Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Green, a prisoner at HMP Forest Bank, on 23 June 2018

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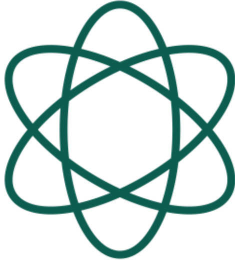
Our vision

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.

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 Paul Green died on 23 June 2018 due to brain cancer while a prisoner at HMP Forest Bank. He was 55 years old. I offer my condolences to Mr Green's family and friends.

The standard of care Mr Green received at HMP Forest Bank was not equivalent to that he could have expected to receive in the community.

There were multiple failings including staff giving incorrect doses of medication, no treatment plan or monitoring when Mr Green started chemotherapy at the prison, a delay in setting up an end of life care plan and a failure to carry out a formal mental capacity assessment when Mr Green refused treatment.

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

Elizabeth Moody
Deputy Prisons and Probation Ombudsman **June 2019**

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Summary

Events

1. On 20 March 2017, Mr Paul Green was remanded in prison custody, charged with violent offences, and sent to HMP Forest Bank. When he arrived, he told the reception nurse he had undergone surgery for a brain tumour in 2015, and that a recent scan suggested it had returned.

2. In June 2017, specialists confirmed that Mr Green had a brain tumour and that his prognosis was two to five years with treatment. In July, Mr Green underwent surgery to remove the tumour, followed by chemotherapy treatment that was administered by prison healthcare staff. Mr Green sometimes refused treatment.

3. Over the next year, Mr Green's condition deteriorated. He died at the prison on 23 June 2018 of bronchopneumonia, a complication arising from his brain cancer.

Findings

4. The clinical reviewer found that the standard of care Mr Green received at HMP Forest Bank was not equivalent to that he could have expected to receive in the community.

5. The clinical reviewer identified a worrying catalogue of failings, including staff not referring Mr Green for mobility or social care assessments, hospital correspondence not being added to Mr Green's electronic medical record, staff's failure to carry out a mental capacity assessment when Mr Green refused treatment and end of life care plans not being set up. There were also very worrying medication errors, including errors in administering Mr Green's chemotherapy medication, a lack of a treatment plan and monitoring when Mr Green was undergoing chemotherapy treatment, and key medication being out of stock or out of date.

Recommendations

- The Head of Healthcare should ensure that all staff consider the range of assessments and interventions that might be relevant to a prisoner and make appropriate referrals.

- The Head of Healthcare should review the current system for logging correspondence ensuring important information is accessible to staff and actioned appropriately.

- The Head of Healthcare should ensure staff are familiar with the principles covered by NICE Guidance NG99 and NG108, and that formal mental capacity assessments are carried out where appropriate.

- The Head of Healthcare should ensure staff are familiar with and apply the principles of the Gold Standards Framework where appropriate.

- The Head of Healthcare should ensure that where a prisoner is undergoing chemotherapy at the prison, staff formulate treatment plans, monitor that individual and record general observations.
- The Head of Healthcare should ensure adequate stocks of required medication are available.
- The Head of Healthcare should review the system in place to record, investigate and prevent future medication errors.

The Investigation Process

6. The investigator issued notices to staff and prisoners at HMP Forest Bank informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

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

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

9. We informed HM Coroner for Greater Manchester West District of the investigation. The coroner informed us of the cause of death. We have sent the coroner a copy of this report.

10. The investigator wrote to Mr Green's family to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They did not respond to our letter.

11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and, where we agree, this report has been amended accordingly. The action plan has been annexed to this report.

Background Information

HMP Forest Bank

12. HMP Forest Bank is a local prison in Salford, serving courts in the North West. It holds up to 1,460 remanded and sentenced men. The prison is managed by Sodexo Justice Services. Sodexo provides primary health care services. There is a 19-bed inpatient unit with 24-hour nursing cover. An agency provides GP services with doctors available from 9.00am to 9.00pm Monday to Friday, 1.00pm to 5.00pm Saturday and 9.00am to 12.00pm Sunday. There is out of hours cover at other times.

HM Inspectorate of Prisons

13. The most recent inspection of HMP Forest Bank was in February 2016. Inspectors reported that most areas of health provision were reasonable, but some required considerable improvement. Prisoners had access to an appropriate range of primary care services and visiting specialist services. Urgent same-day appointments were available, but waiting times for routine appointments were slightly long. Long-term conditions were well managed.

14. The Care Quality Commission (CQC) undertook a focused inspection of healthcare provision at Forest Bank in October 2017 to follow up 'Requirement Notices' that were issued following a previous focused inspection in December 2016. In December 2016, the CQC had found that patients with mild to moderate health issues did not have access to appropriate support and treatment to meet their needs. In October 2017, there had been no change or improvement.

Independent Monitoring Board

15. 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 31 October 2017, the IMB were satisfied with the overall quality of healthcare provision. They reported that there was a wide range of services, reasonable access to GPs and emergency appointments were dealt with in line with NHS standards.

Previous deaths at HMP Forest Bank

16. Since June 2015, there have been eight deaths at Forest Bank, including Mr Green's. Four have been from natural causes, three were self-inflicted and one related to substance misuse. There have been three deaths since. One was self-inflicted and two are awaiting classification.

Findings

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

17. Mr Paul Green was remanded in prison custody on 20 March 2017 and sent to HMP Forest Bank.

18. A nurse conducted Mr Green's reception health screen. Mr Green told her he had undergone surgery for a brain tumour in 2015 and that his last MRI scan (on 7 March 2017) indicated that the tumour had returned. He said he had another appointment at the Christie Clinic in six months' time. He said he sometimes got headaches, felt dizzy and had difficulty walking. He was refusing all medication, including anti-epilepsy medication. The nurse referred Mr Green for a mental health assessment as he reported a history of schizophrenia and anxiety, but he said he did not want treatment.

19. A prison GP also saw Mr Green on 20 March. Mr Green told him that his brain tumour had returned but he did not intend to go to his follow up appointment with the Christie Clinic due in June, or have any further treatment.

20. On 23 March, a mental health nurse conducted a mental health assessment but concluded that Mr Green required a fuller assessment and one to cover social care. (A nurse conducted a more detailed mental health assessment on 10 April, but there is no record of the social care assessment being done.)

21. On 28 March, a prison GP contacted Mr Green's community GP who confirmed his medical history and stated he was unaware of any significant mental illness. The same day, the prison was notified by the Christie Clinic that an MRI had shown evidence of a further abnormality in Mr Green's brain and that a further scan was needed.

22. On 18 April, a nurse told a prison GP that Mr Green had said he was worried about his health and would accept all advised treatment apart from chemotherapy.

23. On 2 May, a prison GP wrote to the consultant oncologist at the Christie Clinic, saying that Mr Green had said he was experiencing similar symptoms to those he had had prior to his original cancer diagnosis. On 9 May, the prison received Mr Green's appointment for a scan on 13 June.

24. On 12 May, a prison GP saw Mr Green who reported dizziness. His notes indicate that he was unaware of recent investigations and an impending MRI scan. On 17 May, a nurse recorded that they had not heard back from the hospital about Mr Green's appointment. She seemed unaware of the 13 June appointment.

25. On 23 May, a prison GP recorded that Mr Green had refused to take his anti-epilepsy medication against his specialist's advice. The GP explained why it was important he take it.

26. Although Mr Green was mobile and able to take care of himself, he frequently declined his medication and complained of feeling dizzy. On 24 May, a mental health nurse recorded that Mr Green needed a full mobility assessment. There is no record that the referral was made.

27. On 13 June, Mr Green had an MRI scan and it showed a tumour in the left frontal lobe. The consultant oncologist discussed the results with him on 21 June and explained that the recommended course of treatment was surgery to remove most of the growth, followed by chemotherapy. Mr Green said he did not want treatment but agreed to see the doctor in a week's time to review that decision.

28. In a letter to a prison GP, the consultant oncologist said that if Mr Green had treatment, his prognosis was two to five years, but without treatment it was months. She asked the GP to speak to Mr Green before his next appointment with her and said she would be grateful for any input that might lead Mr Green to review his decision.

29. The clinical reviewer found that the care Mr Green received at Forest Bank leading up to his diagnosis, was not equivalent to that he could have expected to receive in the community.

30. There is no record that the nurse considered a mobility and falls assessment when Mr Green told her at his reception health screen that he sometimes felt dizzy and had difficulty walking.

31. Correspondence is missing from the SystmOne record (the electronic medical record). There is no trace of the prison GP's letter to the consultant oncologist, and the GP and nurse, who saw Mr Green on 12 and 17 May respectively, seemed to be completely unaware that the prison had received Mr Green's scan appointment for 13 June.

32. There is no evidence that the nurse who saw Mr Green on 23 March referred him for the social care assessment he mentioned in his SystmOne entry. (On 10 April, another nurse did a more detailed mental health assessment but the clinical reviewer feels that, overall, there is little evidence of formal mental health/capacity assessments.)

33. The Deputy Head of Healthcare told us there were processes in place for requesting assessments and interventions, either by the 'task' system or by email, but that these had not been used. She also accepted that the system in place for receiving and acting upon correspondence was not robust. We make the following recommendations:

    The Head of Healthcare should ensure that all staff consider the range of assessments and interventions that might be relevant to a prisoner and make appropriate referrals.

    The Head of Healthcare should review the current system for logging correspondence ensuring important information is accessible to staff and actioned appropriately.

Mr Green's clinical care

34. On 21 June, staff placed Mr Green on an ACCT for two days following a conversation with the consultant oncologist about ending his life. During the ACCT procedures, a senior officer discussed Mr Green's decision to refuse cancer treatment. He recorded that he tried to make Mr Green think about his decision and to talk to his mother about it.

35. On 27 June, Mr Green told a nurse that he had spoken to his mother and his solicitor and had decided he would accept whatever treatment regime his specialist advised even though he also said that he wished his illness would 'just take him'. His self-care appeared, to her, to be of a reasonable standard.

36. On 21 July, Mr Green underwent surgery to remove his tumour. He was discharged from hospital on 2 August.

37. Following his operation, Mr Green was diagnosed with a blood clot in his brain and was given tinzaparin (blood thinning medication) daily in hospital, which the prison was told to continue following discharge.

38. On 3 August, a prison GP recorded that no tinzaparin was available, although subsequent records suggest a significantly reduced dose was administered to Mr Green between 3 and 8 August. This was reported on DATIX (the system for reporting adverse incidents).

39. The consultant oncologist saw Mr Green in her clinic on 8 August and provided a summary to the prison. She was content with Mr Green's progress and said his chemotherapy injection regime (temozolomide) should start on 10 August for five days. She advised of side effects the prison should look out for (fever). She also prescribed anti-sickness tablets to be taken before chemotherapy and advised caution with paracetamol during this time, which could mask a fever. She wished to see Mr Green again in four weeks' time.

40. On 14 August, a prison GP checked some post-operative swelling that Mr Green had on his head. He asked staff to check the circumference of the swelling and Mr Green's blood pressure twice daily for a few days. The swelling was monitored but his blood pressure was not.

41. On 6 September, the consultant oncologist saw Mr Green for another follow-up appointment. She noted that Mr Green said he had not had his first chemotherapy injection as planned. She contacted the prison who said he had been offered it but refused. She was concerned no one had informed her as this impacted on the treatment regime. She did not feel able to start Mr Green's second chemotherapy cycle at an increased dose as he had only had 80% of it at the base dose. She advised that a second cycle be administered at the base dose to start the next day.

42. The consultant oncologist also noted that Mr Green did not feel the current paracetamol dose was keeping his headaches at bay and she asked the prison to increase the dose from 1g twice a day to 1g three times a day. She wanted to see Mr Green again in four weeks' time and suggested that he should also have an MRI scan in October to assess the tumour's progress.

43. On 4 October, the consultant oncologist spoke to a nurse at the prison to confirm Mr Green's treatment regime. It became clear that the second cycle of chemotherapy had been administered at the incorrect dose (too low). A prison GP called the consultant oncologist back to discuss the matter. She was very clear that she had provided the nursing team with specific written instructions and she would be making a complaint to the Governor.

44. The prison GP spoke to Mr Green the same day, apologised and explained the error to him. He explained the complaints process to him and recorded that he

planned to arrange a nurses' meeting to discuss the matter and his care plan. Mr Green said that he was 'not bothered' about the error.

45. On 8 October, a mental health nurse recorded that Mr Green seemed very tired and would not come out of his cell to even have a shower.

46. On 9 October, Mr Green was admitted to Salford Royal Hospital after taking an overdose of 94 paracetamol tablets that he had been hoarding on a daily basis. (A joint Care Quality Commission and NHS England investigation concluded that nursing staff had not supervised medication administration properly, allowing Mr Green to accumulate a large amount.)

47. Mr Green was cared for in hospital and not discharged until 1 February 2018. He saw a consultant psychiatrist on 14 December 2017, who found no evidence of depression or psychosis at that time. He did, however, state that he thought Mr Green needed 24-hour care and he was going to arrange community mental health input once he was discharged.

48. The discharge summary said that Mr Green had stayed bed-bound, by choice, for most of his stay and that hospital staff had found it difficult to assess his actual needs as he was non-compliant and, at times, unresponsive, and aggressive. They felt he had capacity to make decisions about his treatment (although there is no evidence that a formal capacity assessment was done). Efforts had been made to find him an alternative placement but no accommodation could be found. His prognosis was considered to be possibly one to three years and while chemotherapy might increase that forecast, it might also shorten it if he did not have adequate support. Mr Green had refused chemotherapy while in hospital.

49. On 5 February, a prison GP recorded that he had asked Mr Green some questions to understand his mental state. He concluded that Mr Green had the mental capacity to make decisions. On 8 February, the GP performed a Mini Mental State Examination (MMSE) on Mr Green and, on that occasion, concluded that his very low score probably showed that he did not have capacity. There is no evidence that his capacity was formally tested, however. The MMSE focuses on cognition abilities rather than decision making capacity.

50. During February, Mr Green's compliance and engagement fluctuated and he spent most of his time in bed. He struggled to move around but declined physiotherapy or podiatry services. His health appeared to be deteriorating and his dietary intake was poor. Although he was frequently vomiting and was unfit to attend court on 27 February, there is no record that a malnutrition assessment was done, of him being weighed or referred to a dietician.

51. The clinical reviewer considered that descriptions of Mr Green's presentation by February 2018 indicate he was in the last year of his life. There is no evidence anyone considered implementing an end of life plan at this stage.

52. On 9 March, a member of the Swinton Integrated Care Team conducted an Independence Led Assessment. He considered that Mr Green had eligible needs under the Care Act 2014 and without assistance there would be a significant impact on his wellbeing. Health and Social Care Support workers in the prison were supporting him in daily living activities appropriately.

53. On 12 March, a prison GP recorded that he had discussed Mr Green's reluctance to accept medical treatment and apparent diminishing mental capacity with the psychiatrist who saw Mr Green in hospital. The psychiatrist advised a multidisciplinary team meeting involving Mr Green's oncologist, prison healthcare and mental health services. There is no evidence that an MDT was arranged.

54. A prison GP recorded that Mr Green was spending most of his time in bed and had various issues with nutrition, nausea, vomiting and expelling waste. He requested daily monitoring of Mr Green's general observations and intake and outputs. He also asked staff to monitor his weight and pressure sores weekly. There are no records to suggest these instructions were carried out.

55. Mr Green told a prison GP that he did not want anyone to resuscitate him if his heart or breathing stopped and signed a DNACPR (Do Not Attempt Resuscitation) order to that effect on 4 April.

56. On 8 April, Mr Green was admitted to hospital again after displaying symptoms suggesting he had gastritis or a stress ulcer from poor nutrition. He had been found unresponsive in his cell. He was discharged back to the prison's healthcare unit on 10 May. A prison GP saw Mr Green when he was discharged and he said he wanted the DNACPR order to remain in place.

57. On 14 May, a trauma and neurosciences specialist dietitian at Salford Royal Hospital wrote to the prison. She said that Mr Green's oral intake had been minimal during his admission, but he was at a significant risk of 'refeeding' if his oral intake increased rapidly. (Refeeding syndrome is a potentially fatal condition that can occur when food is reintroduced after a period of malnutrition.) She recommended that his potassium, calcium, magnesium and phosphate levels be monitored on daily basis and that, if his oral intake did rapidly improve, pabrinex be used as a supplement. There is no evidence that this letter was considered.

58. On 15 May, a nurse recorded that Mr Green was seen by the palliative care consultant, a nurse from St Anne's Hospice, who completed an End of Life care assessment. The nurse established what medication was required and provided staff with a palliative pathway template, although there is no record that a plan was formulated. Appropriate medication, including anticipatory medicine, was prescribed. Mr Green expressed his preference to die in prison and would only go to a hospice if the prison were unable to care for him. Nursing staff at the prison agreed to deliver care as guided by the plan and undertook syringe driver training.

59. During June, staff continued to support Mr Green. He was provided with an airflow mattress and accepted pressure area care. He declined physiotherapy.

60. On 9 June, a nurse recorded that Mr Green was complaining of pain but to no specific area. She also recorded that there was 'no morphine available', it was 'out of date' and had been 'prescribed incorrectly'. She sent a task to a doctor to change to diamorphine in line with gold standard care and gave Mr Green some midazolam to help settle him, which seemed to work. A prison GP prescribed diamorphine the next day. (Earlier that day, a nurse also recorded that Mr Green's Keppra prescription for epilepsy had expired but he gave him some anyway.)

61. By 21 June, a healthcare support worker sat continually with Mr Green who was generally non-responsive with laboured breathing. District nurses commenced a

syringe driver. Keppra and midazolam were administered to minimise seizures and glycopyrronium to inhibit salivation and excessive respiratory tract secretions.

62. On 23 June, a nurse recorded she felt Mr Green would benefit from diamorphine as his breathing had become faster and erratic - even though he was not in any obvious pain. The stock she found in the cupboard was out of date and, with no out of hours pharmacy service available, she called a local hospice. They were unable to help, but a doctor at Salford Royal Hospital agreed to prescribe some and Mr Green was eventually administered some diamorphine in the early hours. Mr Green died at 2.20am on 23 June. Subsequently, a nurse located stocks of diamorphine and morphine.

63. The post-mortem examination found that Mr Green died from bronchopneumonia (inflammation of the lungs), a complication arising from his brain tumour.

64. We agree with the clinical reviewer that the care Mr Green received at HMP Forest Bank was not equivalent to that he could have expected to receive in the community.

65. Staff failed to carry out a formal mental capacity assessment. This was not considered in relation to Mr Green's treatment refusal or his DNACPR. NICE guidance NG99 highlights the impact a brain tumour can have on behaviour, cognition and personality and NICE guidance NG108 covers decision-making and mental capacity. We make the following recommendation:

    The Head of Healthcare should ensure staff are familiar with the principles covered by NICE Guidance NG99 and NG108, and that formal mental capacity assessments are carried out where appropriate.

66. Palliative and end of life care plans were not formulated when they should have been. Mr Green's tumour and a prognosis of two to five years was confirmed in June 2017. The clinical reviewer considered that descriptions of his presentation in June 2018 indicated he was in the last year of his life. She considered an MDT approach would have provided a clear overview of Mr Green's condition and provided planned care that adhered to clinical guidelines. The Gold Standard Framework is commonly used in primary care for patients who are in their final stages of life and ensures comprehensive care across a range of needs. We make the following recommendation:

    The Head of Healthcare should ensure staff are familiar with and apply the principles of the Gold Standards Framework where appropriate.

67. When Mr Green started chemotherapy at Forest Bank, no treatment plan was drawn up and there is no evidence clinical observations were done. This is despite the consultant oncologist providing detailed instructions about what a treatment plan should include, the medication to be prescribed and action to be taken if any side effects occurred. This failure may trace back to the general problem the unit seemed to have with correspondence, but, regardless, staff should have sought to formulate a treatment plan without being directed by the oncologist. We make the following recommendation:

    The Head of Healthcare should ensure that where a prisoner is undergoing chemotherapy at the prison, staff formulate treatment plans, monitor that individual and record general observations.

68. Errors were made with Mr Green's medication. In August 2017, a prison GP noted he had been given the wrong dose of tinzaparin. In September, the consultant oncologist noticed that healthcare staff had given Mr Green the wrong dose of his chemotherapy injection in phase one of his treatment; in October she realised that he had been given the wrong dose in the second cycle. In June 2018, a nurse recorded that the prison's supply of morphine was out of date and she had had to try and settle Mr Green with an alternative. His epilepsy medication was also found to be out of date. Later that same month, a nurse thought they had run out of morphine (when in fact they had not).

69. The Deputy Head of Healthcare told us that the prion has a medicines policy in place and said she was confident that staff adhered to it. The clinical reviewer established there is a system in place to report, investigate and learn from clinical incidents but their recurrence suggests that more robust investigations are required. We make the following recommendations:

    The Head of Healthcare should ensure adequate stocks of required medication are available.

    The Head of Healthcare should review the system in place to record, investigate and prevent future medication errors.

Mr Green's location

70. Mr Green was located in Forest Bank's healthcare unit when he was not in hospital. He had some special equipment (airflow mattress) to aid his comfort and we are content that his location was appropriate.

Restraints, security and escorts

71. 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.

72. On 20 July 2017, when Mr Green was taken to hospital for his tumour removal, he was double cuffed and an escort chain applied. (Double cuffing is when the prisoner's hands are handcuffed in front of him and one wrist is attached to a prison officer by an additional set of handcuffs. 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.) During surgery, restraints were removed and afterwards, Mr Green was restrained with an escort chain. However, double cuffs were reapplied after Mr Green began pulling on the chain, bruising the escorting officer. Restraints were reduced to an escort chain again five hours later, after Mr Green had complied for a significant period and apologised for his behaviour.

73. Mr Green had a history of violence and his behaviour was sometimes unpredictable. He was assessed as a medium risk of escape. We consider the use of restraints was reasonable.

74. From 8 April to 10 May 2018, Mr Green was a hospital inpatient again. The authorising manager decided that restraints should not be applied as Mr Green was critically ill.

Liaison with Mr Green's family

75. Mr Green had been in touch with his mother throughout his time at Forest Bank but had not wanted her to visit him there. On 8 April 2018, the prison appointed a prison manager as the family liaison officer (FLO). Staff had found Mr Green unresponsive in his cell and he was admitted to the Salford Royal Hospital. The FLO met Mr Green's mother at the hospital and although he was eventually discharged on 10 May, she stayed in contact with Mr Green's mother offering information and support.

76. On 21 June, when Mr Green's condition deteriorated further, the FLO contacted his mother and arranged for a taxi to bring her to the prison. After this visit, the FLO stayed in contact with her advising of his welfare. Mr Green died at 2.20am on 23 June and the duty officer informed her and the police went to check on her welfare. The FLO visited her at her home on 25 June to give advice and support.

77. Mr Green's funeral was held on 23 June and the FLO attended. The prison contributed to the funeral costs in line with national policy.

Compassionate release

78. 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. As a remand prisoner, Mr Green was not eligible for compassionate release.

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