Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Brian Baker, a prisoner at HMP Sudbury, on 1 May 2017

A report by the Prisons and Probation Ombudsman

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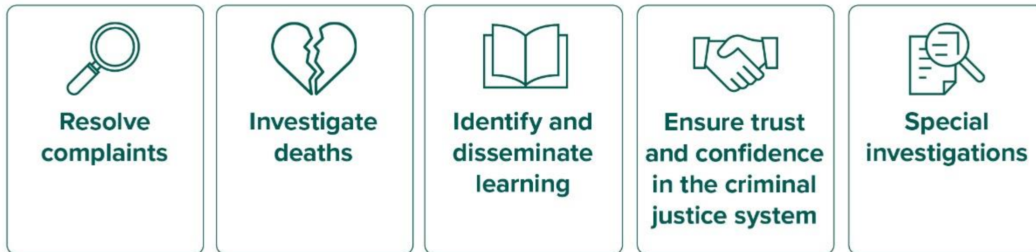
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

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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 Brian Baker had terminal cancer. He died on 1 May 2017 of a pulmonary thromboembolism, caused by deep vein thrombosis, with cancer as a contributory factor, while a prisoner at HMP Sudbury. He was 61 years old. We offer our condolences to Mr Baker's family and friends.

Mr Baker complained of persistent symptoms of excessive wind and abdominal pain before being diagnosed with rectal cancer. We are concerned that there were delays at HMP Dovegate in referring him for investigative tests, which meant that Mr Baker's care fell below what he could have expected to receive in the community. (This is the second death at Dovegate since January 2015 where we have identified a delay of this kind as a concern.) However, after Mr Baker was diagnosed with cancer in September 2015, he received a good level of care and support at both HMP Dovegate and HMP Sudbury.

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
Acting Prisons and Probation Ombudsman **November 2017**

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Summary

Events

1. Mr Brian Baker was serving a seven-year sentence for drug-related offences. He entered prison custody in November 2013, and had been at HMP Sudbury since 21 October 2016.

2. Healthcare staff first saw Mr Baker in August 2014, when he was at HMP Dovegate. He said he had persistent wind. Between August and April 2015, Mr Baker saw nursing staff and prison GPs 12 times for persistent wind and abdominal discomfort. Prison GPs prescribed various medications to try to relieve his symptoms. The symptoms Mr Baker presented with did not flag up any significant concern and were not suggestive of cancer.

3. On 29 May 2015, Mr Baker had a gastroscopy, which showed a fungal infection in his oesophagus. The hospital doctors prescribed antibiotics but his symptoms did not improve. Prison GPs examined Mr Baker but could not find any significant cause for his symptoms. A prison GP made a referral to hospital for further investigation on 8 July, but the hospital lost the referral. Mr Baker eventually had an investigative test in hospital on 18 September 2015, which showed possible rectal cancer. Mr Baker had additional investigative tests in hospital in October. On 26 November 2015, 15 months after first complaining of feeling unwell, an oncology consultant told Mr Baker he had rectal cancer and lesions in his liver.

4. Mr Baker started chemotherapy treatment on 8 February 2016. He had some adverse symptoms from the treatment, such as a pulmonary embolism in July 2016, but continued with treatment up to February 2017. At that point Mr Baker's white blood cell count was low and his body was not coping.

5. Mr Baker's condition continued to deteriorate and prison and healthcare staff offered support. He was able to stay in his cell, at his request, and plans were in place to move him to a hospice or care home if needed. Mr Baker's health deteriorated significantly on 30 April and he went to hospital for treatment. Mr Baker died at 4.05pm on 1 May with his family present.

Findings

6. The clinical reviewer concluded that the delays in referring Mr Baker for routine investigations resulted in his care falling below what he could have expected to receive in the community. We agree with this.

7. The clinical reviewer also concluded the care Mr Baker received after his cancer was diagnosed in September 2015, and the management of his cancer, was comparable to what he might have expected to receive in the community. Communication between prison staff and secondary services was good and staff provided appropriate support. We agree with this.

8. We are satisfied that the decision to allow Mr Baker to remain on his wing and involving him in the decisions about his location were appropriate and evidence of good practice.

9. Mr Baker had regular contact with his family and informed them of his diagnosis and treatment. The support offered to the family after Mr Baker's death was appropriate and in line with national guidance.

Recommendations

- The Head of Healthcare at HMP Dovegate should ensure that, when a medical need has been identified, referrals to hospital are made promptly.

The Investigation Process

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

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

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

13. We informed HM Coroner for Derby and South Derbyshire of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

14. One of the Ombudsman's family liaison officers contacted Mr Baker's son to explain the investigation and to ask if he had any matters he wanted the investigation to consider. Mr Baker's son said he would like to receive a copy of the investigation report.

15. The investigation has assessed the main issues involved in Mr Baker'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.

16. Mr Baker's son received a copy of the initial report. He did not raise any further issues, or comment on the factual accuracy of the report.

17. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Dovegate

18. HMP Dovegate is privately run by Serco. The main prison holds around 933 remanded and sentenced adult men. There is also a therapeutic community, separate to the main prison, which holds up to 200 men.

19. Care UK provides healthcare services. There is an inpatient unit for 12 prisoners and 24-hour nursing cover. Two GPs provide cover Monday to Friday and Saturday afternoons are covered by a nurse prescriber. There is an out of hours GP service at other times. Mr Baker was at Dovegate when he first became unwell and was subsequently diagnosed with cancer.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Dovegate was in January 2015. Inspectors reported that the standard of healthcare was improving, but the facilities were too small for the number of prisoners, the waiting times for routine GP appointments were excessive and too many hospital appointments were rescheduled. There was an appropriate range of primary care services. Prisoners with life-long conditions and complex needs were properly identified and there were relevant clinics, including a weekly GP-led session.

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 30 September 2016, the IMB reported that there had been improvements in healthcare provision at the prison and the Board commended the officers in the in-patient unit for their care, compassion and patience in dealing with men with often complex health conditions.

Previous deaths at HMP Dovegate

22. There have been three deaths from natural causes at Dovegate since January 2015. In the report of our investigation into a death in May 2015 we concluded that there had been a delay in making a referral for investigative tests. The lead GP in that case, Dr Cumberland, accepted that there had been a delay and said this had been due to resource issues at the time (March/April 2015).

HMP Sudbury

23. HMP Sudbury is an open prison that houses over 580 adult men. Care UK has provided primary and mental health services since April 2016. Inclusion, South Staffordshire and Shropshire Healthcare NHS Foundation Trust provide drug and substance misuse services.

24. Sudbury caters for prisoners in the latter stages of their sentence and specialises in rehabilitation and resettlement in preparation for release into the community. A

number of prisoners are released each day on licence to help with their resettlement. Prisoners at Sudbury are required to sign up to a compact-based drug testing regime.

HM Inspectorate of Prisons

25. The last inspection of HMP Sudbury was in April 2017. Inspectors reported that regular governance and quality assurance meetings were well attended, which supported effective collaborative working between the prison, health providers and commissioners. Overall, health services are reasonably good. There is evidence of excellent visible clinical leadership and teamwork. Health staff were easily identifiable and interactions with patient's were very good. Health staff had good access to relevant current protocols and training. The prison has no dedicated end of life facilities, but obtains equipment when required. Effective care planning, involving community services, the prison, health care department and the patient, supported compassionate care.

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 May 2016, the IMB reported that Sudbury was a well run prison providing a positive environment for most prisoners even though it was an old building with a limited budget and low staff numbers. Healthcare was described as patchy with some long waiting lists and the use of agency staff compromising provision.

Previous deaths at HMP Sudbury

27. Mr Baker's death was the second death from natural causes since January 2015. There were no significant similarities with the circumstances of the other death.

Findings

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

28. Mr Brian Baker was serving a seven year sentence for drug-related offences. He had been in prison since November 2013 and did not have any significant on-going physical health issues. He first complained to prison healthcare staff of symptoms relating to his illness in August 2014, while at HMP Dovegate. A hospital consultant diagnosed Mr Baker with rectal cancer in November 2015. Mr Baker transferred to HMP Sudbury on 20 October 2016.

29. On 11 August 2014, at Dovegate, Mr Baker told a nurse that he had wind after taking ibuprofen for a trapped nerve. She gave him peppermint oil to help relieve the wind.

30. Between August and December 2014, Mr Baker saw prison nursing staff and GPs seven times. He complained of persistent excessive wind, abdominal bloating and piles. Prison GPs examined Mr Baker but did not find any significant cause for the bloating and wind. He tried various treatments but Mr Baker did not present any 'red flag' symptoms that suggested he might have cancer.

31. On 8 January 2015, a prison GP reviewed Mr Baker. He said he was still experiencing bloating and excessive wind. The GP advised him to continue with his medications and referred him for a gastroscopy (a procedure where a flexible tube with a camera is used to look inside the oesophagus, stomach and first part of the small intestine).

32. On 18 February, Mr Baker told a nurse that he had painful piles, which were causing discomfort even if he was not using the toilet. He had a GP appointment booked for a few weeks time, but asked for this to be brought forward.

33. On 24 February, Mr Baker expressed his concern to a nurse that he had not yet seen a GP despite healthcare staff assuring him a GP would see him soon. She told him that a GP could not see him on the wing rounds as he needed a thorough check-up, and there was no GP on duty that day. She noted that nursing staff made him another appointment but the GP had been off sick. She put Mr Baker on the GP list for the next appointment.

34. A prison GP saw Mr Baker on 26 February. Mr Baker said he thought he had a severe case of haemorrhoids and was in a lot of pain. He was not able to take suppositories, as they were so uncomfortable. He said he still had excessive wind but was not passing blood. She examined him and noted that his abdomen was distended. She was not able to perform a full rectal examination, as it was too uncomfortable. She advised him to stop all suppositories and steroid creams and to use laxatives, and prescribed a stronger pain relief. She noted that she would review him in two weeks and would refer him to the colorectal surgeon. There is no evidence to suggest that she made the referral.

35. A prison GP reviewed Mr Baker on 12 March. He noted some improvement to his symptoms and he did not find anything significant when he examined him. He diagnosed Mr Baker with possible irritable bowel syndrome (IBS). He arranged for

Mr Baker to have a test for coeliac disease (an autoimmune condition where the body's immune system reacts to gluten, and causes damage to the lining of the intestine), and prescribed mebeverine (a drug used to treat abdominal cramping). He noted that the previous GP had recorded she would refer Mr Baker to a colorectal surgeon, so he took no further action. However, she had not referred Mr Baker.

36. On 29 May, Mr Baker attended hospital for a gastroscopy procedure. The results showed a mild fungus infection in his oesophagus, which was treated with antibiotics. His stomach and small intestine looked normal.

37. On 17 June, Mr Baker told a prison GP that he was still bloated and had rectal pain. An abdominal examination did not show anything significant and a rectal examination was normal. She advised Mr Baker to eliminate gluten from his diet and to continue with the laxatives. She made a referral for a colonoscopy (a procedure where a flexible tube with a camera is used to examine the large intestine) on 8 July.

38. On 23 July, a prison healthcare administrator contacted the hospital to chase the colonoscopy referral. The hospital said they had received the referral on 9 July, but had not made an appointment yet. Mr Baker would receive an appointment to see a general surgery consultant first.

39. On 7 August, the prison healthcare administrator contacted the hospital again and chased the appointment. The hospital said they did not have any record of the referral, so she faxed the referral again to hospital the same day.

40. Mr Baker had a sigmoidoscopy (a procedure similar to a colonoscopy) at the hospital on 18 September. After the procedure, a general and colorectal surgeon told Mr Baker he appeared to have a tumour in his bowel. He took a biopsy and said Mr Baker would need further tests. He said it was likely to be cancerous but thought treatment would be effective.

41. When Mr Baker returned to Dovegate, a nurse offered Mr Baker support. She noted that he was polite but said that he had known something was wrong and felt healthcare staff had not listened properly to his concerns. Mr Baker said he would tell his family of his diagnosis that afternoon.

42. On 21 September, a GP at Dovegate met with Mr Baker and discussed his diagnosis of suspected rectal cancer. She said she had not received any correspondence from the hospital yet but explained what he might expect to happen next. She prescribed a sleeping tablet at Mr Baker's request and changed his pain relief to a stronger dose.

43. Mr Baker attended a hospital appointment with the general and colorectal surgeon, on 15 October. He performed a proctoscopy (a procedure to examine the anal cavity, rectum and the part of the colon nearest to the rectum) and took more biopsies. He noted a polyp (a benign, abnormal growth of tissue, commonly found in the colon) during the procedure, and he took more biopsies for completeness. He booked Mr Baker in for an urgent transanal resection (an operation using local anaesthetic, done through the rectum to remove polyps and tumours from the rectal wall), and for further assessment as he was concerned that they might have been missing a cancer.

44. On 20 October, the hospital colorectal multi-disciplinary team (MDT) met to discuss Mr Baker's biopsy results, which showed tubular adenoma (a benign rectal tumour). A CT scan (which uses special x-rays to create detailed scans of areas inside the body) and MRI scan (which uses magnetic fields to produce detailed images of inside the body) showed possible lesions in his liver. The MDT team made a plan to carry out a further examination under general anaesthetic and a biopsy, and to discuss the liver lesions with surgeons.

45. On 26 November, Mr Baker saw the general and colorectal surgeon in his clinic. He explained that although the previous two biopsies were benign, biopsies from the transanal resection showed rectal cancer. He said there were also lesions in Mr Baker's liver and he had arranged an MRI scan to assess this further. He explained that Mr Baker could have surgery on his bowel, and he might require surgery for the potential liver lesion. Mr Baker took some information leaflets about the cancer and surgery.

46. We are satisfied that Healthcare staff at HMP Dovegate reviewed Mr Baker's medical history, undertook relevant examinations and blood tests, and prescribed appropriate treatments according to his symptoms. When his symptoms persisted, it was appropriate to make a referral for him to have further routine investigations in hospital. As the prison GPs did not find any significant cause for his symptoms, the hospital referrals for further examination were routine, and not urgent.

47. However, despite recording that she would make a referral in February 2015, a prison GP did not do so. She also noted she would refer Mr Baker for investigation in June, but did not make the referral until three weeks later. The hospital then lost the referral. A hospital consultant eventually reviewed Mr Baker in August, six months after she should have made the first referral.

48. The clinical reviewer found that Mr Baker's initial symptoms were atypical and did not indicate any serious cause for concern and noted that the prison healthcare team invested large amounts of time and effort in managing a complex problem. However, he found that Mr Baker should have been referred for routine investigations in February 2015. He said that that it would be reasonable to conclude that the delay in referring him would have had some sort of impact on Mr Baker's condition, but that it was not possible to say whether the outcome would have been different if Mr Baker had been referred in February 2015. He concluded that the delays in referring Mr Baker for routine investigations resulted in Mr Baker's care falling below what he could have expected to receive in the community.

49. We agree with the clinical reviewer that Mr Baker should have been referred for tests earlier. This is the second investigation into a death at Dovegate where we have expressed concern about a delay in making a hospital referral. We repeat the recommendation we made in the previous case for HMP Dovegate to ensure there are no unnecessary delays in future.

The Head of Healthcare at HMP Dovegate should ensure that, when a medical need has been identified, referrals to hospital are made promptly.

Mr Baker's clinical care after diagnosis

50. On 18 December, Mr Baker had a MRI scan of his liver. The results of the scan were discussed with him at a clinic appointment with the general and colorectal

surgeon on 24 December. He explained to Mr Baker that the MRI showed multiple liver metastases (spreading cancer) and therefore surgery would not offer a cure as previously thought. Mr Baker would be better suited to chemotherapy and possibly radiotherapy, which would help to control the growth of the tumours. He referred him to a consultant oncologist at the hospital.

51. On 5 January 2016, a prison GP discussed the diagnosis and treatment options with Mr Baker. Mr Baker said he did not have any questions. He attended an appointment with the specialist registrar in oncology at the hospital on 6 January. Mr Baker said he felt relatively well in himself but had some slight rectal discomfort. The registrar explained that chemotherapy would be the best treatment option but would not cure the cancer. He explained the side effects and gave Mr Baker some written information.

52. A nurse saw Mr Baker in his cell on 24 January, to offer support. They had a lengthy discussion about his diagnosis and treatment options. She told him that he could contact healthcare staff at any time if he needed to. Mr Baker said he felt 'at ease' after their conversation.

53. Mr Baker started chemotherapy treatment on 8 February. Nursing staff created a care plan to ensure they were meeting Mr Baker's care needs. The care plan also included signs to look out for, should Mr Baker become unwell. The oncology department telephone number was added to Mr Baker's list of approved telephone numbers, to enable him to call any time he needed.

54. Healthcare staff saw Mr Baker regularly, and noted that he appeared to be tolerating the chemotherapy treatment well. However, Mr Baker had his treatment postponed on 7 March to enable urgent dental treatment and restarted on 4 April.

55. In May 2016, Mr Baker started to experience some side effects of the chemotherapy treatment. He was feeling bloated and was having increased stool frequency. He saw prison GPs who advised him about appropriate medications to take.

56. Mr Baker attended an oncology clinic appointment on 18 May, with an oncology nurse. She gave Mr Baker advice on his stool issues and said he had become anaemic. She said they would review him regularly. Mr Baker said he was coughing a lot, but it could have been due to him stopping smoking.

57. A consultant clinical oncologist reviewed Mr Baker on 22 June. He noted that the side effects of the chemotherapy treatment were stable and Mr Baker would be able to continue with his next cycle of treatment. He had arranged a CT scan to assess the response to treatment.

58. Mr Baker attended hospital for a CT scan on 20 July. When he returned to Dovegate, the hospital rang the healthcare centre, as the scan showed that Mr Baker had a pulmonary embolism (blood clot on the lung) and would need to return for anti-coagulant (blood thinning) therapy. Mr Baker returned to hospital via ambulance that afternoon. Mr Baker had an anti-coagulant injection while in hospital and returned to Dovegate with prescribed medication.

59. On 27 July, Mr Baker saw a specialist registrar in oncology for review. Mr Baker was not experiencing any symptoms from the pulmonary embolism. He told Mr Baker that the recent CT scan also showed that the liver lesions had increased in

size. The oncology team, therefore, advised a change to his chemotherapy drug to try to control the cancer growth. Mr Baker started the new chemotherapy treatment on 1 August.

60. Mr Baker attended an oncology clinic appointment with the specialist registrar in oncology on 10 August. A nurse also attended the appointment. The registrar advised Mr Baker to keep having the anti-coagulation treatment while having chemotherapy, as chemotherapy was a risk factor for blood clots. He explained that Mr Baker would have another scan after round six of treatment to see how he had responded.

61. The oncology clinic took regular blood samples from Mr Baker. On 2 September, a blood test showed that his white blood cell count was low, a side effect of chemotherapy treatment. A nurse explained this to Mr Baker and told him to inform healthcare staff if he felt unwell.

62. Mr Baker was transferred to HMP Sudbury on 20 October. A nurse visited the prison and trained nurses there in how to care for Mr Baker. Healthcare staff created a new care plan for him, which was also shared with the out-of-hours GP service.

63. On 14 November, Mr Baker attended a MDT meeting with the prison Governor, prison staff and healthcare staff to discuss his care plan. Mr Baker said he was tolerating the chemotherapy treatment well and did not require any additional support. He said he knew to tell staff if he needed support or felt unwell.

64. On 30 November, Mr Baker attended an oncology clinic appointment. The clinical summary noted that the recent CT scan showed the lesions had responded to the chemotherapy treatment. However, as Mr Baker's white blood cell count was still low, the consultant reduced his chemotherapy dose.

65. On 20 December, Mr Baker attended a prison MDT meeting. Mr Baker said the oncology clinic had postponed his chemotherapy treatment as his white blood cell count was still low. He did not have any adverse symptoms from the treatment and said he was feeling well. Mr Baker had lost weight but prison staff considered this to be due to him consuming fewer calories as part of a better diet.

66. A specialist registrar in oncology reviewed Mr Baker on 28 December. He noted Mr Baker's white blood cell count had improved, and if it stayed stable, he would have his next chemotherapy dose on 3 January 2017, as planned.

67. On 8 January, Mr Baker complained of abdominal pain. A nurse contacted the out-of-hours GP service, who sent a GP to examine him. The GP diagnosed Mr Baker with acid reflux and prescribed a medication to reduce the symptoms.

68. On 10 January, the Oncology Clinic postponed Mr Baker's chemotherapy again, because he had a low white blood cell count and mouth ulcers.

69. On 13 January, Mr Baker went to the Accident and Emergency Department at hospital with abdominal pain. After examination, hospital doctors considered the pain to be due to the liver cancer.

70. On 15 February, Mr Baker attended an oncology clinic appointment with an oncology nurse. His white blood cell count was low and he still had a slight cough

after a lower respiratory infection earlier in the month. She discussed Mr Baker with the specialist registrar and they made the decision to give Mr Baker a break from treatment. They would review him after his CT scan, which was due on 8 March.

71. Mr Baker attended an oncology clinic appointment on 22 March. CT scan results showed that the liver lesions had progressed significantly and Mr Baker had ascites (abnormal accumulation of fluid) in his abdomen and pelvis. He was also taking antibiotics for swelling of his right testicle. Mr Baker looked less well and had lost weight. He said he was disappointed that the cancer had progressed and a counselling appointment was booked for him to discuss a possible treatment option to try to control the cancer and maintain his quality of life.

72. On 23 March, a nurse printed off some information about the possible chemotherapy treatment for Mr Baker, to help him understand his treatment and prognosis. The nurse also contacted the oncology department and asked them to refer Mr Baker to the Macmillan Nurses for emotional support, which they agreed to do.

73. A nurse went to see Mr Baker in his cell on 29 March. She noted he looked lethargic. He said he was feeling 'ok' emotionally and had been looking at treatment trials that might be suitable for him. She contacted the nurse specialist at the oncology clinic who said Mr Baker's prognosis was likely to be less than six months. The nurse said she had referred him to the Macmillan Nurses and a local hospice for symptom control and emotional support. Mr Baker had a follow-up appointment at the oncology clinic in the next few days. She told Mr Baker that support was available should he need it.

74. On 2 April, Mr Baker went to hospital due to urine retention and abdominal ascites. He remained in hospital for four days, during which he had the ascites drained and a urinary catheter inserted to drain the retained urine. Hospital staff told Mr Baker that it was likely his prognosis was about three months. A nurse visited him in hospital and told Mr Baker that the prison and the local hospice would provide support to him.

75. Mr Baker returned to Sudbury on 6 April. Later that day, a MDT meeting took place. Mr Baker did not attend because he was feeling unwell. He said he was happy for prison and healthcare staff to discuss his medical information during the meeting. Mr Baker did not have any mobility issues, but social care would need to assess him for any additional needs. A nurse went to see Mr Baker in his cell. He said he did not want resuscitation if his heart or breathing stopped and signed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order (which means that, in the event of cardiac or respiratory arrest, no attempt at resuscitation will be made. All other appropriate treatment and care would continue to be provided).

76. On 7 April, prison and healthcare staff implemented a support intervention plan for Mr Baker. This included details of his diagnosis and preferences. Staff logged daily conversations and observations in the document.

77. Mr Baker attended an appointment with the specialist registrar in the oncology clinic on 12 April. They discussed possible chemotherapy treatment, but due to the severe side effects, Mr Baker said he would like two weeks to think about it. Mr Baker decided not to have the treatment.

78. On 13 April, a staff member from the local hospice visited the healthcare centre and discussed Mr Baker's care with a nurse. She noted that the prison were doing all they could to help and support Mr Baker. They visited Mr Baker in his cell. He told them that he did not have any additional needs.

79. On 18 April, Mr Baker went to hospital suffering from a blocked catheter and worsening ascites. He spent a few days in hospital before returning to Sudbury on 21 April. A nurse went to see Mr Baker in his cell on 22 April. He said he was struggling to sit up in bed to drink. The nurse gave him some straws, which appeared to resolve the issue. Mr Baker's care needs increased, he had become incontinent and had little energy, but his pain was well controlled. On 24 April, a prison GP prescribed a high calorie food supplement and artificial saliva lozenges, as Mr Baker reported a dry mouth.

80. On 26 April, a social worker and an occupational therapist visited Mr Baker in his cell for an assessment. They ordered him a hospital bed and mattress, an over-bed table, commode, wheelchair and pressure cushion to help meet his changing care needs and ensure he was comfortable.

81. On 27 April, a prison GP reviewed Mr Baker who said the anti-coagulant medications were causing abdominal pain. He advised Mr Baker that the injections were to stop a pulmonary embolism, however given his diagnosis it was his choice whether to continue having the injections. After this Mr Baker decided on a daily basis whether he wanted the injections.

82. On 27 and 28 April, nursing staff noted that Mr Baker had not been eating or drinking much. They encouraged him to drink more fluids and increase his fluid intake.

83. On 30 April, Mr Baker's condition deteriorated significantly. He was admitted to hospital, where he received end of life care. A hospital doctor confirmed Mr Baker had died at 4.05pm on 1 May. The post-mortem report found that Mr Baker died of a pulmonary embolism (blood clot to the lung), caused by deep vein thrombosis. Other significant contributing factors were cancer, dehydration and immobility.

84. The clinical reviewer found that the management of Mr Baker's cancer, after it was first diagnosed in September 2015, was comparable to that which he could have expected to receive in the community. Staff at HMP Dovegate and HMP Sudbury managed a serious deteriorating condition very well. There was good communication between primary and secondary care services and a good multidisciplinary approach.

Mr Baker's location

85. While at Dovegate, Mr Baker was located on 'F' wing, which at the time housed normal location prisoners that were 'non smokers'. Healthcare staff gave Mr Baker the opportunity to move to the inpatients unit in healthcare, but he refused and said he had a strong support network on 'F' wing.

86. Mr Baker was transferred to Sudbury, an open prison, on 21 October 2016. He was located on West 7 unit at Sudbury. He appeared settled and had a support network of friends. He had a carer who helped him to collect his meals and with basic needs. Healthcare staff visited him on the unit if needed. When Mr Baker's

condition deteriorated, social services and occupational health appropriately assessed him for additional equipment to help keep him comfortable, and to help meet his care needs. When Mr Baker's condition became terminal, the prison liaised with local hospices in supporting Mr Baker and offering accommodation if the need arose.

87. Mr Baker's accommodation and location were appropriate. As his needs changed, prison and healthcare staff reviewed him appropriately. He was happy to stay in his cell for the duration of his illness, as he had a good support network. Social services and occupational health assessed Mr Baker appropriately and ordered additional equipment to enable to stay in his cell. Mr Baker was fully involved in the decision-making process and consistent review of his changing needs was evidence of good practice.

Restraints, security and escorts

88. 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.

89. Mr Baker attended his hospital appointments accompanied by one officer. Appropriately, the officer did not restrain Mr Baker for any of his hospital appointments.

Liaison with Mr Baker's family

90. On 22 February 2017, the Governor of Sudbury granted Mr Baker release on temporary licence (ROTL) for various dates in the following months for hospital appointments, and to allow him to spend more time with his sons. (ROTL can be granted for precisely defined and specific activities that cannot be provided in the prison.) Mr Baker's sons also visited a potential hospice with him on 28 April.

91. The family liaison officer (FLO) met with Mr Baker's sons at the hospital on 30 April and offered support. Prison staff maintained a dignified distance to give Mr Baker and his sons some privacy. She provided ongoing support to Mr Baker's sons following his death.

92. Mr Baker's funeral was held on 26 May. The prison contributed to the cost of the funeral, in line with national guidance.

93. We are satisfied that the prison provided an appropriate level of support to Mr Baker's family.

Compassionate release

94. 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.

95. On 6 April 2017, the Head of Residence at Sudbury contacted the Public Protection and Casework Unit for advice on the compassionate release process, as the current guidance was out of date. She asked for clarification on a number of areas before formally submitting an application. She continued to collate information about Mr Baker's condition and potential release addresses while she waited for a response.

96. On 12 April, during an oncology clinic appointment, the specialist registrar agreed to prepare a report for Mr Baker's application for compassionate release. The Head of Residence received the report on 25 April.

97. On 26 April, the Public Protection and Casework Unit responded to the Head of Residence with up to date guidance to follow. She continued to keep the application under review and was looking for suitable release accommodation. However, Mr Baker died before suitable accommodation was found and so the prison could not submit the compassionate release application.

98. We are satisfied that Sudbury appropriately considered Mr Baker's early release on compassionate grounds.

Inquest

99. The inquest, held on 13 December 2023, concluded that Mr Baker died from natural causes.

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