placed upon prison and healthcare staff by the ageing prison population but highlighted a number of successful local initiatives. It highlighted the need for a national strategy for older offenders.

27. Shortfalls in staffing were often exacerbated by the need to escort elderly prisoners to hospital and provide supervision. This reduced the number of staff for day to day duties, impacting on out of cell time. The board repeated its regret that the End of Life suite, completed in 2013, remained unused, reportedly due to lack of funding.

Previous deaths at HMP Littlehey

28. Mr Barimore was the thirteenth prisoner to die of natural causes at HMP Littlehey, since January 2016. There are no significant similarities with those cases.

Findings

The diagnosis of Mr Barimore's terminal illness and informing him of his condition

29. On 12 September 2014, Mr Michael Barimore was sentenced to nine years imprisonment for sexual offences. He was sent to HMP Peterborough. On 20 April 2015, he was transferred to HMP Littlehey. At his initial health screen at Littlehey, Mr Barimore told a nurse that he took medication for high blood pressure and suffered from tinnitus (ringing in the ears).

30. On 2 December 2015, prison GP examined Mr Barimore after he reported left sided chest pain that he had had for the past six weeks. His chest was clear with no tenderness and the GP diagnosed musculoskeletal pain. He agreed to review Mr Barimore and consider a chest X-Ray in a month if there was no improvement.

31. Mr Barimore continued to experience chest pain and on 22 December, prison GP examined him. Again, Mr Barimore's chest was clear with no local tenderness. He told the GP that paracetamol did not ease the pain and the GP prescribed co-codamol (a pain killer). The GP noted in the medical record that Mr Barimore was awaiting a chest X-Ray.

32. The prison GP saw Mr Barimore again on 12 January 2016. His condition had not improved. Again, he noted that Mr Barimore was awaiting a chest X-Ray. He arranged blood tests and prescribed ibuprofen. Mr Barimore continued to report chest pain at a follow up appointment with him on 2 February. He said that ibuprofen did not help. The results of the tests, including the chest X-Ray, were normal and the GP remained unsure of the cause of the pain. He arranged an electrocardiogram (ECG), a test that records the rhythm and electrical activity of the heart, and prescribed a different painkiller naproxen.

33. Mr Barimore saw a different GP on 16 February, and again on 24 March. He continued to report chest pain, which had now moved to his shoulder. As before, GPs considered Mr Barimore's pain to be musculoskeletal and treated him accordingly.

34. On 18 April, a prison GP examined Mr Barimore. He continued to report upper back and chest pain. She confirmed that the results from a recent ECG and chest X-Ray were normal and the pain seemed to be muscular. She referred Mr Barimore to the physiotherapist.

35. On 31 May, a physiotherapist examined Mr Barimore and completed an assessment of his movement and pain. He diagnosed costovertebral dysfunction (an injury in the joints connecting the ribs to the spine) and advised exercise. Mr Barimore returned for a follow up appointment on 23 June. He was still in pain and unable to do exercise without taking painkillers. Mr Barimore asked for stronger pain relief and the physiotherapist considered that he might be 'drug seeking'. He advised him to continue to build up his exercises.

36. A prison GP examined Mr Barimore again on 4 July. He told her that he found exercise too difficult. He continued to take paracetamol, co-codamol and anti-inflammatory drugs but they did not help. She arranged a neck and spine X-Ray

and prescribed amitriptyline (used to treat symptoms including chronic long-term pain caused by arthritis, spinal problems and fibromyalgia).

37. On 13 July, Mr Barimore had the X-Ray. Due to a delay in receiving the results (which showed no abnormalities), he was not seen by a GP until 19 August, when a GP examined him. Mr Barimore described ten months of pain. He arrived at his appointment in a wheelchair and told the doctor he could no longer walk and the painkillers did not help. She requested a PSA test (a blood test used primarily to screen for prostate cancer), bone profile, a range of blood tests and weight monitoring. She agreed to see him again in a week. She suspected that Mr Barimore was suffering from old scoliosis (an abnormal curvature of the spine) and osteoarthritis but was unsure due to the high level of pain that he was experiencing.

38. The GP saw Mr Barimore again on the morning of 26 August. He said that he had stopped taking painkillers as they were not helping and he thought he should be in hospital. They discussed the results of his blood tests, which showed some abnormalities and she referred him to hospital orthopaedics.

39. When the GP saw Mr Barimore again on 2 September, Mr Barimore had lost over 10 kg in weight. She was concerned and after speaking to the on call orthopaedic doctor, she changed Mr Barimore's referral from 'routine' to 'urgent' under the two week cancer referral pathway. Under the NHS pathway, patients with suspected cancer are required to be seen by a specialist within two weeks and to start treatment within 31 days thereafter.

40. On 8 September, Mr Barimore was seen in the orthopaedic department at hospital (within the 2 week waiting timescale). The consultant considered that he was suffering from a multi-level degenerative condition of the spine, but requested a Magnetic Resonance Imaging scan to complete a diagnosis (MRI uses strong magnetic fields and radio waves to produce a detailed image of the inside of the body). A GP saw him the next day and prescribed tramadol (opioid-based pain medication), and asked him to keep a pain diary.

41. Prison doctors monitored the use of tramadol but it had little effective impact. On 19 September, a prison GP considered prescribing morphine but was advised against it without a firm diagnosis.

42. On 20 September, Mr Barimore was taken to A&E at the hospital due to his pain, but was discharged from hospital the same day. A prison GP saw him the next day and prescribed baclofen, a muscle relaxant.

43. On 26 September, Mr Barimore had an MRI scan at the hospital. It showed he had pleural effusion (an accumulation of fluid in the chest or lungs) and collapsed vertebra, later confirmed as spinal metastases (the term used for malignant cancer growth, which is at a distance to the original site of the cancer). The hospital doctor told Mr Barimore he probably had cancer.

44. A prison GP saw Mr Barimore the next day. He told her that the hospital doctor had said that he had probable cancer and if that were the case, he would just have to deal with it. He had an appointment arranged for 30 September, to drain

the fluid from his lungs. She prescribed morphine with immediate effect for his pain.

45. Mr Barimore was now under the care of the Oncology department at the hospital. On 29 September, a specialist palliative care consultant spoke with him and confirmed that it was likely that he had developed cancer and that treatment options would depend on the outcome of further tests.

46. On 6 October, Mr Barimore was admitted to a hospice for two weeks. He was prescribed a fentanyl patch (an opioid pain medication with a rapid onset and short duration of action) to help with his pain relief. He had additional diagnostic tests and on 13 October, his consultant clinical oncologist confirmed that the origin of his cancer was in his lungs. He was also diagnosed with adenocarcinoma (a type of cancerous tumor that can occur in several parts of the body), pleural effusion, bone metastases and adrenal metastases. The consultant explained this to Mr Barimore and proposed palliative radiotherapy.

47. While at the hospice, a doctor completed ‘do not attempt resuscitation’ (DNAR), form with Mr Barimore. (In the event of cardiac or respiratory arrest no attempt at resuscitation would be made. All other appropriate treatment and care would continue to be provided.) The DNAR remained under review until Mr Barimore’s death. Mr Barimore returned to Littlehey on 21 October.

48. It was not until August 2016, that a doctor considered that there may be underlying reasons for Mr Barimore’s history of ongoing pain and referred him to the hospital orthopaedics department he clinical reviewer considers that Mr Barimore’s symptoms of ongoing unexplained chest and shoulder pain should have triggered earlier consideration of other possible causes. Although initial tests and a chest X-Ray did not identify any abnormalities, Mr Barimore’s continued pain was described as severe and did not respond to conservative treatment.

49. In these circumstances, the National Institute for Health and Care Guidance (NICE) suggests that a secondary care opinion would have been appropriate in June 2016, after three months of treating the shoulder pain, and possibly earlier if the chronic chest pain was also considered.

50. The clinical reviewer does not consider that the delay in a secondary referral had an impact on Mr Barimore’s prognosis but has made a recommendation regarding the introduction of a care pathway to consider other causes of severe, long standing pain that does not respond to conservative treatment. We do not repeat the clinical reviewer’s recommendation but draw it to the attention of the Head of Healthcare to address.

Mr Barimore’s clinical care

51. After his diagnosis, healthcare staff at Littlehey cared for Mr Barimore, supported by specialists from the hospital and the hospice. They developed care plans to help manage palliative care, mobility and pain, and later dyspnoea (breathing difficulty), skin integrity and radiotherapy care.

52. Mr Barimore continued with radiotherapy treatment after his return to prison. He had his medication ‘in-possession’, meaning that he had it with him and could

self administer. Initially, this did not include his oramorph (morphine) which he had to take at the healthcare centre. However, after discussion between prison and healthcare staff he was later allowed oramorph in a bottle for overnight use. Doctors regularly reviewed and amended the dose as necessary.

53. On 25 October, a prison GP reviewed Mr Barimore in his cell. He said that he was fine with the pain and that it was better when he was lying down. She arranged for Mr Barimore's mattress to be replaced and when another GP saw him on 11 November, he confirmed that this had helped. He told the GP that he was generally comfortable and eating well. The GP noted in the medical records that Mr Barimore's prognosis at that time depended on his response to chemotherapy.

54. On 16 November, Mr Barimore saw the consultant oncologist at the hospital and they discussed chemotherapy treatment. The consultant explained that the treatment involved a risk of sepsis, and as a precaution, his temperature needed monitoring. The consultant wrote to the prison to explain this and the healthcare team developed a neurosepsis care plan. Chemotherapy was planned to be every three weeks beginning on 7 December.

55. On 20 November, Mr Barimore was admitted to hospital when healthcare staff were unable to control his severe pain. A nurse manager visited him on the ward the next day and he told her that his medication had been altered and the pain was under control. He was referred to the palliative care team for pain management. A nurse spoke to Mr Barimore later that evening and they discussed resuscitation and end of life care. Mr Barimore said he wanted to be cared for at his son's home and, if that was not possible, at the hospice. On 23 November, he was discharged from hospital was sent back to Littlehey.

56. Mr Barimore had chemotherapy treatment on 7 December and again on 30 December. He was also still having radiotherapy. On 30 December, the palliative care consultant reviewed him and recorded that he was responding well to treatment. Mr Barimore's other main concern was leg oedema (swelling caused by fluid retention). He was prescribed diuretic medication and stockings.

57. On 23 January 2017, Mr Barimore had more chemotherapy treatment and a blood transfusion. When a nurse spoke to him on 28 January, he asked about rescinding his DNAR as he felt so well. After some discussion, Mr Barimore agreed to keep the DNAR in place.

58. Mr Barimore's legs continued to swell and when a prison GP reviewed him on 3 February, she described him as having gross cellulitis (an infection of the deeper layers of the skin and underlying tissue), which was not responding to antibiotics. He remained at risk of sepsis and the GP arranged for his admission to hospital for review. On the way to hospital, Mr Barimore told the ambulance crew that he wanted to rescind the DNAR and receive all treatment. He was discharged from hospital the same day having had his medication changed. Mr Barimore's consultant reviewed him again on 7 February, they discussed the DNAR and he agreed to keep it in place.

59. Though Mr Barimore's legs improved with the change of medication, on 8 February he was admitted to a hospice for intravenous antibiotic therapy and

assessment. He returned to Littlehey on 14 February, but on 23 February was admitted to hospital for more antibiotic therapy. He returned to prison on 1 March. While an inpatient, Mr Barimore missed some chemotherapy treatment and due to the cellulitis could not receive it.

60. On 17 March, a prison GP examined Mr Barimore after he reported a small painful lump on the side of his forehead. He continued to receive specialist care and had further tests. Healthcare staff saw him regularly in line with his various care plans.

61. On 17 May, Mr Barimore saw his oncologist who confirmed that the results of a recent scan indicated that his cancer had spread. He considered the lump on Mr Barimore's temple to be a further spread to his brain. Palliative radiotherapy was planned but they also discussed immunotherapy (therapy using medicine to stimulate the immune system to recognise and destroy cancer cells).

62. On 27 May, a nurse saw Mr Barimore. He told her that he was having radiotherapy to the lump on the side of his head but that a second lump had been found at the base of his skull and that this pressed on the optic nerve and caused him double vision. More radiotherapy was planned for June but Mr Barimore could not begin immunotherapy.

63. Mr Barimore had daily radiotherapy to his brain between 6 and 9 June in an attempt to reduce his double vision. A prison GP saw him on 20 June, when he reported increased back pain and reduced sensation in his feet. She sent him to hospital, where the medical team arranged an MRI scan before returning him to prison. The next day, an oncology doctor told him that he was not suitable for immunotherapy due to his current condition and instead arranged further support from the palliative care team.

64. On 26 June, Mr Barimore's consultant reviewed him as a follow up to his meeting with the oncologist. She noted that he had deteriorated considerably since she last saw him in April. The consultant confirmed that he was not well enough to begin immunotherapy and had no active treatment planned. Mr Barimore could move around his cell but otherwise used a wheelchair. He complained of constipation and she prescribed laxatives. The consultant noted that his prognosis was now likely to be less than three months.

65. On 28 June, Mr Barimore was admitted to hospital after a fall and had a suspected fractured shoulder. While there as an inpatient, he had his planned MRI scan. He returned to Littlehey on 3 July, and a prison GP reviewed him in his cell the next day. Mr Barimore said he had double vision and back pain. He could not get in or out of bed without help or get to his medication locker. She contacted the hospice, who agreed to admit him the next day.

66. Prison healthcare staff contacted the Hospice regularly and visited Mr Barimore on a number of occasions. Hospice staff described him as comfortable and able to mobilise.

67. A nurse visited Mr Barimore on 12 July, and discussed his discharge with hospice staff who no longer felt he needed to be there. Mr Barimore needed oxygen and a social care package and the nurse sent a referral for a social care

assessment to the prison team. The nurse also spoke to Mr Barimore's oncologist, who confirmed that it was no longer appropriate for him to have his medication in-possession and that this would have to be administered.

68. The prison outlined plans for Mr Barimore's return to prison but on 14 July, his oncologist contacted them to say that his condition had deteriorated and his discharge from the hospice was no longer appropriate.

69. On 15 July, Mr Barimore died from lung cancer at the hospice at 5.00pm.

70. When Mr Barimore was diagnosed with lung cancer, it had already spread. He had chemotherapy to try to reduce the tumour and stop its spread to other organs and radiotherapy to relieve his pain. Specialist oncology, palliative care consultants, and prison GP's discussed treatment plans with him. Mr Barimore spent time in hospital and at a local hospice where good communication between staff was maintained.

71. The healthcare team at Littlehey were responsive to changes in treatment plans and medication. Care plans were appropriate and regularly reviewed. We are satisfied that post diagnostic care was of a good standard and equivalent to that which Mr Barimore could have expected to receive in the community.

Mr Barimore's location

72. For the majority of his time at Littlehey, Mr Barimore lived on 'I' wing, a wing for older prisoners. In October 2016, staff gave him the option to move to a larger, specially adapted cell, on a different wing, when he returned to Littlehey after a two week hospital admission. Mr Barimore did not want to move and told staff that he preferred to stay where he was, with his friends.

73. In February 2017, Mr Barimore spent a week at the hospice. He returned to the hospice on 4 July, for specialist, end of life care. There was some discussion about Mr Barimore's discharge back to Littlehey and a care plan with social care support was arranged. However, due to his deteriorating condition, Mr Barimore stayed at the hospice until his death on 15 July.

74. We are satisfied that Mr Barimore was appropriately located in accordance with his wishes.

Restraints, security and escorts

75. When prisoners have to travel outside of the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk taking into account factors such as the prisoner's health and mobility.

76. From the beginning of January 2017, until the time of his death, Mr Barimore went to hospital for treatment on twenty four separate occasions. He had nine appointments in January and February, during which two officers went with him and restrained him using 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). Within this period, he also spent a week in a local hospice where no restraints were used.

77. From March onwards, Mr Barimore went to hospital accompanied by two officers but, almost exclusively, without any restraints. (There was one single hospital appointment in April when restraints were used.) He was not restrained when he began radiotherapy treatment on 5 June, or during his hospital and hospice admissions in late June and July.

78. We are satisfied that overall, the use of restraints was appropriately considered.

Liaison with Mr Barimore's family

79. On 21 November 2016, after Mr Barimore's readmission to hospital, a prison officer contacted Mr Barimore's son, his nominated next of kin. He explained that he was the prison family liaison officer and arranged for Mr Barimore's son to visit him in hospital. He stayed in contact until after Mr Barimore's discharge and return to prison.

80. On 28 June 2017, two senior prison managers visited Mr Barimore in hospital after his admission with a suspected fractured shoulder. One manager explained that they had taken over responsibility for liaison with his family. Mr Barimore said that he kept in regular contact with his son who visited him weekly. The manager later contacted Mr Barimore's son to discuss the arrangements for his next visit.

81. Both managers had regular contact with Mr Barimore's son over the next two weeks. They kept him updated about Mr Barimore's condition and helped with visiting arrangements. On 15 July, a manager telephoned Mr Barimore's son after a significant deterioration in his father's condition. He advised him to consider visiting him as soon as he could.

82. Mr Barimore's son was with him when he died. A manager spoke to him shortly afterwards and offered his condolences. They briefly discussed some of the practical issues to follow, including coroner and funeral arrangements, and agreed to speak again the next day.

83. A manager spoke to Mr Barimore's son regularly during the next few weeks. He offered for the family to visit the prison and to attend the prison memorial service. He also explained that the prison would contribute towards the funeral costs.

84. Mr Barimore's funeral was held on 9 August. The prison contributed towards the cost in line with prison service instructions.

Compassionate release

85. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months.

86. The prison first considered the possibility of release on compassionate grounds in November 2016, but it was not until 9 March 2017, that Littlehey submitted an

application to the Public Protection Casework Section (PPCS) of the Her Majesty's Prisons and Probation Service for consideration.

87. On 5 April, the prison received the decision. PPCS officials refused the compassionate release application because Mr Barimore did not meet the necessary criteria. Specifically, at that time, his life expectancy was not assessed to be three months or less and although clearly very ill, he was not physically incapacitated.

88. However, the Governor at Littlehey kept Mr Barimore's case under review and on 28 June, after deterioration in his condition, the prison began a second application for his compassionate release. Mr Barimore died before staff submitted this application.

89. We consider that compassionate release was appropriately considered.

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