

**Investigation into the circumstances surrounding the  
death of a man  
at HMP Norwich in May 2008**

**Report by the Prisons and Probation Ombudsman  
for England and Wales**

**February 2010**

This is a report of an investigation into the death of a man. He died aged 55 in HMP Norwich. He had been in prison for over 25 years and, sadly, appeared to be quite close to being released back into the community when he was diagnosed with terminal cancer. He died a few short weeks later. I would like to offer my condolences to his family.

The man's case was investigated first by an investigator. Unfortunately, the investigator had to retire from the Ombudsman's office due to injury and the case was passed a senior investigator, in June 2009. The Ombudsman's Family Liaison Officer remained the same throughout the investigation. I very much regret the long delay in completing this investigation and offer my sincere apologies to the man's family. I recognise that the delay can only have added further upset to what was an already distressing situation for them.

I would like to thank the clinical reviewer and her assistant from NHS Norfolk for their help in providing a clinical review of the man's medical treatment. I would also like to thank two members of staff from HMP Wellingborough and HMP Norwich for their co-operation with this investigation.

This is another investigation that highlights the lack of healthcare facilities within the National Offender Management Service for terminally ill prisoners who require 24 hour end of life care. At present only the Nelson Unit at Norwich offers sufficient resources and expertise to cope with such prisoners. The healthcare provided in prisons should be equitable with that provided in the community. Therefore there is an urgent need for more facilities of this nature throughout the country. I am aware that moves are afoot to remedy this situation but I am concerned that the current guidance to staff may dissuade them from pursuing applications for compassionate release when no definitive life expectancy can be determined.

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

**Jane Webb**  
**Deputy Prisons and Probation Ombudsman**

**February 2010**

## **CONTENTS**

Summary

The Investigation Process

HMP Wellingborough and HMP&YOI Norwich

Events leading up to the man's death

Issues

Recommendations

## SUMMARY

The man was sentenced to life imprisonment in 1983. In May 2006 he was transferred to HMP Wellingborough. In December 2007, he attended a mandatory lifer oral hearing at the Parole Board. The hearing was adjourned to 30 April 2008 pending his completion of a training course and an escorted town visit.

In March 2008, the man began asking more frequently for pain relief medication because of back pain. On 3 April, a wing officer returned from leave and noticed that he was looking unwell and had lost weight. The officer told a nurse that he was concerned about the man's health. The nurse examined the man and made an appointment for him with the prison doctor. The man had reported weight loss and altered bowel habits over the previous six weeks.

On 10 April, healthcare staff were called to the man's cell because he was short of breath. He was suffering from persistent vomiting and was unable to tolerate food. He saw the prison doctor the following day. The doctor noticed pitting oedema (swelling) in the man's legs and a considerable heart murmur. The doctor faxed an urgent referral to the General Hospital and an appointment was made for 16 April.

Following his appointment at hospital the man was admitted the same day. He underwent a number of tests over the next few days and, on 21 April, was told that he had terminal cancer which had spread to his liver. He was given "months (may be weeks)" to live. An application for compassionate release on medical grounds was partially completed on 22 and 23 April but was not submitted to the Governor for signature. On 24 April, Wellingborough contacted HMP Norwich with a view to him transferring to the Nelson Unit – a unit specialising in end of life care.

On 29 April, the man's consultant told Wellingborough that he required 24 hour hospice care. Norwich – the only prison able to cope with his healthcare needs – agreed to accept him as soon as he was fit to travel. He was taken there by ambulance on 7 May and died eight days later.

This case raises issues about compassionate release and the dearth of facilities in the National Offender Management Service with the resources and expertise to offer end of life care to terminally ill prisoners. I make a national recommendation to amend the advice to staff in chapter 12 of PSO 4700 about applications for compassionate release. I also address a number of issues raised by the man's family.

## **THE INVESTIGATION PROCESS**

1. The investigation was led by one of the Ombudsman's investigators. A Family Liaison Officer was appointed. Notices of the investigation were sent to staff and prisoners at HMP Wellingborough and HMP Norwich inviting them to contact the investigator if they wished. He obtained copies of the man's prison record and Inmate Medical Record (IMR). He visited Wellingborough and Norwich and spoke to relevant staff. The Family Liaison Officer and the investigator also visited the man's two sisters and brother-in-law at the home of one of the sisters. Their concerns were incorporated into the investigation. The Family Liaison Officer remained the family's point of contact throughout the investigation.
2. The Ombudsman commissioned an independent clinical review into the care received by the man at both Wellingborough and Norwich. An infection control nurse working for NHS Norfolk undertook the review. Her report appears at Annex 1. The medical care received by the man at General Hospital is not within my remit but the Family Liaison Officer advised his family of the procedure for addressing any questions they had about this.
3. Unfortunately, the investigator left the Ombudsman's employment due to ill health before the investigation was concluded. The case was passed to one of the senior investigators in June 2009. She visited Norwich and read through all of the man's prison record. She also spoke to the Principal Officer (PO) and the nurse at Wellingborough by telephone. She visited the Early Release and Recall Section of the Ministry of Justice and obtained a copy of the documents concerning the man's application for release on compassionate licence.

### **Issues raised by the man's family**

4. The man's family said that when they visited him at Wellingborough on Lifer's Day (15 April 2008) he looked seriously ill. Another prisoner came up to them when they arrived and told them that the man had been ill for some weeks. The family said they felt that Wellingborough did not know how to cope with managing a terminally ill life sentence prisoner. They felt that the prison would benefit from adopting processes to help them if they faced the situation again.
5. The family were very concerned about an argument between prison and hospital staff on the day that the man transferred from General Hospital to Norwich (6 April). They said that the argument was about who would cover the cost of the private ambulance and took place over the man's bed. They felt that it was inappropriate that such an argument should have taken place in front of him. His family were also unhappy about the behaviour of one of

the hospital consultants. My family liaison officer advised them on the best way to pursue their complaint.

6. The family said they were promised that they would be involved in the decision about where the man spent the remainder of his life. However, they did not feel that this had happened. They felt that the decision to move him to Norwich was taken without discussion. They said that his strong preference was to be moved to a hospice in the North West, close to them. When they arrived at hospital on 6 April they thought that it was to discuss the options for where he was going. Instead they found he was moving to HMP Norwich that same day.
7. The man's family said they had last visited him at Norwich on Sunday 11 May, and described their experience as "atrocious". They said that they had arranged to arrive at 11.00am but no one at the prison gate seemed to be aware of that and they were told that they could not come in until 2.00pm. They saw him at 2.25pm. They were not able to see him in his room, necessitating him being put in a wheelchair and being uncomfortable. The family, whose round trip to Norwich was over 500 miles, were then required to leave the prison at 4.00pm.
8. The family were also concerned that the man had been in hand cuffs while in hospital. However, they had high praise for the escort staff from Wellingborough whom they considered to have been polite, kind and understanding. They were also complimentary about the communication between themselves and Wellingborough, with the reservation that they felt that they had initiated most of the contact.

## **HMP WELLINGBOROUGH AND HMP&YOI NORWICH**

### **HMP Wellingborough**

9. Wellingborough is a category C training prison that holds adult men including life sentence prisoners. The prison holds up to 646 prisoners. Wellingborough offers a number of offending behaviour courses such as Enhanced Thinking Skills (ETS) and assessment for others such as Controlling Anger and Learning to Manage It (CALM). There are vocational workshop spaces for 120 prisoners, running courses in painting and decorating, carpentry, joinery, industrial cleaning and mechanics. A purpose built learning and skills centre offers places on over 100 full time and part time education courses. The healthcare centre does not provide 24 hour healthcare and there are no in-patient facilities.

### **HMP&YOI Norwich**

10. Norwich is a local prison serving the courts of East Anglia. It holds remand and sentenced adult men and young offenders. The adult men occupy the area of the prison that includes the healthcare centre. The healthcare centre provides 24 hour healthcare cover and has space for a maximum of 23 inpatients. On the ground floor of the centre is an elderly patients unit, the Nelson Unit. This unit has been designed and equipped to enable older and less able prisoners to be supported and cared for within the confines of the prison environment.
11. The role of Nelson Unit means that the prison has good links with palliative care teams and frequently employs the Liverpool Care Pathway (LCP) in caring for prisoners. The LCP is a key recommendation in the National Institute for Health and Clinical Excellence (NICE) guidelines for supportive and palliative care. It is a continuous quality improvement programme for the care of a dying patient. It has been developed in order to transfer the hospice model of care into other settings, including prisons. The LCP provides guidance on different aspects of care required, including comfort, pain control and when to discontinue medical treatment. Because of the level of expertise in end of life care at Norwich, it is quite common for prisoners with very short life expectancy to be transferred there.

## KEY EVENTS

12. The clinical review at Annex 1 offers a more detailed account of the chronology and nature of the man's clinical interventions in the years before his death. The review concentrates on his health since he transferred to Wellingborough in 2006.
13. The man was transferred to Wellingborough from The Wolds on 9 May 2006. His clinical records show that he suffered from mild aortic stenosis (a narrowing of the aortic valve in the heart), diagnosed in 2004, and was being treated for symptoms of paranoid thought and obsessive/compulsive disorder (OCD). He had been prescribed a low dose of Olanzapine (an anti-psychotic drug) to treat his OCD. On reception at Wellingborough he told healthcare staff that the only effect the Olanzapine appeared to have was to make him sleep and he did not continue to take it. He had a history of suffering from anxiety and depression but his clinical record reports his symptoms as stable since 2006.
14. The man attended a Mandatory Lifer Oral Hearing on 13 December 2007. Every life sentence prisoner who has exceeded the minimum time they must serve in prison has regular Parole Board hearings to determine whether they are suitable for release and, if not, what they need to accomplish before they can be reconsidered. At this time he was part way through a cognitive skills booster course and was preparing for a third escorted town visit. (Escorted visits form part of the assessment of whether a life sentence prisoner is suitable for release. His previous escorted absence was in late 2006.) The panel decided to adjourn his parole hearing until his course was finished and he could successfully complete a third escorted absence from the prison. They also requested a report from a psychologist specialising in autism. His hearing was adjourned until 30 April 2008.
15. In March 2008, the man's clinical notes show that he asked more frequently for pain relief medication. On 27 March, he was seen in the healthcare centre because he had become unwilling to collect his weekly medication. The notes do not record any signs of physical illness.
16. A mental health nurse who had not met him before interviewed the man on 1 April. He is recorded as telling the nurse that he was fine apart from experiencing some backache that he said had recently improved.
17. Two days later, on 3 April, an officer returned to work after two weeks leave. He thought the man looked unwell and had lost weight. The officer told a nurse that he was concerned about him. The nurse spoke to the man on the wing and noticed that he looked pale and had visibly lost weight. The man told him that he thought he was suffering from a virus. The nurse

established that the man had lost weight in the previous six weeks and his bowel habits had altered. The man did not feel that his health warranted further investigation and said he did not want to waste healthcare staff time.

18. Nevertheless the nurse made an appointment for the man to be seen in the healthcare centre the following day. Staff took blood samples and clinical observations (blood pressure, pulse and weight). An appointment was made for him with the prison doctor.
19. On 10 April, wing staff called healthcare staff to see the man on the wing as he had become short of breath. He had been vomiting persistently and could not digest any food. He was reluctant to be treated and declined an offer of ibuprofen. The following morning the doctor examined him in the healthcare centre. The man did not want to attend his appointment but healthcare staff escorted him from the wing. He appeared pale and the doctor noticed he had pitting oedema (swelling) in his legs and a considerable heart murmur. In the light of his previous heart problems, the doctor referred him to the cardiology department at the general hospital by fax the same day.
20. An appointment was made with the hospital for 16 April. Healthcare staff visited the man daily and treated him for his oedema. On 11 April, he was encouraged to tell his family that he was unwell and he telephoned them with the news. His brother-in-law telephoned the prison afterwards but healthcare staff refused to divulge information about him without first obtaining his consent. He gave permission for staff to tell his family about his symptoms and the nurse spoke to the brother-in-law later the same day.
21. The man met his family during a Lifer Day at the prison on 15 April. The nurse told the brother-in-law that the prison would ensure that the man received the same level of treatment and care that he would have if he were in the community. The family told the investigator that they were shocked by his appearance that day. He had lost a lot of weight, looked 'yellow' and could hardly stand because of his swollen legs. They realised that he was seriously ill.
22. On 16 April, the man was admitted to hospital following his outpatient appointment and his family were told. A meeting was held at Wellingborough to determine the level of restraint and how many staff were required to remain with him while he was in hospital. The initial diagnosis from the hospital was that his condition was serious but not life threatening. It was decided that he should have restraints applied and be accompanied by two members of staff. However, if resuscitation by medical staff was required then the escorting officers could remove the restraints without first obtaining permission from a governor.

23. Between 17 and 19 April the man underwent several scans at hospital that revealed deep vein thrombosis (blood clots) in his legs, multiple pulmonary emboli (clots in his lungs) and indicated likely metastasis (malignant tumour cells which have migrated from a primary tumour) in his liver. During this period the nurse made repeated attempts to speak to medical staff at the hospital and the man but little success. All of the information he received about the man's condition came from the shifts of escort staff when they returned to the prison. On 19 April, the nurse visited the hospital. The man asked him to telephone his brother-in-law, which he did.
24. Regular contact was maintained with the hospital and the man and staff also visited him in their own time. On 21 April, tests confirmed the presence of metastasis in his liver and he was told he had only "weeks or months" to live. He asked the Principal Officer (PO) (the lifer manager at Wellingborough) to tell his family. He asked that the prisoners on the wing not be told. The PO gave hospital staff a copy of Chapter 12 of Prison Service Order (PSO) 4700 (the application for compassionate release on medical grounds) to complete. The following day a new risk assessment was made and the restraints were removed from the man. He asked that the other prisoners on the wing be told of his condition and a Notice to Prisoners was prepared.
25. The hospital completed their section of the application for compassionate release on 22 April. The man's consultant described his life expectancy as "months (may be weeks)". He also wrote, "The patient is critically unwell with reduced life expectancy. His condition will continue to deteriorate." The consultant added that he was unable to offer an opinion as to whether the man was capable of re-offending.
26. The prison's probation officer completed the relevant section of the application the next day on 23 April. The officer wrote that he had been told that the man was likely to die while still at hospital. The man and his family had made the decision that he should not be resuscitated if his heart stopped. He therefore did not include a release plan as he thought that it was not appropriate given the expected imminence of the man's death.
27. The PO also completed his section of the application on 23 April. He wrote, "The man's current medical condition severely inhibits his ability to move, breathing is difficult and he finds it hard to walk more than 10 yards. Given these severely inhibiting factors he is not capable of causing harm and there is no risk [to the public]". He concluded:

"The prognosis for the man is extremely poor, as stated in the Doctor's report life expectancy is measured in weeks. Taking into account all of these factors I fully believe that he meets all of the criteria laid down in Chapter 12 of PSO 4700 and have no hesitation in recommending he be given early release under the auspices of the PSO."

The section of the form that should be filled in by the Governor is not completed. The PO told the investigator that he had passed the application to the Governor for completion but the Governor and the Deputy Governor did not think that the man fitted the criteria for compassionate release. Consequently the application went no further.

39. On 24 April, the PO telephoned HMP Norwich and asked whether they would consider the man for a place on Nelson Unit. The initial response was positive. His cell was cleared and his property cards were taken to hospital where he signed them. (His family collected his property when they visited the hospital on 27 April.)
40. Also on 24 April, the man's solicitors sent a fax to the Lifer Review section in the National Offender Management Service (NOMS) asking that he be considered for compassionate release during his scheduled mandatory lifer oral hearing on 30 April. (This was the hearing adjourned from December 2007.) Lifer Review section in NOMS decides on the release of life sentence prisoners on licence. It is a separate process from applications for compassionate release on medical grounds, which are decided by the Public Protection Casework Section in the Ministry of Justice.
41. The notes of a case review that took place in Wellingborough after the man's death show that, on 29 April, the nurse and the PO were told by the consultant that he had only "weeks or more" to live. The consultant confirmed that the man required the sort of care provided by a hospice and agreed that, if he were to remain in prison, then Norwich would be suitable. The nurse reported in the case review that he immediately discussed the options for care with the man. He said:

"I discussed this in detail with the man who was not concerned where he was to be cared for but more concerned that he would be comfortable. During these discussions my feeling was he was anxious and nervous about possible release to a community setting and was more accepting of HMP Norwich. It should be noted that he had spent some 24 years in prison. I subsequently completed the referral to HMP Norwich which was faxed the same day."
43. Also on 29 April, in response to the letter from the man's solicitors, a caseworker from Public Protection Casework Section telephoned Wellingborough to ask if they had started the application process for his compassionate release. The casework file shows that someone returned the call and told the caseworker that it was not yet clear how seriously ill he was. She said she would make enquiries about the hearing scheduled for 30 April and called back later to confirm that it had been cancelled. (The hearing was cancelled because it was an oral hearing requiring him to

attend in person and he was too unwell to do so.) The caseworker wrote in the file that she would wait for a further update from the man's solicitors and added, "Prison are not inclined to pursue compassionate release."

Applications for compassionate release must come from the prison in the first instance and the caseworker made a note to check the position again on 24 May.

44. An entry on EMIS (the man's electronic clinical record), on 2 May reports that the MacMillan nursing team at the hospital told Wellingborough that they had talked to the man about his thoughts about dying. They reported that he did not mind which environment he was in but was more concerned with the nature of "the end". The MacMillan team also said that he may only have "days" left to live. The same day he was fitted with a syringe driver and the hospital told Wellingborough that he was too poorly to be transferred to Norwich. By 6 May he was sufficiently improved to make the journey to Norwich and he was taken there by ambulance on 7 May.
45. The day after the transfer on 8 May, the nurse emailed Norwich to ask how the transfer had gone. The Deputy Head of Healthcare replied that all was well and the man was pleased to be with them and had passed a settled night. On 11 May, the man's family visited him at Norwich. The next day she emailed the nurse to say that the visit had gone well but that there was a noticeable deterioration in the man's condition.
46. The caseworker in Public Protection Casework Section telephoned the lifer manager at Norwich on 12 May to request an update on whether an application for release on compassionate grounds was forthcoming. After discussion it was decided that Norwich would complete a new application for compassionate release. The application was received on 14 May.
47. On 13 May, an MP wrote to the Secretary of State for Justice asking that the man be transferred to a hospice closer to his family for humanitarian reasons. The letter was passed to the Parliamentary Under Secretary with responsibility for prisons for reply. The Head of Casework in Public Protection Casework Section and the Head of the Public Protection Unit discussed the man's case. His condition had deteriorated to the extent that it was felt that he would not survive a six hour car journey to a hospice in the North West. The Head of Casework asked the Lifer Manager at Norwich to discuss with the man's family whether they wanted him to move to a hospice in the North West, or a hospice local to Norwich or for him to remain in prison. The Lifer Manager at Norwich said he would discuss the options with the family when they next visited three days later on 16 May. The man died the day before.

## ISSUES

### The man's application for compassionate release on medical grounds

48. Chapter 12 of Prison Service Order 4700 gives guidance to staff about applying for compassionate release for life sentence prisoners on medical grounds. Paragraph 12.2.1 says:

“The criteria for compassionate release on medical grounds for those prisoners serving a life or IPP sentence are as follows:

- The prisoner is suffering from a terminal illness and death is likely to occur very shortly (**although there are no set time limits 3 months may be considered to be an appropriate period for an application to be made to Lifer Review and Recall Section**) [bold in original – Lifer Review and Recall Section is now part of the Public Protection Casework Section], or the lifer is bedridden or similarly incapacitated, for example those paralysed or suffering from a severe stroke; and
- The risk of re-offending (particularly of a sexual or violent nature) is minimal; and
- Further imprisonment would reduce the prisoner's life expectancy; and
- There are adequate arrangements for the prisoner's care and treatment outside prison; and
- Early release will bring some significant benefit to the prisoner or his/her family”.

49. The application form has a number of sections that must be completed by the prison's lifer manager, a registered medical practitioner, the probation officer who works at the prison and the prison Governor. The application is then passed to the Public Protection Casework Section in the Ministry of Justice.

50. On 16 April, the man's condition was described by hospital staff as “serious but not life threatening”. This diagnosis changed, on 21 April, to “weeks or months”. On the same day, the PO initiated an application for compassionate release on medical grounds. The application was completed by all parties, except the Governor, by 23 April. The consultant wrote that the man had “months (may be weeks)” to live. The PO wrote that the man's life expectancy was “measured in weeks” and said he was satisfied that he met all the criteria for compassionate release. On 29 April, the consultant said that the man had “weeks or more”. On 2 May, it was reported that the MacMillan nurses at the hospital felt he might only have days to live.

51. On 29 April, the same day that the consultant told the PO and the nurse that the man had “weeks or more” another member of Wellingborough staff told Public Protection Casework Section that it was not yet clear how seriously ill he was. In a memo of 7 May to a caseworker in NOMS pre-release section, the PO wrote that:

“Chapter 12 of PSO 4700 was completed however without a definite life expectancy it was not submitted as it was felt that the man did not meet the criteria in line with the PSO.”

52. It appears to me that by the end of April it was quite clear that the man was terminally ill and had weeks to live. The consultant’s opinion that the man had “weeks or more” was reiterated to the PO and the nurse on 29 April. The MacMillan team at the hospital told the nurse that the man may have “days” left to live on 2 May. The guidance in PSO 4700 requires that “death is likely to occur very shortly”. It does not require a definitive life expectancy to have been set, although it offers a guide of three months. I consider that senior management at Wellingborough were mistaken if they believed that he did not fit the criteria because a definitive life expectancy had not been set. I consider that the application for his compassionate release should have been pursued - although I note that there is some doubt as to the man’s own wishes in this matter. In two conversations, reported by the nurse and the MacMillan team at the hospital, the man appears to have indicated that he was happy to remain in prison.
53. It is apparent from this sad case, and from many others the Ombudsman has investigated, that it is extremely difficult to judge a terminally ill person’s life expectancy. Diseases such as cancer are often unpredictable – especially when a person has underlying medical conditions. Moreover the medical profession is by and large unwilling to give a definitive opinion on the length of time a person may have left. It is far more common for ‘weeks’ or ‘months’ to be given than a specific number of weeks or months. The man offers an example of how a person’s prognosis can change rapidly from day to day. On 16 April, he was told that his condition was not life threatening and less than a month later he died.
54. I do not believe therefore that it is helpful that the current guidance gives a guide period of three months. I believe it encourages prison staff to think in terms of definite time periods rather than looking at each case on its merits.

**I recommend that the guidance in chapter 12 of PSO 4700 on applications for compassionate release on medical grounds be revised to remove the guide period of three months or to otherwise make clear that a definitive life expectancy is not required before an application may be made.**

[The National Offender Management Service accepted this recommendation in their response to the draft report.]

### **The man's transfer to Norwich**

55. The PO first contacted Norwich about the possibility of the man moving to Nelson Unit (the prison's specialist unit for elderly and infirm prisoners which occupies the ground floor of the 24 hour in-patient healthcare centre) on 24 April. At this stage he had been diagnosed with a terminal illness and Wellingborough, which has no in-patient facilities, would be unable to provide the level of nursing and care he required. On 29 April, the PO and the nurse were told that the man required 24 hour care consistent with that provided by a hospice. At present Norwich is the only prison with the necessary resources and expertise to care for prisoners in this situation. Given that the application for compassionate release was not being pursued, Norwich was the only possible destination for him.
56. I have already said that I believe that the man's application for compassionate release should have been pursued (if indeed that was his wish). His family are from the North West and in order to visit him in Norwich they had to make a 600 mile round trip by car. Clearly this was difficult for them. Not only did it add to the distress they were already suffering but it also meant they could not spend as much time with him in his last days as they would have liked. In June this year the Ombudsman made a national recommendation to the Department of Health and Ministry of Justice that they should jointly review the provision of healthcare facilities for elderly, long term sick and terminally ill prisoners to ensure a better geographical spread. This recommendation has been accepted and a review is underway. Matters would be enormously eased in the meantime if all prisoners requiring 24 hour hospice care were at least considered for compassionate release.

### **The use of restraints at the General Hospital**

57. The man's family told the original investigator that they were concerned that he had been hand cuffed to an officer when he was initially admitted to hospital. I have not seen a copy of the escort risk assessment or bedwatch paperwork completed by Wellingborough. The second investigator spoke to staff at Wellingborough who looked for it in the prison but were unable to find it. She was told that all of his prison records including the risk assessments and bedwatch paperwork had been transferred to Norwich with him on 7 May. She visited Norwich and examined all of his considerable prison record but the risk assessment and bedwatch paperwork was not there. Staff at Norwich had no memory of having seen it.

58. I am aware from the Family Liaison log completed by Wellingborough that a risk assessment meeting on 16 April (attended by two governors, a prison doctor, a prison nurse and the PO) decided that the man should be escorted at the hospital by two officers and that restraints be applied. The escort staff were told that, if a medical emergency required that he be resuscitated, they were to remove the restraints without first asking permission from the Duty Governor. This was a break from standard practice that changes to the level of restraint or escort must be agreed by the Duty Governor. On 22 April, the day after he had been told that he was terminally ill, the restraints were removed. Further on 30 April the decision was taken to reduce the escort to a single officer.
59. I am unable to examine the reasoning behind these decisions because I have not seen the paperwork. However, in the circumstances I believe that Wellingborough acted reasonably. When the man arrived at hospital on 16 April his diagnosis was not thought to be life threatening. Restraints and a two officer escort is standard practice for any non-bedridden prisoner staying in outside hospital. Regular reviews appear to have taken place and the restraints were removed once it was made clear that he was terminally ill. Later, when he deteriorated further, the escort was reduced. I note too that his family were very complimentary about the staff who escorted him at hospital.

### **The argument at General Hospital on 6 May**

60. The man's family told the investigator and family liaison officer that, on the day he transferred to Norwich from hospital, prison staff and hospital staff had an argument about who would pay for the escort in a private ambulance and how the escort and the nurse would return. I share the family's view that it was wholly inappropriate for a discussion of this nature to take place in front of a prisoner and his family. It can only have been the cause of further distress at what was already a very upsetting time for them. The first investigator wrote to the Governor of Wellingborough and asked for his views on the incident.
61. He replied that he felt the argument was indeed "unseemly" and that he would have "paid and sorted it out later". He said that the investigator's points would be 'taken on board'.
62. I am pleased that the Governor agrees that it was inappropriate to engage in an argument about a relatively trivial sum of money in front of a gravely ill patient and his family. There is no doubt it was. However, I also recognise that the family are in general very complimentary about staff from Wellingborough and this seems to be an isolated incident. There is certainly a significant amount of evidence that the PO and the nurse in

particular made every effort to be sensitive to the man's needs. I make no formal recommendation in this matter but I trust that Wellingborough's future management of terminally ill prisoners in outside hospital will be informed by this report. [NB: the prison responded at draft stage that local action had been taken over this matter and that in future the prison would take responsibility for any transfers and liaise with the hospital about payment at a later date.]

### **The visit to Norwich by the man's family on 11 May**

63. The man's family were angry that they waited some three and a half hours between arriving at Norwich and seeing him. They were unhappy that they were then only allowed to see him for an hour and a half. My original investigator contacted Norwich to ask for their comments. The Deputy Head of Healthcare responded by email. She said that she had come into the prison specifically to facilitate the visit on that Sunday. She had arranged that the family could arrive at a time convenient to them but had told them that they would not be allowed in the prison over lunchtime and would have to leave by tea time roll check at about 4.00pm. She said that she had given the family her on-call work mobile telephone number (also against normal practice) but had not received a call from them saying that they were having problems in gaining entry to the prison. She said the gate and security had been briefed in advance as the visit would not be taking place in the visits centre but in or near to Nelson Unit.
64. The Deputy Head of Healthcare said she had explained to the family that decisions about whether visits could take place on the unit were reviewed daily and depended in the main on the health of the prisoner. She said the man was well enough to be moved around by wheelchair and so the visit took place in the centre office, around the corner from Nelson Unit. Had he been unable to leave his bed the family would have been able to visit him in his room. She said she had arranged (against normal practice) for his family to be shown around Nelson Unit. She said she arrived in mid-afternoon and spent a significant amount of time talking to the family.
65. She said the man looked tired throughout the visit and she suggested several times that he return to his room. However he and his family were keen to be together. Eventually she said she was taking him back to his room as he was "clearly exhausted". She then showed his family around the unit and his brother-in-law helped him back into his bed. She said she escorted the family out of the prison and both the man's sisters expressed "heartfelt thanks" for the care that he was receiving and the effort that had gone into the visit. She forwarded a copy of another email that she sent to the nurse at Wellingborough the following Monday in which she described the visit as having been very successful. She said she was disheartened to hear the family's subsequent account of their visit as they had not complained to her at any point. She added that the man was very poorly at

the time and she felt that he could not have coped with longer than the amount of time his family had spent with him.

66. I am sorry that the man's family felt unhappy and upset by their visit to Norwich on 11 May. I am satisfied that the staff at Norwich, especially the Deputy Head of Healthcare, made genuine efforts to ensure that the visit went well for all parties and broke with established practice to do so. Indeed I know from previous investigations that Norwich have considerable experience with visits of this nature and I have praised them in the past for the efforts that they make. It is also apparent that the Deputy Head of Healthcare was not only unaware that the family were unhappy but was under the impression that the visit had been successful. I do not believe there is any redress that I can offer the family in this matter but I draw the attention of the Governor to their view of what happened as a learning point.

### **The findings of the clinical review**

65. The clinical review provides a comprehensive account of the man's medical history over the five years before he died. In summary, the review concludes that overall he was cared for appropriately in Norwich and Wellingborough. I share the clinical reviewer's assessment that the care he received was equitable with that he would have received in the community with the exception of the fact that he was not transferred to a hospice near his family once his life expectancy was deemed to be only months.
66. The review praises the officer for noticing the man's weight loss and referring him to healthcare. It is also noteworthy that the healthcare team at Wellingborough held a review of his case once he had been transferred to Norwich. He was the first life sentenced prisoner to be diagnosed with a terminal illness at Wellingborough and I am pleased that there was a formal review to learn from his case. As a result of this internal review several recommendations were put forward to change practice at Wellingborough including the introduction of a Well Man clinic and a review of how information is shared with the next of kin. I welcome these changes in practice and include a copy of the review in the annexes to this report.
67. The review makes a number of recommendations and I draw them to the attention of the head of healthcare at Wellingborough for their consideration.

## **RECOMMENDATION**

I recommend that the guidance in chapter 12 of PSO 4700 on applications for compassionate release on medical grounds be revised to remove the guide period of three months or to otherwise make clear that a definitive life expectancy is not required before an application may be made.

[The National Offender Management Service accepted this recommendation in their response to the draft report.]