Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Murphy, a prisoner at HMP Risley, on 11 March 2019

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*

OGL

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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 John Murphy died on 11 March 2019, of pneumonia following a stroke, while a prisoner at HMP Risley. He was 84 years old. I offer my condolences to Mr Murphy's family and friends.

The investigation found that several aspects of Mr Murphy's care were not managed in line with national guidelines and were below the standard he could have expected in the community. There were weaknesses in continuity of care at HMP Liverpool and Risley, as healthcare staff did not obtain Mr Murphy's community records promptly and no secondary health screen was conducted at Risley. Mr Murphy's blood pressure was not monitored regularly and nurses did not consistently use clinical assessment tools, or take neurological observations after falls. When he was last admitted to hospital, the prison did not keep in regular contact with hospital staff for updates on Mr Murphy's condition.

I am also concerned that prison managers authorised the use of restraints, although Mr Murphy had limited mobility which had been further impaired by the after-effects of a stroke. The prison failed to give priority to authorising the removal of the restraints when an escort officer expressed concerns about the impact on Mr Murphy's rehabilitation.

I am also concerned that incomplete contact details for Mr Murphy's next of kin led to a delay of seven days before she was informed that he was seriously ill and had been admitted to hospital.

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

Sue McAllister CB
Prisons and Probation Ombudsman **October 2019**

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Summary

Events

1. On 16 February 2018, Mr John Murphy was sentenced to three years in prison. He was sent to HMP Liverpool, where healthcare staff noted that his medical conditions included high blood pressure and previous chronic lymphoid leukaemia, as well as mobility, memory and hearing problems.

2. Mr Murphy transferred to HMP Risley on 1 March. A nurse conducted an initial health screen and a prison GP re-prescribed his blood pressure medication. In the following months, some readings showed that Mr Murphy's blood pressure was raised. He was also diagnosed with a mild cognitive disorder and had recurrent falls. Healthcare staff created a disability care plan, arranged social care and provided disability aids.

3. In the early hours of 22 February 2019, the night officer found Mr Murphy on the floor and radioed a medical emergency. A nurse examined Mr Murphy, asked the night officer to monitor him and arranged for the prison GP to review him later in the morning.

4. At around 9.00am, a further emergency was called after some prisoners found Mr Murphy in his cell, showing symptoms of a stroke. Mr Murphy was taken to hospital and doctors diagnosed a right-sided stroke. His condition worsened and he died at 10.30pm on 11 March.

Findings

5. Reception healthcare staff at Liverpool and Risley did not comply with the National Institute for Health and Clinical Excellence (NICE) guidelines on continuity of care, as Mr Murphy's community medical records were not requested during the reception procedures. In addition, Mr Murphy did not have a secondary health screen at Risley.

6. Mr Murphy had longstanding hypertension. Healthcare staff should have continued to monitor his blood pressure in prison, in accordance with the NICE guidelines on the management of hypertension. As this did not happen, Mr Murphy's clinical care was not of the required standard and not equivalent to that he could have expected to receive in the community.

7. Although healthcare staff sometimes used the National Early Warning Score (NEWS) tool to assess the severity of Mr Murphy's illnesses, scores were not always recorded in his medical records, or fully explained when considered alongside clinical observations.

8. There is no evidence that healthcare staff assessed Mr Murphy's level of consciousness with a recognised assessment tool, or followed the requirement in NICE guidelines to carry out neurological observations, after unwitnessed falls.

9. After Mr Murphy was admitted to hospital, healthcare staff had limited contact with hospital clinicians. In 17 days, they only contacted the hospital four times

(on the latter occasion, at the hospital's request). We consider that they should have sought updates more frequently.

10. In spite of Mr Murphy's reduced mobility and advanced age, security risk assessments for hospital appointments and his final admission to hospital authorised the use of restraints. An escort officer noted that Mr Murphy had weakness on one side of his body and a cannula for intravenous treatment in one of his hands. When the officer expressed concern that the restraints might impair Mr Murphy's rehabilitation, several hours elapsed before the prison reviewed the risk assessment and authorised the escort staff to remove the restraints.

11. Mr Murphy's next of kin details were not fully completed when he went into prison. This led to a delay in notifying his next of kin when he became ill and was admitted to hospital.

Recommendations

- The Heads of Healthcare at HMP Liverpool and HMP Risley should ensure that, in line with NICE guidelines and PSO 3050 Continuity of Healthcare for Prisoners, reception staff routinely request prisoners' community health records.
- The Head of Healthcare at Risley should ensure that all new prisoners receive secondary health screens.
- The Head of Healthcare at Risley must develop a clear protocol for the management of prisoners with hypertension and ensure that prisoners with high blood pressure are effectively managed and monitored, in line with NICE guidelines.
- The Head of Healthcare at Risley should ensure that staff consistently use the National Early Warning Score (NEWS) system to assess and monitor patients with acute symptoms and to support clinical decision-making.
- The Head of Healthcare at Risley should ensure that prisoners at risk of falls have an appropriate risk assessment, in line with NICE guidelines and that after an unwitnessed fall, neurological observations are taken.
- The Head of Healthcare at Risley should ensure that there is regular and effective liaison with secondary care services when a prisoner is in hospital.
- The Governor should ensure that next of kin contact details are completed, kept up to date and readily available if a prisoner becomes seriously ill.
- The Governor and Head of Healthcare at Risley 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; are based on the actual risk the prisoner presents at the time; and are not used during serious or invasive treatment, unless there are exceptional reasons for doing so.
- The Governor should ensure that all relevant sections of the risk assessment are completed, including medical information on how the prisoner's current state of health has an impact on his mobility; and confirmation that prison staff have taken this information into account in assessing the prisoner's current level of risk.

The Investigation Process

12. Notices were issued to staff and prisoners at HMP Risley informing them of the investigation and asking anyone with relevant information to contact the investigator. Four prisoners indicated that they wished to see the investigator, but they did not respond when invited to provide information.

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

14. NHS England commissioned an independent clinical reviewer to review Mr Murphy's clinical care at the prison.

15. We informed HM Coroner for Cheshire of the investigation. He gave us the cause of Mr Murphy's death. We have sent the coroner a copy of this report.

16. Mr Murphy's wife, his next of kin, asked her sister and brother-in-law to act on her behalf. One of the Ombudsman's family liaison officers contacted them to explain the investigation. They had no specific concerns for the investigation to consider.

17. Mr Murphy's sister and brother-in-law received a copy of our initial report. They commented that they had no concerns at the beginning of the investigation, as they had previously been assured by the prison that Mr Murphy was being well cared for and was in good spirits. They were shocked and distressed by the findings of the investigation. They wished to thank Mr Murphy's 'buddy', staff and prisoners who had showed compassion to him, the escort officer who asked for his restraints to be removed and prisoners who had offered to give information.

18. The initial report was shared with HM Prisons and Probation Service. They identified no factual inaccuracies. They accepted our recommendations and their action plan has been annexed to this report.

Background Information

HMP Risley

19. HMP Risley is a medium security training prison, which holds over 1,000 convicted men. Bridgewater Community Healthcare NHS Trust provides healthcare services in the prison. There is 24-hour healthcare cover, with a doctor on duty during the day and nurses on duty overnight. The prison also has access to regional inpatient places at other prisons, including HMP Preston, HMP Liverpool, HMP Manchester.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Risley was in June 2016. Inspectors reported that health services were reasonable, but governance and oversight were underdeveloped. The range of primary care services was adequate, although prisoners waited too long to see a GP. Inspectors found that secondary health screens were not routinely completed, information for prisoners was poor and the management of chronic diseases required improvement. Social care arrangements were excellent and there was effective liaison with the local authority.

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 2018, the IMB reported that the healthcare accommodation was clean and well-equipped and feedback from a patient survey was good. A healthcare improvement adviser attended several times a week and contributed to implementation of the Prison Health Improvement Plan, a multidisciplinary approach to wellbeing across the prison.

Previous deaths at HMP Risley

22. Mr Murphy was the ninth prisoner to die at Risley since March 2017. Two of the previous deaths were due to natural causes, one was a homicide, two were self-inflicted, two were drug-related and the cause of death has yet to be established in the other case. We have previously made recommendations on risk assessments and the use of restraints.

Key Events

23. On 16 February 2018, Mr John Murphy was sentenced to three years in prison, for historic sexual offences and sent to HMP Liverpool. It was his first time in prison.

24. At an initial health screen, a nurse recorded that Mr Murphy had high blood pressure, previous chronic lymphoid leukaemia, as well as mobility and memory problems. The nurse referred Mr Murphy to the GP, to the older persons' practitioner, and for a social care needs assessment. He also noted that he should be allocated a ground floor cell. A prison GP then reviewed Mr Murphy and re-prescribed amlodipine (a medication to treat high blood pressure and coronary heart disease).

25. A nurse conducted a secondary health screen on 26 February, noting that Mr Murphy had a history of high blood pressure and hearing loss.

Transfer to HMP Risley

26. Mr Murphy transferred to HMP Risley on 1 March. A nurse conducted a health screen. She noted Mr Murphy's history of high blood pressure and took a further reading, which showed that his blood pressure was raised. (Some of his subsequent blood pressure readings also showed raised levels.) The nurse referred Mr Murphy to the GP. There was no secondary health screen.

27. On 15 March, a prison GP reviewed Mr Murphy and his medication and continued the amlodipine. He also requested blood tests and a wheelchair assessment (which was conducted later that day). Shortly after the consultation, Mr Murphy's community GP telephoned the prison GP to advise that Mr Murphy had been diagnosed with lymphoid leukaemia and was under the care of a consultant haematologist at Aintree University Hospital. The prison GP later re-referred him to this specialist.

28. In April, Mr Murphy had recurrent falls. It was noted that a risk assessment was completed and he was referred to the falls prevention clinic. (The risk assessment could not be found in the medical records.)

29. At an appointment on 19 April, a prison GP diagnosed a mild cognitive disorder and referred Mr Murphy to the memory clinic.

30. On 15 May, a community occupational therapist from Warrington Borough Council assessed Mr Murphy and recommended a pendant alarm and social care package. Mr Murphy declined to receive any care or assistance.

31. On 17 June, it was noted in Mr Murphy's personal records that he had a disability care plan due to a spinal injury, hearing impairment, dementia, limited use in both hands and his left arm and used a walking aid, but was waiting for a wheelchair.

32. Over the next few months, Mr Murphy was monitored by healthcare staff and attended outpatient hospital appointments for leukaemia and orthopaedic, cognitive and memory problems. He was allocated a prison buddy, who helped with cleaning, laundry and collecting meals.

33. On 5 October, Mr Murphy had a fall and was admitted to hospital. When he returned to Risley on 7 October, he agreed to a support package and was referred to a physiotherapist. (Mr Murphy had further falls in November and December.)

34. On 10 October, it was noted in Mr Murphy's personal records that a further assessment for external social care had taken place (on 4 October), in consultation with his wing carer and healthcare staff. Formal social care was approved and began on 16 October. The same day, a mental capacity assessment was completed. (This was repeated on 18 December.)

35. Mr Murphy's key worker saw him frequently from 31 October. (A key worker is a prison officer, allocated to a prisoner to support them through their sentence, with weekly or fortnightly contact.)

36. On 6 February 2019, a nurse reviewed Mr Murphy and found that his blood pressure was raised. The nurse created cardiovascular disease management and hypertension care plans and tasked the pharmacy to start anti-hypertensive medications. It is unclear whether they were prescribed. A further check on 14 February, showed Mr Murphy's blood pressure was raised.

37. At 4.40am on 22 February, a member of staff found Mr Murphy on the floor of his cell and called a code blue emergency. (A code blue indicates that a prisoner is unresponsive or has breathing difficulties.) A nurse attended and examined him. Mr Murphy was surprised and dazed and said he had been sleeping on the floor. The nurse thought that his bed might have been too high and needed to be adjusted. She checked there were no injuries and helped him back to bed. She asked the night officer (an operational support grade) to monitor him and record entries in the wing observation book. The nurse checked Mr Murphy again at around 6.00am and arranged for him to see the prison GP later in the morning.

38. At around 9.00am, prisoners on the wing found Mr Murphy in his cell, with symptoms of a stroke. A further code blue was called and a nurse attended. Mr Murphy was on his bed, alert, but with left-sided weakness, a left facial droop and difficulty speaking. An ambulance was called at 9.10am and paramedics took him to Warrington Hospital. Two prison officers escorted him, using restraints.

39. At 10.00am on 23 February, one of the escort officers advised the prison that due to minimal movement on one side of Mr Murphy's body and a cannula on his right arm, there was concern that the restraints might slow down his rehabilitation with the physiotherapy team. The restraints were removed at around 4.00pm.

40. Healthcare staff contacted the hospital for updates on 23 and 27 February and 3 March and were told that Mr Murphy had suffered a right-sided stroke.

41. On 7 March, the hospital telephoned the prison, asking the healthcare department to contact them about plans for Mr Murphy's discharge. The next day, the Healthcare Manager and the Head of Healthcare visited Mr Murphy and held a meeting with hospital staff in the stroke unit to discuss his care. He remained unwell and doctors prescribed end of life medication. The team discussed the options for accommodating Mr Murphy's end of life care, such as a nursing home.

42. In the afternoon of 11 March, the hospital telephoned to say that Mr Murphy had deteriorated and his end of life care would continue in hospital. Mr Murphy died at 10.30pm.

Contact with Mr Murphy's family

43. On 23 February, healthcare staff noted that Mr Murphy was mostly sleeping and that consideration had been given to contacting his next of kin, but he had not consented to this. During the first two days, escort staff asked him several times if he wanted his next of kin informed that he was in hospital. However, he was unable to communicate and they were unsure whether he understood them.

44. A prison manager was assigned as the prison's family liaison officer (FLO). On 25 February, he noted in the prison's family liaison log that there were no contact details for Mr Murphy's next of kin, so he tried to get this information from the Probation Service. On 28 February, the chaplaincy gave the FLO a telephone number for Mr Murphy's wife. The FLO attempted to contact her immediately but did not get through until the following day. He then explained what had happened and gave her the hospital details. The FLO remained in contact to answer queries and the prison chaplain arranged for the family to visit Mr Murphy. On 11 March, the prison passed on a request for Mr Murphy's family to go to the hospital, as his health was deteriorating.

45. On 12 March, the FLO telephoned Mr Murphy's wife and offered his condolences. The next day, he visited her to explain the processes to be followed. Mr Murphy's brother-in-law and sister-in-law were also there. He invited them to visit the prison and see Mr Murphy's cell and remained in frequent contact to provide additional support. The prison held a memorial service on 24 March and Mr Murphy's next of kin attended. Mr Murphy's funeral took place on 27 March. In line with national policy, the prison contributed to the funeral expenses.

46. Mr Murphy's next of kin told the investigator that they very impressed with the support given by the FLO and chaplaincy staff after Mr Murphy's death.

Support for prisoners and staff

47. The prison posted notices informing staff and other prisoners of Mr Murphy's death, and offering support.

Post-mortem report

48. The Coroner confirmed that the cause of Mr Murphy's death was 1a aspiration pneumonia, 1b stroke.

Findings

Clinical care

Continuity of care

49. National Institute for Health and Clinical Excellence (NICE) guidelines and PSO 3050 *Continuity of Healthcare for Prisoners* set out the expectation that prisons ensure continuity of care for prisoners on transfer. This includes considering relevant clinical information and carrying out a general health assessment, equivalent to a primary care assessment when registering with a new GP in the community. Following an inspection in June 2016, HM Chief Inspector of Prisons found that secondary health screens were not routinely completed at Risley.

50. Neither Liverpool, nor Risley obtained Mr Murphy's community medical records for up to date information about his health conditions and treatment. Mr Murphy did not receive a secondary health screen at Risley. We make the following recommendations:

The Heads of Healthcare at HMP Liverpool and HMP Risley should ensure that, in line with NICE guidelines and PSO 3050 *Continuity of Healthcare for Prisoners*, reception staff routinely request prisoners' community health records.

The Head of Healthcare at Risley should ensure that all new prisoners receive secondary health screens.

Management of Mr Murphy's high blood pressure

51. NICE guidelines on the management of hypertension emphasise the importance of regular monitoring and recording of blood pressure in hypertensive patients.

52. High blood pressure, if untreated, increases the risks of problems such as heart attacks and strokes. Mr Murphy's history of high blood pressure was identified on his reception into prison and was found to be raised during subsequent checks. Although he initially received medication, it was stopped in April 2018, without explanation. Mr Murphy was not referred to the prison's long-term conditions clinic or to the prison's GP for this condition and there is no evidence that a prescription request on 6 February 2019 was actioned. Appropriate care plans were put in place 11 months after Mr Murphy arrived at Risley.

53. The Head of Healthcare told the clinical reviewer that the failure to manage Mr Murphy's high blood pressure was due to staff shortages and the use of high numbers of agency staff, so it had been difficult to assign staff to clinics. She said that the healthcare department is now fully staffed and they are addressing the issue of running appropriate clinics. The Head of Healthcare also said that nurses and GPs had seen Mr Murphy regularly. However, the investigation found no evidence that they had conducted blood pressure reviews and no readings were recorded in the medical records. We agree with the clinical reviewer's findings that the management of Mr Murphy's high blood pressure was not equivalent to that he could have expected to receive in the community. We make the following recommendation:

The Head of Healthcare at Risley must develop a clear protocol for the management of prisoners with hypertension and ensure that prisoners with high blood pressure are effectively managed and monitored, in line with NICE guidelines.

Clinical assessments and use of the National Early Warning Score (NEWS)

54. The Royal College of Physicians National Early Warning Score (NEWS) tool is a system to identify the severity of acute illnesses and the risk of deterioration. The score is calculated after recording blood pressure, heart rate, oxygen saturations, breathing rate, level of consciousness or new confusion and temperature. The clinical reviewer found that the use of NEWS was inconsistent at Risley. Scores were often not recorded, or were not clarified alongside clinical observations. We make the following recommendation:

The Head of Healthcare at Risley should ensure that staff consistently use the National Early Warning Score (NEWS) system to assess and monitor patients with acute symptoms and to support clinical decision-making.

55. Mr Murphy had a number of falls at Risley and prison nurses assessed and treated him. However, the clinical reviewer found no evidence that they had used an assessment tool such as the Glasgow Coma Scale (GCS) to assess his level of consciousness, or completed neurological observations after these falls, as specified in NICE guidelines. Although an entry in the medical record indicated that a falls risk assessment had been completed following a fall in April 2018, the assessment was not in the record. We make the following recommendation:

The Head of Healthcare at Risley should ensure that prisoners at risk of falls have an appropriate risk assessment, in line with NICE guidelines and that after an unwitnessed fall, neurological observations are taken.

56. Mr Murphy was admitted to hospital on 22 February 2019 and remained there until his death on 11 March. Healthcare staff only contacted the hospital for updates four times (on the latter occasion in response to the hospital's request for contact about discharge planning). Healthcare managers then visited Mr Murphy on 8 March and discussed his care with members of the stroke unit.

57. We consider that healthcare staff should have maintained better and more frequent contact with hospital staff for updates on Mr Murphy's condition and to help plan his discharge when they expected him to be released from hospital.

The Head of Healthcare at Risley should ensure that there is regular and effective liaison with secondary care services when a prisoner is in hospital.

Emergency response

58. PSI 03/2013 on Medical Emergency Response Codes sets out the actions staff should take in a medical emergency. It states that if an emergency code is called over the radio, an ambulance must be called immediately. Staff should ensure there are no delays in calling an ambulance and it should not be a requirement

for a member of the healthcare team or a manager to attend the scene before calling an ambulance.

59. Risley's control room log indicates that the code blue emergency was called at 9.09am and that a nurse was attending. The next entry, at 9.15am, stated that the nurse "confirmed ambulance is required." The time of the phone call for an ambulance was not recorded. The nurse's entry in the medical record states that an ambulance was already on the way when the code blue was called. This is ambiguous, but we take it to mean that an ambulance had been called before she arrived at the cell.

60. Although the control room log suggests that there was at least a six-minute gap between the code blue and the request for an ambulance, North West Ambulance records show that the call was received at 9.10am. On balance, taking account of the ambulance records and the nurse's record, we accept that there was no delay. However, prison managers will wish to satisfy themselves that control room staff are aware of the requirement to request an ambulance immediately when a code blue is called.

Security risk assessments and the use of restraints

61. When prisoners have to travel outside of the prison, a risk assessment determines the nature and level of security arrangements, including restraints. 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.

62. 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.

63. Mr Murphy was an elderly category C prisoner, with reduced mobility. There had been no problems with his behaviour in prison. He went to hospital several times between October 2018 and February 2019. The medical section of most of the risk assessments indicated no objections to the use of restraints, and noted Mr Murphy's use of a wheelchair. (Oddly, one of the healthcare staff recorded that there was no impaired mobility as he had a wheelchair.) Individual risk factors were reportedly based on Mr Murphy's OASys assessment and security staff assessed him as low risk to the public, adults and staff and medium risk to children. However, the OASys document viewed during the investigation had related these factors to his risk in the community and had indicated his risk in custody was low on every factor.

64. Despite the ratings on the individual elements, prison staff assessed Mr Murphy, overall, as a medium risk to the public. He was restrained with an escort chain for each hospital appointment, including during his journey and final admission to hospital after his stroke on 22 February. (The medical section of the risk assessment had not been completed for the latter journey.) On 23 February, when an escort officer raised concerns that the restraints would potentially impair

Mr Murphy's rehabilitation, it took around six hours for the prison to review his risk and authorise their removal.

65. The Prison Service has a duty to protect the public when escorting prisoners outside prison. It also has a responsibility to balance this by treating prisoners with humanity. We are concerned that in spite of Mr Murphy's age, poor mobility and an escort of two prison officers, prison staff concluded that he should be restrained. It is of particular concern that they seemed to misinterpret the OASys assessment and that they authorised restraints when Mr Murphy's mobility had been further impaired by an apparent stroke. We make the following recommendation:

The Governor 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; are based on the actual risk the prisoner presents at the time; and are not used during serious or invasive treatment, unless there are exceptional reasons for doing so.

The Governor should ensure that all relevant sections of the risk assessment are completed, including medical information on how the prisoner's current state of health has an impact on his mobility; and confirmation that prison staff have taken this information into account in assessing the prisoner's current level of risk.

Next of kin details

66. Prison Rule 22 instructs that prisons should inform the next of kin immediately if a prisoner becomes seriously ill. There was an unacceptably long delay in notifying Mr Murphy's next of kin, his wife, that he was in hospital. This was because prison staff had only recorded the name of his next of kin, but no contact details during Mr Murphy's reception into prison. They had also listed her as his daughter, rather than his wife. We make the following recommendation:

The Governor should ensure that next of kin contact details are completed, kept up to date and readily available if a prisoner becomes seriously ill.

67. We are satisfied that once contact was made, the prison's family liaison officer provided a high level of support to Mr Murphy's next of kin.

Compassionate release

68. 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.

69. As the prison did not maintain regular contact with the hospital, it is unclear exactly when Mr Murphy's end of life care began. Healthcare staff became aware of it when they visited on 8 March. Mr Murphy's condition deteriorated very quickly and there is no evidence that his life expectancy was confirmed. The prison did not make an application for compassionate release. However, we

are satisfied that, in the circumstances, there was insufficient information to support such an application.

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