

**Circumstances surrounding the death of a man, a former
prisoner at HMP Camp Hill, in February 2008**

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

January 2009

This is the report of an investigation into the death of a man who died from natural causes at his family home in February 2008. He was 64 years old. He had been released on temporary licence from HMP Camp Hill before being granted release on compassionate grounds by the Secretary of State. 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.

Before his death, the man's family had already contacted my office as he wanted to raise a number of concerns. These centred on the care he had received whilst in prison and the events surrounding his release from custody. My Terms of Reference provide authority to investigate, to the extent appropriate, the deaths of those released from custody (either temporarily or permanently). The death of the man is one such case. I would like to add my personal condolences to those already expressed to his family on behalf of this office by my senior family liaison officer..

The investigation was undertaken by one of my investigators. I am grateful for the assistance he received from staff at HMP Camp Hill. In particular, I would like to thank the Governor and his staff for all that they did to assist my investigation. I would also like to thank the Chief Officer of the relevant Probation Area, and his staff for their assistance.

The man was diagnosed with terminal cancer in October 2007 and was granted release on temporary licence two months later. In January 2008, he moved from the prison's local hospital to a local hospice. He then moved to another hospice a week later. The man was granted release from custody on compassionate grounds on 13 February 2008. He returned to the family home a week later and died on 25 February.

The initial conditions of the man's compassionate release from custody meant that he had to stay within the grounds of the hospice and he was not allowed to return to his family home. This came as a surprise to him and his family. After additional work was carried out by staff of the relevant probation area, the conditions of the licence were revised and he was allowed to return to his home. It appears that information about the initial conditions of his release was not fully explained to him and his family. This led to a very difficult relationship between the Probation Service and the man, and his family. There was also poor communication between staff from a second probation office and Camp Hill leading up to the man's release from custody. I have made a recommendation about improvements to communication between the Prison and Probation Services.

A doctor was appointed by the Primary Care Trust to undertake a review of the man's clinical care and I appreciate his assistance. The clinical reviewer raises a number of learning points that the prison health partnership will need to consider seriously. I trust the Primary Care Trust in partnership with HMP Camp Hill will develop an action plan to address them in a timely manner. I must apologise for the delay in issuing this report.

Stephen Shaw CBE
Prisons and Probation Ombudsman

January 2009

SUMMARY

The man was born in 1943, he was 64 years old when he died at home with his family on 25 February 2008. He died from natural causes as a consequence of a metastatic gastric adenocarcinoma (a malignant growth of glandular tissue in the stomach).

The man was sentenced to four years imprisonment at Crown Court in April 2007. He had been initially remanded into custody at HMP Lewes on 6 November 2006. He transferred to HMP Camp Hill on 1 May 2007.

During his first reception health screen on 6 November 2006, he saw a doctor about problems with his prostate. It was also recorded that he had previously been diagnosed with emphysema and suffered from depression.

On 3 February 2007, he collapsed while his family were visiting him at Lewes. After he was seen by a prison doctor he returned to the visits hall.

Following a blood test on 2 July, the medical officer at Camp Hill suspected the man might have gastrointestinal cancer. A referral was made to the local hospital, and he was seen at the hospital on 19 July 2007. As the possibility of cancer was considered to be high, it was planned that a colonoscopy (telescopic examination of the large bowel) would be first carried out, followed by a computer topography (CT) scan of his abdomen.

The man attended the local hospital for a colonoscopy on 16 August. At this examination no cancer was detected but he was diagnosed with diverticulitis. (The diverticulum is a small sac-like structure that sometimes forms in the walls of the intestines. Diverticula can trap particles of food and become very inflamed and painful; this condition is called diverticulitis.)

He had a CT scan of his abdomen on 4 September. The results of the procedure suggested upper gastrointestinal (stomach) or pancreatic cancer. On 23 October, the man was told he had cancer and was informed that his prognosis was very poor. A course of palliative chemotherapy began.

He was admitted to the local hospital on 11 December. Whilst he was in hospital, a bedwatch was carried out by prison staff. The initial security risk assessment was that handcuffs were to be used and two officers needed to be at his bedside. After a further risk assessment it was decided that handcuffs were no longer to be used and the escort was reduced to one officer. A final revision of the risk assessment led to the man being allowed to stay in hospital without an escort. He was also given a mobile telephone by his family so that he could keep in contact with them and the prison. His family were allowed to visit him whilst he was in hospital.

On 14 December 2007, as the man's life expectancy was a matter of months, he was released on temporary licence (ROTL). He was transferred to a local hospice on 18 January 2008, before moving the following week to a second hospice nearer to his family. An exclusion zone was created around the area where the victim of the man's crime still lived. The conditions of this exclusion zone were that the man was

to remain within the grounds of the second hospice and he was also not allowed to contact his victim.

The man was granted release on compassionate grounds by the Secretary of State for Justice on 13 February. However, the conditions of his compassionate release from custody came as a surprise to both him and his family. He had to remain within the grounds of the hospice and was still not allowed to enter the exclusion zone although his family home was within the zone. The family had expected that he would be immediately released from the hospice and be able to return to the family home. Staff at the local probation area explained the conditions of his licence. During the following week probation staff reviewed the conditions of his licence so that he could enter a revised exclusion zone which included the family home.

The man returned to the family home on 21 February 2008. During the following weekend his condition deteriorated and he passed away at 10:15pm on 25 February in the company of his family.

The clinical review carried out by an appointed doctor and a panel of his colleagues identified issues relating to the care for the man. The clinical review concludes that the care he received whilst in custody was not comparable to what he would have received in the community. The review also highlights areas of practice that could be improved. The review makes a number of recommendations for service improvement and I have endorsed six of them. I believe it is important that the prison health partnership consider the findings from this report and develop an action plan to address these learning opportunities. I have also made a specific recommendation about improving communication between Camp Hill and the probation area.

THE INVESTIGATION PROCESS

1. The investigation was opened on 13 March 2008 when my investigator issued notices announcing the investigation to both staff and prisoners. The notices included an invitation to those who wished to contribute to the investigation to make themselves known to him. One prisoner asked to see him. My investigator also studied all relevant probation and prison records relating to the man. These included his main prison record and his medical records.
2. My investigator visited Camp Hill on 25 April and discussed aspects of the man's treatment with both staff and prisoners. He interviewed the Head of Offender Management and an officer. My investigator also interviewed two prisoners who had both shared a cell with the man. They were able to provide background information concerning him and his care whilst in custody. My investigator also interviewed two members of staff from the relevant probation area. These staff had dealings with the man and his family after he moved to the second hospice.
3. The Primary Care Trust (PCT) commissioned a doctor from the PCT's Public Health Department and a panel of his colleagues to carry out a review of the man's clinical care. I am most grateful to them for undertaking such a thorough review.
4. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the Post Mortem report. Upon completion, this report will be sent to the Coroner to assist him in his enquiries into the man's death.
5. In mid-February 2008, before he died, my office was contacted by the man's because he wanted to raise a number of concerns about the care he had received whilst in custody. His family also had concerns about how his release from custody had been handled. My terms of reference provide me with the authority to investigate the deaths of those prisoners who have been released from custody (either temporarily or permanently). Once my office had been officially notified of his death, I decided to investigate using my discretionary powers.
6. My senior family liaison officer and my investigator met the family to discuss their concerns. These were:
 - The family recalled that in February 2007 the man had collapsed in the visits hall at Lewes prison. The family said that neither he nor his family were given an explanation about what was wrong with him on this occasion.
 - The family said that the man felt he did not get the care he needed from Camp Hill's healthcare centre because he was under the care of the prisons local hospital.

- The family said that there were conflicting diagnoses following the possibility of cancer being raised. Having initially been told the man had cancer, they were then told that it was not cancer but diverticulitis.
- The family said that there were problems with hospital procedures not being carried out and appointments being cancelled.
- They pointed out there was an occasion whilst in hospital, after the man's bedwatch staff had been withdrawn, when he slipped on water, fell to the floor and hurt his head.
- The family had concerns about the man's medication. They said that management of his pain control was not consistent and there were delays in him receiving his pain medication/relief. They had concerns about the withdrawal of his anti-depressant medication and the effect that this had. The family pointed out that he did not get his antibiotics for a urinary tract infection.
- They felt that he had not been supported by staff at Camp Hill on an occasion when he had been vomiting blood.
- The family also said that they were told that Camp Hill told staff in the local hospital that they could not cope with the man's condition and that he should not return to prison.
- The family also raised a concern about Camp Hill not informing them when he was admitted to hospital.
- The family said they had been distressed by an officer coming to risk assess the man and the hospice, and taking photographs of him as he was taken out of the ambulance when being rushed to the hospice. Whilst they said they understood the security issues, they felt that this was insensitive when he could barely walk.
- The family were not happy with the treatment both they and the man received from staff of their local probation area.
- From the family perspective, the issue of the man's release from custody after he moved back to their area, was not handled well and his return to the family home was delayed. Due to the fragility of his health the family did not fully accept the extent of the exclusion zone.
- Whilst the family had concerns about his care at Camp Hill, they were also keen to compliment staff whom they felt had been very supportive to them before and after the man's death. They named the Head of Offender Management, members of the chaplaincy and a particular officer. The family were also extremely grateful to fellow prisoners for all they had done to care for and support the man whilst he was ill.

7. The clinical reviewer, the clinical review panel and my investigator have explored the points raised by the family and I hope that this report provides them with answers to their questions.

HMP CAMP HILL

8. Camp Hill is a category C training prison situated near Newport on the Isle of Wight. The prison was built in 1912 using prisoner labour from nearby Parkhurst. Camp Hill has a varied regime with education and various offending behaviour programmes. At the time of the investigation the prison could hold up to 595 adult male prisoners.
9. There are nine residential units, ranging from Victorian style galleried units to single corridor buildings. Some of the units have specific functions. St Stephen's holds prisoners who have reached the enhanced level of privileges. There is also a segregation unit that can hold up to 19 prisoners.
10. Health services at Camp Hill and the other two prisons on the Isle of Wight are commissioned by the Isle of Wight NHS Primary Care Trust. The prison's healthcare is clustered with HMP Albany and is provided by HMP Parkhurst. Parkhurst provides healthcare to the 1,500 or so prisoners on the island and has a 12 bed in-patient facility (mainly providing psychiatric treatment). Prisoners' medical needs are catered for by way of out-patient clinics and core day primary nursing cover. There are three nurses on duty from 7:30am to 5:30pm, Tuesday to Friday, and from 7:30am to 5:30pm, Saturday to Monday. During weekends and evenings, one member of healthcare staff is on duty. General practitioners (GPs) from Medina Healthcare, a local community practice, attend Camp Hill for four sessions of three-hours each week. Evenings and weekends are covered by on-call doctors from the local PCT. There is no nursing or healthcare cover at Camp Hill during the night.
11. The most recent report of a full announced inspection by Her Majesty's Chief Inspector of Prisons was published in January 2007. She found that the healthcare service at the prison offered a broad range of clinical services for prisoners and there was good chronic disease management. However, Her Majesty's Chief Inspector of Prisons said that prisoners were unhappy with the delivery of care from the doctors, dentist and optician, particularly the waiting lists. The Chief Inspector also said that staffing levels were barely adequate and prohibited the introduction of additional nurse led clinics.
12. In its latest report (2006-2007), the prison's Independent Monitoring Board (IMB) drew attention to the problem of recruitment of staff and the impact this had on the induction of new prisoners. The report also drew attention to the number of prisoners with mental health problems who were located in the segregation unit whilst awaiting assessments.
13. Since 2004, my office has investigated two deaths through natural causes at Camp Hill. There was no link between the circumstances surrounding this investigation and the previous death at Camp Hill. There was also no link in the recommendations made here and those in investigation reports into deaths through natural causes at Parkhurst and Albany.

KEY EVENTS

14. During his first reception health screen as a remand prisoner at HMP Lewes on 6 November 2006, it was noted that the man had seen a doctor about problems with his prostate. It was also recorded that he had previously been diagnosed with emphysema and suffered from depression. A referral was also made to the mental health in-reach team as he told staff that he had previously tried to commit suicide. He was allowed to keep his medication (Venlafaxine to treat his depression and Tamsulosin for his prostate problems) in possession.
15. At around 10:10am on 3 February 2007, the man collapsed in the visits hall at Lewes in front of his family. He told staff that he did not have any chest pain and, after being given oxygen, he walked to the healthcare centre. He saw one of the doctors who told him to “take things easy” and an appointment was made to return to see the doctor on 6 February. He returned to the visits hall at around 11:00am.
16. On 12 February, the man attended the healthcare centre as he still felt unwell. He told staff that he thought he had either a bladder infection or kidney stones. An appointment was made for him to see the doctor the following day. A test of his urine was carried out when he saw the doctor. It was negative for protein and blood.
17. The man was given enhanced prisoner status on 2 March under the Incentives and Earned Privileged Scheme (IEPS). There are three tiers to the IEPS – Basic, Standard and Enhanced – and the incentives include in-cell televisions, more private cash, wearing own clothes, more time out of cell and community visits.
18. On 11 April 2007, the man was sentenced at Crown Court to four years imprisonment. He arrived at HMP Camp Hill as a category C sentenced prisoner on 1 May.
19. On 2 July, following the result of another blood test, a referral was made for suspected gastrointestinal (stomach) cancer. It was recorded on the referral form that the man had suffered from constipation since November 2006 and had increasing abdominal pain and tenderness. A fast track referral form was faxed to the prisons local hospital, the following day. He was due to attend the hospital on 5 July but this appointment was cancelled by the prison. The reason for the cancellation was not recorded and my investigator could find no further information about it.
20. The man went to hospital on 19 July and a sigmoidoscopy was performed to look inside his colon. (A sigmoidoscope is a long flexible tube that can be swallowed and allows the surgeon to see inside the body.) As the possibility of cancer was high, a colonoscopy (a telescopic examination of the large bowel) was to be carried out first, followed by a computer topography (CT) scan of his abdomen.

21. The man returned to hospital again on 16 August for the colonoscopy. At this examination no cancer was detected but he was diagnosed with diverticulitis. The CT scan of his abdomen followed on 4 September. The results suggested upper gastrointestinal or pancreatic (stomach) cancer. On 13 September, a colorectal cancer multi-disciplinary meeting decided that a liver biopsy was necessary to clarify his diagnosis.
22. During the afternoon of 7 September, the man was seen by a senior nurse as he had a slightly raised temperature. On 10 September, he was seen by a prison doctor who prescribed antibiotics.
23. On 23 October, the man saw a colorectal nurse specialist at the hospital. He was informed of the results of the CT scan. He was also referred to the Macmillan Nursing Service as he had experienced problems with abdominal pains.
24. A guided liver biopsy was carried out on 29 October. The biopsy showed adenocarcinoma (a type of cancer). The man began to receive palliative chemotherapy but suffered significant side effects which required in-patient admission to the prisons local hospital.
25. Four days later on 2 November 2007, the colorectal nurse specialist wrote to the Governor of Camp Hill summarising the man's prognosis. She said that, although it was difficult to predict his life expectancy, it was not expected to be more than a year and possibly less if he did not respond to treatment. The colorectal nurse specialist informed the Governor of the man's nutritional needs. She also confirmed her support on compassionate grounds for any action which would assist him or his family.
26. The man went to the prisons local hospital on 6 November for an endoscopy of his stomach. (An endoscopy is a test that looks inside the body. The endoscope is a long flexible tube that can be swallowed. It has a camera and light inside it.)
27. On 15 November, the consultant surgeon made a referral to the consultant in clinical oncology. On 26 November, the consultant in clinical oncology wrote to the consultant surgeon about the review he had carried out with the man the previous day. He said that the man remained rather weak and tired with some intermittent abdominal pain and vomiting. He confirmed that the man wanted to try palliative chemotherapy again. He was aware that this would not cure his cancer but it might improve his symptoms and prolong his life. The consultant in clinical oncology concluded that the man's life expectancy was in the region of three to six months although it could be shorter or slightly longer if he responded well to chemotherapy
28. The consultant in clinical oncology wrote on 6 December to a doctor at Camp Hill, about another consultation with the man the previous day. He also wrote to the Governor of Camp Hill. In his letter he summarised the man's prognosis and treatment. The consultant in clinical oncology wrote that he was in no

doubt that the man's condition was terminal and he supported his release from custody on compassionate grounds.

29. On 11 December, the man was admitted to the prisons local hospital as he was vomiting, had severe abdominal pain and was dehydrated. Whilst he was in hospital, a bedwatch was carried out by prison staff. The initial security risk assessment on 11 December was that handcuffs were to be used and two officers needed to be at his bedside. This was revised on 14 December; only one officer was to be at his bedside and restraints were no longer to be used. Later that same day he was released on temporary licence (ROTL). He was also given a mobile telephone by his family so that he could keep in contact with them and Camp Hill. The man's family were allowed to visit him whilst he was in hospital.
30. The man was discharged from hospital on 2 January 2008 and returned to Camp Hill. He returned to hospital two days later when he became ill again. On his return to hospital the security risk assessment was that he no longer required officers at his bedside.
31. On 7 January, the consultant in clinical oncology wrote to the prison doctor about the man's consultation at his clinic on 3 January. He said that he had told the man that further chemotherapy was unlikely to have a significant effect on his cancer. He had therefore stopped his chemotherapy. The consultant undertook to try further treatment if the man's condition improved significantly but he did not think that this was likely. If his vomiting continued, he thought that he should be re-admitted either to hospital or to the local hospice.
32. When interviewed as part of this investigation, a deputy team manager and a probation officer from the relevant probation area were able to clarify what happened around this time. The probation officer was the man's offender manager. (The offender manager is responsible for post-release supervision of the prison licence which includes assessing an offender's risks and needs, planning manage these risks, considering the victim's perceptive and risk issues and deciding what activities need to be carried out and how they will be delivered. They are also responsible for reviewing the offender's progress against their sentence plan and for adjusting the plan in the light of changing circumstances.)
33. The probation officer said that, from a Probation Service point of view, nothing of note was learnt after the man was sentenced until 2 November 2007 when staff received a phone call about him. A member of the Public Protection Team at Camp Hill had telephoned to inform them that the man was seriously ill and in hospital. Up until that point probation staff had not known that he was seriously ill and did not have information about his illness. The member of the Public Protection Team had asked whether the man could be released on temporary licence. The victim liaison officer (VLO) for the victim of the man's offence, expressed concerns about release on temporary licence (ROTL) being granted and the head of the Public Protection Team at Camp Hill was informed on 2 November of the victim's concerns. He stated that he would recommend to the Governor that the man should not be granted ROTL. There was no

further contact between the prison and staff of the probation area until 4 January 2008.

34. On that day (4 January), the probation officer contacted Camp Hill and was told that the man had already been released on temporary licence to the prisons local hospital. The Deputy Team Manager said it was normal practice for the prison to inform staff at the probation area whenever a prisoner was considered for temporary release so that a risk assessment could be carried out. This did not happen in this case. He also stressed the importance of the victim of the man's crime being briefed by the VLO about what was happening. The prison informed the probation officer that the man was unable to get out of bed unaided and that his death was imminent. The probation officer retrospectively agreed to ROTL being granted with conditions that the man did not contact the victim of his crime and was excluded from certain geographical areas. She was also informed by Camp Hill that the Governor was in the process of applying for what she referred to as a "Royal Prerogative", that is the Secretary of State for Justice would remit the man's custodial sentence and he would be released subject to licence conditions.
35. Around 5:45pm on 5 January, the man fell over and cut his head. Hospital staff carried out neurological observations until midnight.
36. A week later, on 11 January 2008, a probation officer based at Camp Hill, contacted the probation officer to inform her that the man was still in hospital. He said that the man would be transferred HMP Lewes the following week with the intention of releasing him from there to a hospice. The probation officer expressed her concerns about moving him to a hospice in the proposed area as the victim of his crime still lived there. She informed the probation officer based at Camp Hill that she would be requesting an exclusion zone so that the man was not allowed to be near his victim. The probation officer based at Camp Hill also informed the probation officer that the prison was no longer applying for a "Royal Prerogative" for him.
37. A fax was received by the probation staff from Camp Hill on 15 January. The prison asked whether the exclusion zone could be reduced as the man was going to move to a hospice near his family. The VLO was asked to consult the victim about his living within the exclusion zone.
38. The prison's head of offender management, contacted the probation officer on 17 January. She explained that the man was very ill and she was trying to arrange for him to be released to a hospice near his family. The probation officer explained the victim's issues and the fact that the hospice was very close to the victim's address and within the exclusion zone.
39. The probation officer based at Cam Hill contacted the senior probation officer (SPO), on 18 January to say that the man was going to be moved to the prisons local hospice. He said the intention was that the man would then move into another hospice, at one of two areas near where his family were living. The senior probation officer gave the probation areas preferred area and asked

for the probation office based at camp hill to keep the VLO up to date with any developments.

40. Later that day, the Deputy Team Manager contacted the probation officer based at Camp Hill and reviewed the man's position. He had taken over responsibility for the man and his release from custody whilst the probation officer was on leave for two weeks. The probation officer based at Camp Hill said that the intention was that the man move to a hospice in either in two areas close to where his family were living, but not the area that the probation area preferred. The probation officer based at Camp Hill told the Deputy Team Manager that the man was no longer receiving treatment for his condition and was only having pain relief. The Deputy Team Manager explained the licence conditions that his team recommended:
 - The man was to remain in the hospice/hospital grounds
 - There was to be no direct or indirect contact with the victim
 - The man was not to enter the exclusion zones.
41. The probation officer based at Camp Hill named the proposed hospice. When interviewed by my investigator, the Deputy Team Manager said that the probation officer based at Camp Hill was dismissive of the probation area's influence over the choice of hospice. The probation officer based at Camp Hill said that this was the decision of medical consultants. The Deputy Team Manager did not agree with this. He said that the consultants should be informed of the exclusion zone and then work out where the man could be cared for.
42. The Deputy Team Manager then spoke to the Head of Offender Management about the prison's intention to move the man to a hospice and where this would be. He stated that this was contrary to the exclusion zone recommended by the VLO and was without the agreement of the probation area. He added that there was no current risk assessment package to protect the victim. The Head of Offender Management explained that the medical director of the prisons local hospice and consultant in palliative medicine had chosen that hospice in the family's local area so that the man could be near them. The Deputy Team Manager expressed his concern about the proximity of the hospice to the victim and repeated the view of the VLO. He asked the Head of Offender Management to consider a hospice in another area as this would enhance the safety of the victim and give more assurance. He said that it would also only be a minor journey for the family to visit the man. The Head of Offender Management agreed to look into this.
43. The Deputy Team Manager then spoke to the VLO who requested that the man be excluded from the family's local area and ideally move to a hospice in a neighbouring area. He also contacted his manager who agreed that the preferred option was a hospice in the neighbouring area. The head of public protection said that, if Camp Hill decided to select a hospice in the family's local area then the licence condition would have to say the man could:
 - Not leave the grounds

- Not have direct or indirect contact with the victim
- Not enter any part of an identified holiday park.

The Deputy Team Manager faxed this information to the Head of Offender Management.

44. The Head of Offender Management also wrote to the Early Release and Recall Section of the Ministry of Justice on 18 January. She enclosed an application for early release on compassionate grounds for the man. Staff at the probation area were not informed about this action. On the same day the man was transferred from the prisons local hospital to the local hospice.
45. On 21 January, the probation officer based at Camp Hill telephoned the Deputy Team Manager to inform him that the man was now in the prison's local hospice. He told him that the Head of Offender Management had informed the medical director of the said hospice that the man could not move to a hospice in the area where his family lived. The probation officer based at Camp Hill said that the medical director was not happy about the situation and suggested that the Deputy Team Manager was to blame. The Deputy Team Manager did not accept this, saying that the licence conditions were suggested by his office and that Camp Hill had accepted them. He said that the Head of Offender Management was in a position to balance all the issues. She thought the family's local area exclusion zone was inappropriate and she had the final decision about where the man moved to. He said that he was not in a position to consider all the factors as he had not received all the medical assessments. The probation officer based at Camp Hill also confirmed that the issue of a "Royal Prerogative" was still being sought, although he had previously said (on 11 January) that this was no longer the case. The probation officer based at Camp Hill suggested that, if this was granted, the man could move to the area where his family lived. He was unable to clarify if this was the case when pressed by the Deputy Team Manager. The probation officer based at Camp Hill phoned back later the same day to say that the man was going to move to a hospice in the neighbouring town to where his family lived. The Deputy Team Manager sent a fax to the Head of Offender Management summarising his discussions about the case and his understanding of what had been agreed.
46. On the following day, the medical director of the prisons local hospice wrote to the medical director of the hospice based in the family's neighbouring town. He summarised the man's treatment and prognosis and thanked him for accepting the man as an in-patient.
47. The probation officer based at camp Hill telephoned the Deputy Team Manager on 24 January and informed him that the man was going to move to the other hospice the following day. He said that the man would be released on temporary licence and that the nursing staff at the hospice would not know that he was a prisoner. He confirmed that the medical director of the new hospice did know that the man was a prisoner. The Deputy Team Manager asked what procedures were in place by which either Camp Hill or the probation area would be informed if the man left the hospice. The probation officer based at camp Hill was unable to confirm what procedures were in place so the Deputy Team

Manager contacted the Head of Offender Management. He said that the man was not under the direct supervision of the probation area whilst he was on ROTL, and asked her what involvement she expected from his team. The Deputy Team Manager said that, as his team had not visited the hospice in the family's neighbouring town, he was unable to inform her of any specific factors that needed to be considered as part of her ROTL risk assessment. He also asked whether the medical director of that hospice and his staff had been advised to contact either Camp Hill or the relevant probation area if the man left the hospice.

48. The probation officer contacted the Head of Offender Management on 4 February to inform her that she had returned from leave. She discussed the Deputy Team Manager's fax, sent on 24 January, and requested answers to the issues he raised. The Head of Offender Management replied that the man's ROTL was being reviewed on a weekly basis, he was being visited by staff from Lewes prison every week, and there was no need for staff from the probation area to visit him. The Head of Offender Management said that all the staff at the hospice to whom she had spoken were aware that the man was a serving prisoner. If anything happened, they would inform her or staff at Camp Hill. They discussed how long it would take for the agencies to be made aware if the man left the hospice grounds. The Head of Offender Management informed the probation officer that this was not known and it would depend on how much time staff at the hospice took to inform her. The Head of Offender Management confirmed that both the man and his family were aware of the licence conditions and the consequences of him leaving the hospice.
49. When interviewed as part of this investigation, the Head of Offender Management said that the man had been confined to hospital, was in a wheelchair, had lost six stones in weight and could barely walk or put his slippers on. The Head of Offender Management confirmed that he was also receiving morphine through a syringe driver (a drip inserted into his stomach). She felt that the probation area were not basing their risk assessment on the risks that the man posed. The Head of Offender Management said:

“... he was a very, very poorly man with not a lot of strength and not a lot of will and he was just wanting to spend his last days with his family, his last few days and this was relayed to the Probation Department. We had physically seen him, we encouraged them to go and physically see him, but they were intimating they still had major concerns about his ability to pose a risk to the victim and their concerns that the victim had raised with them about him being in the vicinity of that borough again. We felt these were mitigated by his current healthcare condition and we made that known to the Probation Area and I was very disappointed with their response in terms of getting him home as fast as possible they ought to have done really.”
50. On 5 February, the probation officer received a telephone call from the new hospice asking how long it would take to get the “Pardon” agreed. The probation officer was informed that the hospice only accepted short term patients and that the man would need to move on. The probation officer said

she did not know when the “Pardon” would be granted and advised the caller to contact the Head of Offender Management for more information. The Deputy Team Manager advised the probation officer to clarify with the Head of Offender Management what further involvement she wanted from the probation area. The probation officer was unable to contact the Head of Offender Management as she was not getting a response to her messages.

51. Around noon on 12 February, the Head of Offender Management contacted the probation officer to tell her that the man had been granted release on compassionate grounds. She said that the hospice wanted to discharge him as soon as practicable. The probation officer pointed out the licence conditions and said that she did not understand why the Head of Offender Management was saying that the hospice wanted to send the man to his family home which was within the exclusion zone. The Head of Offender Management told the probation officer that she would need to apply for licence conditions to the Early Release and Recall Section either directly or through her.
52. The Deputy Team Manager then spoke to the staff nurse at the hospice to find out their understanding of the situation. He was informed that the Head of Offender Management had already told them about the man’s “Pardon” earlier that morning. The staff nurse thought that the man would now be able to leave and return to the family home. The Deputy Team Manager explained that he was to be released early on a probation managed licence. Probation were asking for the same licence conditions (the exclusion zone, not to leave the hospice and not to contact the victim) to continue. The staff nurse thought that the man would be surprised by this and the Deputy Team Manager offered to visit the hospice, with the probation officer, later that day. The Deputy Team Manager said it appeared that both the man and the staff at the hospice expected him to receive a “Pardon” with immediate release and no conditions attached.
53. The Deputy Team Manager then spoke to a member of staff at the Early Release and Recall Section. He said that the Secretary of State had not yet signed the papers granting compassionate release. The Deputy Team Manager explained that the probation area had only recently found out that the man was not allowed to remain long term at the hospice. The Deputy Team Manager told the member of staff at the Early Release and Recall section that his team had not visited the hospice or the man’s family home and still did not know where it was within the area. He said that they wanted to continue with the current licence conditions. The member of staff at the Early Release and Recall section agreed that the compassionate release would not be forwarded to the Secretary of State for signature until the Deputy Team Manager had visited the man.
54. The probation officer and the Deputy Team Manager then visited the hospice where they met the staff nurse and asked about the man’s general wellbeing. The staff nurse confirmed that the man got on well with his daughter who would do anything for him. When the probation officer and the Deputy Team Manager met the man they explained the conditions of his release. When interviewed, they recalled that he was very surprised as he was under the impression that

he would be released without any conditions. They also agreed to meet the man's family to explain the conditions of his release from custody. It became apparent to them that he did not appear to have empathy with the victim. He told them that anyone would have given the victim "a good kicking after the way he was talking to me". The man's confirmed to them, in their view, he should not be allowed within the exclusion zone without specific probation permission. Towards the end of their visit, the man told them the address of his family home which was within the exclusion zone.

55. The probation officer later rang the man's wife to explain the situation with regard to his release on licence. When interviewed, the probation officer recalled that the man's was very distraught. She said that the Head of Offender Management had told her that the "Pardon" had been granted and that her husband would be home in a couple of days. She added that the Head of Offender Management had told her the exclusion zone would be reduced so that he could come home and it was just a question of "rubber stamping" the papers. The probation officer confirmed that, although she had not spoken to the Head of Offender Management about the situation, her manager had. The probation officer said that she was under the impression that the Head of Offender Management would be in contact to explain the misunderstanding. She also mentioned during her conversation with her that the man would be able to move out of the hospice into a nursing home in the same area, or another neighbouring town.. The probation officer was given the address of the family home and agreed to meet the man's wife the following day (13 February).
56. The following day the probation officer completed Multi-Agency Public Protection Arrangements (MAPPA) paperwork and recommended MAPPA level one due to the man's ill health. (MAPPA involves the assessment and management of the serious offenders. The aim is to ensure that a risk management plan is drawn up for the most serious offenders that benefits from the information, skills and resources provided by the individual agencies, including the police, co-ordinated through MAPPA.)
57. There are three levels of MAPPA:
 - Level three - Anyone subject to level three is considered as being the highest risk case, where more than one agency will take responsibility for the management of the person concerned.
 - Level two - As with level three, anyone who has been identified as falling into the level two heading would be managed by more than one agency, very often limited to probation and the police. However, it is possible to involve more agencies if the circumstances warrant it.
 - Level one - An offender on level one MAPPA is normally managed by a single agency. This is the lowest monitoring procedure available under the MAPPA system.

58. The probation officer also contacted the Adult Protection Team to check the history of any domestic violence incidents which might have occurred at the family home. This is a standard check when a licensee is hoping to move into a specific address.
59. Around 11:00am on 13 February, the Head of Offender Management rang the Deputy Team Manager. She told him that the man's wife had phoned her and was very distressed. The man's wife had told her that the probation officer had said her husband would not be allowed to live at the family home. The Deputy Team Manager confirmed that, from his understanding, this was not what the probation officer had told her. The conversation between the Head of Offender Management and the Deputy Team Manager then centred on the man's licence conditions. The Head of Offender Management felt that the licence conditions should now be relaxed whereas the Deputy Team Manager thought that they should stay in place.
60. The Deputy Team Manager contacted the member of staff at the Early Release and Recall Section after his telephone conversation with the Head of Offender Management. He confirmed that the Secretary of State agreed the early release on compassionate grounds on the basis that the victim's issues were considered. He told the Deputy Team Manager that three licence conditions would be imposed:
- No victim contact
 - Not to enter stipulated areas
 - To reside as directed.

The Deputy Team Manager noted in the contact log that this was a suitable balance of the rights of the victim and offender. He recorded that it was unfortunate the man and his family had been, "led to believe they would get a full pardon and have no restrictions upon him and that we [Probation] did not know they had been told this".

61. The probation officer then took a copy of the licence to the hospice so that the man could sign it. Prior to her meeting with him, the probation officer was informed by a member of staff that the Head of Offender Management had spoken to the man and his wife, and they were expecting good news. The probation officer explained that nothing had changed from the previous day and that the man was to be released with conditions in place. There then followed what the probation officer described to my investigator as a very difficult meeting with them. The man's wife made it very clear to the probation officer that, from her conversations with the Head of Offender Management, she had been given the impression that her husband would be allowed to return home. She also indicated to the probation officer that she would be taking the matter further. After the man had signed his licence the probation officer informed him that the Deputy Team Manager would visit him at the hospice on 15 February.
62. The probation officer then had a meeting with the Deputy Team Manager and they discussed trying to accommodate the man's move to the family home. The probation officer contacted the VLO to enquire whether the exclusion zone

could be revised so that the man could return to the family home. The Deputy Team Manager also discussed this with the man's wife. He explained the importance of balance between the rights of the victim and offender, and the risk of accidental contact between the man and his victim. The man's wife then contacted the probation officer who confirmed that they were investigating whether her husband could go home. The probation officer told the man's wife that she would need to meet senior managers and carry out a home visit, and the process might take some time. The man's wife told her that she would tell the hospice not to pursue the option of moving her husband to a nursing home as he would get better care at the hospice. The probation officer indicated that she was happy for the man to move into a nursing home until a decision about the exclusion zone had been reached.

63. After the visit the Deputy Team Manager also sought a medical view from the hospice as to whether the man could be adequately cared for at the family home. He wrote:

“During our visit to see [the man] on Tuesday this week [the probation officer] and I learnt that he would like to move to live with his wife rather than enter a nursing home and since then we have looked into this possibility. We are working as quickly as possible and hope to conduct the necessary home visit and conclude the assessment by Wednesday 20th February, or earlier if possible. To aide our assessment would you please tell me your assessment as to the whether it is feasible for the man to live at [family address] and what medical support would be needed and if, and by whom, this could be provided. I would also appreciate your view as to the likelihood of the man needing to be moved back into a nursing home at a future date and where this could be too. This is because for geographical reasons [named establishments] remains a problematic nursing home for him. [The probation officer] and I are available on the telephone for most of today for further discussion and I would be grateful if your assessment could be faxed to this office when available”

64. On 14 February, the probation officer and the Deputy Team Manager met the VLO and they agreed a reduced exclusion zone. They noted that the hospice would have to confirm that a care plan could be put in place to care for the man at home. The Deputy Team Manager contacted the family to confirm that the probation officer would carry out a home visit the following day. He informed them that he would also check with the hospice that the proposed move was medically possible and that arrangements could be made to meet his clinical needs at home. He said that he intended the process to be completed by the following Wednesday (20 February).
65. The probation officer and her colleague made the home visit on 15 February. They were met by the man's wife and her daughter, who showed them around the house. They also confirmed that the man's two granddaughters lived at the house. The probation officer explained that the purpose of her visit was to assess risks and she explained the revised licence conditions. She

emphasised that the man would not be allowed to enter the exclusion zone, and the consequences if he did not abide by the licence conditions. The man's wife and daughter explained how they intended to care for him after he returned home. The probation officer outlined the further action she would need to take to try to accommodate his return home and informed the family that this should be completed by 20 February.

66. On 18 February, the probation officer contacted Social Services who confirmed the following day that they had no concerns about the man returning to the family home. On the following day, she contacted the Early Release and Recall Section to inform them of the revised licence conditions.
67. The probation officer received the revised licence for the man on 20 February and she immediately informed his wife. She told her that the Deputy Team Manager would visit the hospice for the man to sign the new licence and that he would be allowed to leave the hospice the following day. She explained that the hospice would arrange transport to bring him home and that they would travel outside the exclusion zone.
68. The man was duly moved from the hospice to his family home on 21 February.
69. On 25 February 2008, the probation officer visited the man at home. She spoke to him, his wife and daughter. His daughter asked them about the Ombudsman's office as they wanted to discuss their concerns about her father's care and he also wanted to tell "his side of the story". The probation officer suggested that they contact my office with a view to the man being interviewed. The probation officer noted in the contact log after the visit that, when the man was moved from the hospice, they gave a "Do not resuscitate" sign to the ambulance staff. This had clearly upset the family and the probation officer noted that the man had deteriorated since his last visit. Around 10:15pm he died at the family home. After receipt of the draft report the man's family did not agree with the probation officers recollections of events. They said that the man was unconscious all day, and indeed died later that evening. The family said she did not visit or speak to him, or his family, on that day.
70. The post mortem report records the man's death as being due to natural causes, as a consequence of a metastatic gastric adenocarcinoma (a malignant growth of glandular tissue in the stomach). An inquest did not take place as there were no suspicious circumstances surrounding his death.

ISSUES CONSIDERED

Clinical care

71. A review of the man's medical care was undertaken by a doctor on behalf of the prison's local Primary Care Trust and a panel was convened to discuss the review's findings. The panel comprised a Chair, the medical director of the prisons local hospice and consultant in palliative medicine, a member of the Independent Monitoring Board.
72. Before the panel convened it was presented with a chronology of the man's care and ten clinical reports. At the review meeting the panel considered in turn each of the clinical reports and also asked questions of those present. The panel then retired, accompanied by my investigator, to consider its recommendations. Draft verbal recommendations were fed back to the attendees who were able to remain to the end of the meeting. The panel concluded that the man's care was not equivalent to the standard he would have received had he been in the community. As a result of the discussion some of the clinical reports were also updated to include further information.
73. The man's family had a number of concerns relating to his treatment while in custody. I set them out in the paragraphs that follow, along with the review panel's conclusions on each of the matters raised.
74. First, the family felt very strongly that an earlier diagnosis of the man's condition could have led to immediate treatment and a better prognosis. They felt that he had not received appropriate treatment for his condition.
75. The family said that in February 2007 the man collapsed in the visits hall at HMP Lewes. He told staff that he did not have any chest pain and, after being given oxygen, he walked to the healthcare centre. He saw one of the prison doctors who told him to take things easy and appointment was made to see another doctor. After he had seen the prison doctor, he returned to the visits hall. It was never explained to either the man or his family what was wrong with him on this occasion. The family talked about how frightening this incident had been and how he had become hot, and told them that his skin felt "itchy". He then glazed over and began to have a fit. The family said this was especially frightening for his grand-daughters who were both present at the visit.
76. The review panel concluded that the reason for the man's collapse was not certain. The panel said that when he saw the prison doctor after his collapse it was thought that he might have fainted. He did not appear to have any further medical problems whilst he was in Lewes. The panel judged that the man received prompt nursing and medical attention at Lewes after collapsing during a visit.
77. The family said that it was after this that the man said he was in pain and the medical tests began. The family said that his white cell count was below what it should have been, and his cancer count was "through the roof". He told his

family that he did not get the care he needed from Camp Hill healthcare centre because he was under the care of the hospital. The family said that he would be told to go away by healthcare staff as he had a hospital appointment. They said that he asked for pain relief but was not given it because he was having tests under the care of the hospital.

78. The panel said that it was clear that, prior to 23 October 2007, healthcare staff at Camp Hill had not been informed of the findings of the man's medical tests or discussions by the multi-disciplinary team (MDT). He was still being treated as suffering from diverticulitis. Opiate (pain relief) medication was not prescribed as it can make diverticulitis worse. It was also not prescribed due to the problems associated with management of pain relief medication in prison and the need to avoid trade in illicit use of drugs. The panel also did not think that there was recognition by the hospital's multi-disciplinary team of the fact that the man was a serving prisoner and the associated restrictions.

The hospital cancer multi-disciplinary team meetings should be requested to take special account of the needs of prisoners.

79. The family drew attention to the fact that, having initially been told the man had cancer, they were then told that it was not cancer but diverticulitis. The hospital wanted to do either a colonoscopy or endoscopy and he was told, by the hospital, that he needed to take certain medication in advance of this. The whole procedure was explained to him by the hospital. According to his family, he told the prison that he needed the medication in advance of the test. However, the prison healthcare centre told the man that he needed a medical enema, which his family said he was given to administer himself in his cell. When he then went to hospital he was told that he could not have the investigative procedure because he had not been given the necessary medication beforehand. This meant that the procedure was delayed by a month, at which point he had a repeat colonoscopy instead of the planned endoscopy.
80. The panel considered the evidence concerning the delays in the man's treatment. Although gastrointestinal cancer was suspected in July 2007, prompt action was not taken to confirm the diagnosis. The panel recommended that this process should be much more closely managed. They concluded that the problems administering the bowel preparation were due to administrative and communication problems within Camp Hill. It was noted that these problems have now been overcome.

The progress of the case of a prisoner for whom a fast track referral has been made or who is actively being investigated or treated for cancer should be tracked by prison healthcare.

81. The family explained that, on one occasion when the man went to hospital, he was given another colonoscopy - even though he told the staff that he did not need one and required an endoscopy instead. The family said that another appointment was made for him but he could not go because there were

insufficient prison officers to escort him to hospital and the appointment was missed.

82. The family said that a growth was found after five months of treatment for diverticulitis. The family feel that the man could have had five more months of cancer treatment, had it been diagnosed earlier.
83. The panel said that it was not clear what the man was told following his colonoscopy on 16 August. It was thought that both he and Camp Hill's healthcare team might have interpreted "no cancer in the large bowel" as "no cancer in his body". There was confusion about the procedures to check his bowel. The lack of proper preparation of the man's bowel also meant that when the tests were carried out the results were not as clear as they could have been. The panel recommended that a policy should be produced by Camp Hill, in consultation with the local Primary Care Trust, with regard to bowel preparation for colonoscopy.

The prison healthcare team should produce a policy on bowel preparation for colonoscopy.

84. The panel considered that the delay obtaining a liver biopsy and therefore confirmation of the man's cancer was unacceptable. It was the consensus of the panel that, if his diagnosis of cancer had been made earlier, he would have received better care for his symptoms. It was also felt that he might have received earlier consideration for release from custody. However, the panel believed that, when the diagnosis was first considered in July 2007, a cure would not have been possible even then.
85. In October, the man was about to learn his cancer diagnosis and prognosis. The panel felt that in the community there would have been the opportunity for a patient's family to be involved in this process. Although the panel suggest that this option should be considered for prisoners, I recognise that there are security implications and so make no formal recommendation.
86. The review panel noted that, after the man's diagnosis of possible cancer an out-patient appointment was cancelled. The appointment was cancelled by security and not healthcare staff. The panel agreed that this was not acceptable. The panel judged that prisoners having attendance at a fast track referral should have priority for hospital appointments.

Prisoners for whom a fast track referral has been made or who are actively being investigated or treated should have priority for escort to out-patient appointments.

87. The panel concluded that the prisons local Primary Care Trust, in partnership with the three prisons on the island, should set up a joint working group. The group should aim to establish a clear pathway for the management of the care for patients with terminal illnesses. This should link with a project being undertaken by healthcare on the island and the Kings Fund concerning accommodation for terminally ill prisoners. It should include a robust system to

ensure the appropriate and timely access to advice and medication for control of the symptoms of terminally ill prisoners.

The Primary Care Trust and the three prisons on the Isle of Wight should set up a joint working group to establish a clear management pathway for patients with a confirmed or potential cancer diagnosis or terminal illness including appropriate pain management.

88. The family also drew attention to an occasion whilst in hospital, after the man's bedwatch staff had been withdrawn, when he slipped on water that was on the floor and hurt his head.
89. Although this is outside my terms of reference, the review panel noted that after the incident where the man had a fall at the prisons local hospital some actions were not noted on the clinical record. Although an incident form was completed by staff at the hospital, there was nothing documented in the man's medical record about his fall. The incident form recorded that, at around 5:45pm on 5 January 2008, he had fallen and had a cut to his forehead. Neurological observations were started and a hospital doctor was contacted although there are no medical records to say whether he came to see the man. The observations continued at approximately hourly intervals until midnight. The review panel suggested that the hospital review its documentation for incidents when a patient falls.
90. The family said the man had a locked cupboard in his cell which contained his controlled drugs. They said they understood the security concerns surrounding prescribed drugs in prison, and the risk of medication being stolen, but they have argued that he was in pain because the healthcare unit ran out of medication. They have alleged that he would put in another repeat prescription for his drugs but it would take three to four days to be filled. In addition, he had a morphine syringe driver inserted when he was in the hospital but could not retain it in prison. Whilst the prison had to put security first, the man's family felt that this was inequitable. Had he been going home rather than to prison, he would have been able to keep the morphine line in and his pain would have been controlled. The family felt that he would have done anything, even "gone into solitary," if that would have enabled him to keep his morphine line in and have some pain relief.
91. The review panel acknowledged that administration of controlled drugs is a complex issue in prison. Healthcare staff assess each prisoner particularly in relation to in possession medication and the time and mode of administration of medication. If a syringe driver is the most appropriate mode of administration then the patient has to be admitted to the hospital or a local hospice. There is also limited access to prisoners during the night (8:00pm until 7:30am) when the prison is in patrol state. (Patrol state is when prisoners are locked up and staff numbers are reduced to the minimum needed to patrol and maintain the security of the prison.)
92. The family pointed out that the man had been on prescribed anti-depressants for about six or seven years. They said he normally would have had to come

off them gradually but, because of his treatment and the effects, staff at the hospital had to stop all non-vital medications. The family felt that this could not have helped his mental state.

93. The panel said that it was normal practice to send a summary of the prisoner's medical record to the local hospital when a patient is admitted. It was not clear whether this did or did not happen on 2 November 2007. It was suggested that the anti-depressant medication might have been stopped because he was vomiting.
94. The family felt that some of the man's suffering was unnecessary. For example, he did not get his antibiotics for a urinary tract infection (UTI). After he went back to prison he asked daily, for three weeks, for his antibiotics for the UTI, but never received them. On another occasion, he told them he had been vomiting blood, which had been really worrying for him.
95. The panel noted that, at 4:58pm on 7 September 2007, the man was seen at Camp Hill by the senior nurse. It was noted that he had a slightly raised temperature. The nurse told the panel that, if she had had any cause for concern or if the man's temperature had been very high, he would have been seen by the on-call doctor. He was seen in the clinic on 10 September and a doctor prescribed antibiotics. The Head of Offender Management confirmed when interviewed by the panel that there was no delay in the man receiving the antibiotics.
96. When interviewed as part of this investigation, the Head of Offender Management said that the prisons on the Isle of Wight had a clustered healthcare arrangement and the pharmacy is housed in HMP Parkhurst. The pharmacy has to distribute the medication for all three island jails (Albany, Camp Hill and Parkhurst), which is up to 1,500 prisoners. She admitted that Camp Hill had previously received medication quite late in the afternoon. This could impact on the issuing of medication as it had to be checked and sometimes they received three large boxes. This would mean the medication for 200 - 300 people had to be checked, certified and then sorted into some sort of chronological order ready for administering to prisoners. She said that Camp Hill had experienced problems which had been raised with the Primary Care Trust managers. The Head of Offender Management confirmed that the arrangements for issuing medication have now been changed. There is now a pharmacy runner and Camp Hill receives medication much earlier during the day. I welcome this.
97. In a supplementary note dated 22 June 2008, the Head of Offender Management told the panel:

"I have made checks as requested on the night of 2nd of November 2007 to see if [the man] raised with staff the fact that he was vomiting blood and distressed. There is no written record at all on this date or the previous night or the night after. I can only conclude that this was not reported to the night staff at the time, but instead to the day staff

the following morning, he was sent to Healthcare the next (3rd) morning and re-admitted to the local hospital that day.”

98. The panel noted the concerns raised by the family about possible delays to the issue of the man’s medication. Medication for the three prisons on the island is issued by staff at Parkhurst which can mean that there are delays in its receipt elsewhere. Although there was no clear evidence of the delays being more than a few hours, the panel felt that this should be remedied as soon as practicable.

Prison healthcare should introduce as soon as possible Patient Group Directives (PGDs)/nurse prescribing to increase prisoners’ access to medication, including antibiotics.

99. The family also said that they were told that Camp Hill told staff in the hospital that they could not cope with the man’s condition and that he should not return to prison.
100. The panel thought that this referred to concerns raised by healthcare staff with regard to the regime at Camp Hill. As already mentioned, Camp Hill does not have 24 hour healthcare facilities. The man would have been locked up overnight along with the other prisoners. Healthcare staff felt that this was unsuitable for him as he was unwell. When my investigator spoke to prisoners and staff at Camp Hill it was apparent that the man’s regime was relaxed. Officers would let him out of his cell during patrol state.
101. The family were also concerned about Camp Hill not officially informing them on several occasions when the man was admitted to hospital. This was especially frustrating on the occasion when his daughter visited the prison and was told that he was in hospital. His daughter said that she could have gone straight to the hospital and not sat in the prison car park for over two hours. The family said that the Head of Offender Management was aware of this problem. She had told prison staff to keep the family informed whenever he left the prison, but they had failed to do this.
102. In her written response to my investigator dated 22 May 2008, the Head of Offender Management said:

“It is generally accepted by Governor grades that it is good practice to inform the next of kin when a prisoner goes to outside hospital due to a serious injury or an accident or if they make an attempt on their own life. I did raise this verbally at a Governors’ morning meeting (which is attended by Governor grades, Principal Officers, Head of Chaplaincy, Head of Probation, Head of Learning and Skills, and Head of Programmes) that it would be decent to inform his family when [the man] did go to outside hospital and then get subsequently admitted. It appears that on this occasion ... this did not happen. I think one of the problems here was the frequency he went out, which sometimes was during the night. There was also written instructions regarding this. I did not give anybody the responsibility to action this and the Duty

Governor of the day would not necessarily have known when [the man] would have had a visit booked. I believe the above may have led to the family not being informed on this occasion. It is clear for this incident that I need to formally raise this process and make individuals responsible for informing families of such incidents.”

Bedwatch and the use of restraints

103. Whilst the man was a hospital in-patient, a bedwatch was carried out by prison staff. The initial security risk assessment identified that an escort chain should be used and two officers needed to be in attendance. The assessment was subsequently revised: handcuffs were no longer to be used and only one officer was to escort him. This was entirely appropriate and enabled the nursing staff to have easy access when they carried out their duties.
104. My investigator found no evidence that Camp Hill did not adhere to the instructions in Prison Service Order (PSO) 6300 (Release on Temporary Licence). The prison allowed the man to be released on temporary licence in December 2007 and he was given a mobile telephone. This enabled him to keep in contact with both his family and Camp Hill.
105. From the bedwatch log, my investigator believes that the staff involved with the man’s care behaved with compassion and sensitivity. The security arrangements at the hospital seem to have been suitable, and to have struck a good balance between public protection and respect for the man himself.

Risk assessment of the hospice

106. The family were distressed by the action taken when the man moved to the prisons local hospice. An officer accompanied him to risk assess him and the hospice. The officer took photographs as he was taken out of the ambulance when being rushed to the hospice. Whilst the family said they understood the security issues, they felt that this was insensitive and “over the top” when he could barely walk. I appreciate that this was difficult for the family but, due to the nature of the man’s offence, it was necessary for the prison to carry out the risk assessment. Camp Hill would usually have carried out the assessment in good time but, due to the nature of his illness, they hurried the procedure. This ensured that the man was accommodated in a timely manner at the hospice. I am sure, with the benefit of hindsight, Camp Hill would have approached the assessment in a different manner which was more sensitive to his situation. There may also be learning points in terms of the instructions given to staff over the taking of photographs.

Actions by the area probation

107. The family were unhappy with the treatment they and the man received from staff at the relevant probation area, after he was granted release on compassionate grounds. The family had concerns generally about the approach taken by the Deputy Team Manager and the probation officer.

108. The family said that the issue of the man's release from custody was not handled well and that his return to the family home was delayed. This meant that he only spent five days at home with his family before his death. The family felt that the probation officer delayed the man's return to the family home and they were not happy with her conduct. The family also did not fully accept the limitations of the exclusion zone. The family made it clear that they did not hold Camp Hill or the Head of Offender Management responsible for what happened to the man after he was granted release from custody on compassionate grounds.
109. From my investigation it is clear that the man and his family may not have had a clear understanding of what release on compassionate grounds entailed. I think that this was a major stumbling block and led to a very poor relationship between the family and staff of the relevant probation area. It was also unfortunate that there was a breakdown of communication between Camp Hill and the probation area. This meant that they were not working together towards a common aim to ensure that the family received a consistent message. I think that action should have been taken at early juncture when it became known that the man was going to be released on temporary licence. I also think that it would have been helpful if the probation officer, in her role as Offender Manager, had visited him whilst he was still at Camp Hill to carry out a risk assessment before he was released. This would have given her a better idea of the potential risk he posed to his victim.
110. Staff at the probation area reacted immediately they were informed about the man's imminent release and tried to ensure a balance between public safety and his needs. Once the probation officer and deputy team manager were made aware of his intention to return to the family home, they tried to accommodate this in a timely manner. They contacted the Victim Liaison Officer to make arrangements for the exclusion zone to be revised and they carried out necessary checks. When interviewed, the Deputy Team Manager made it very clear that this was not the only case that the probation officer was working on (she had a caseload of over 70) and every effort had been made to speed up the process of returning the man to the family home. This action was necessary to ensure public protection issues were clearly addressed and adequate support was put in place for him to be able to come home.
111. I realise that this was a difficult situation for the family and I sympathise with their frustration with what they perceived as a poor service. The issue of the licence conditions was very emotive and it appears that this led to some breakdown of the relationship between staff at Camp Hill and the probation area. Both parties maintained what they saw as the moral high ground. The fact is that the man had committed a violent offence and, due to the concerns for the safety of his victim, an exclusion zone was created. I think that staff of the probation did everything possible to accommodate the man's needs after his release. My investigator did not uncover any evidence to suggest that either the Deputy Team Manager or the probation officer delayed the process. Indeed, I recognise the hard work they carried out to ensure that he could spend his last days at home with his family. However, I think that the failure of staff at Camp Hill and the probation area to work together meant that a difficult

situation was made worse. Better communication between them could have avoided a lot of the animosity that occurred after the man's release on compassionate grounds was granted.

112. I recommend that a meeting is arranged between the Governor of Camp Hill and the Chief Officer of the Probation Area. The aim of the meeting should be to try to find out why communication failed on this occasion and to look at ways to improve links in the future.

I recommend that a meeting is arranged between the Governor of Camp Hill and the Chief Officer of the Probation Area. The aim of the meeting should be to look at communication failures and ways to improve links in the future.

113. The family were very complimentary about the support they received, towards the end of the man's life and after he died, from staff at the prison's local hospital, the last hospice, **St Michael's Hospice** and Camp Hill, especially the Head of Offender Management and **a particular officer**. They also appreciated the contributions of the Chaplain, the Sister, and two prisoners.

CONCLUSION

114. The man moved to Camp Hill in May 2007 and died, at his family home, of natural causes in February 2008 after being released from custody.
115. I would like to commend the efforts taken by Camp Hill with regard to the support he was given after he was admitted to hospital and when the security restrictions were lifted.
116. As already mentioned, I think that there was a failure by both staff at Camp Hill and the probation area to work together. Poor communication between them made a difficult situation worse. I have recommended that the Governor and Chief Officer consider my report and reflect on how to improve communication in the future.
117. The clinical review panel has concluded that the care the man received was not satisfactory and not equivalent to that he would have received in the wider community. The panel also concluded that, had the diagnosis of his terminal condition been made earlier, it could have meant him spending more time with his family. After his diagnosis of terminal cancer I am satisfied that adequate support was given to him. The findings of my own investigation, and the clinical review, highlight that improvements to medical practices at Camp Hill need to be made. I endorse the recommendations from the clinical review. These will need to be addressed by the Isle of Wight Primary Care Trust in partnership with the Governor of Camp Hill.

RECOMMENDATIONS

HMP Camp Hill and the Probation Area

1. I recommend that a meeting is arranged between the Governor of Camp Hill and the Chief Officer of the Probation Area. The aim of the meeting should be to look at communication failures and ways to improve links in the future.

Accepted - The Area Office will facilitate a meeting to discuss the communication failure between the establishment and Probation and ways to improve this in the future.

Clinical

2. The progress of the case of a prisoner for whom a fast track referral has been made or who is actively being investigated or treated for cancer should be tracked by prison healthcare.

Accepted - Systems are in place to ensure the fast tracking of referrals. This is monitored by Prison Healthcare Commissioners' GP Partnership working with area referred to identified leads in all three Primary Care areas to oversee all two week referrals in the Healthcare Cluster.

3. Hospital cancer multi-disciplinary team meetings should be requested to take special account of the needs of prisoners.

Accepted - The role of the healthcare lead is to ensure appropriate and timely communication with the multi-disciplinary team (MDT) and ensure attendance of the appropriate clinician at any meetings/discussions re the prisoner's treatment plan.

4. Prisoners for whom a fast track referral has been made or who are actively being investigated or treated should have priority for escort to out-patient appointments.

Accepted - In the event of more than two prisoners requiring escort, Healthcare staff clinically prioritise the fast track referral. Should there be requirement for more than two fast track referrals on one day negotiations with the duty Governor will take place with an expectation that all fast track referrals will attend their appointment.

5. The prison healthcare team should produce a policy on bowel preparation for colonoscopy.

Accepted - Healthcare staff respond to clinical requests received regarding preparation for any procedures.

6. The Primary Care Trust and the three prisons on the Isle of Wight should set up a joint working group to establish a clear management pathway for patients with a confirmed or potential cancer diagnosis or terminal illness including appropriate pain management.

Accepted - Part 2 applies with the addition of ongoing work with departments at the hospital to progress a clear cancer care pathway for prisoners. This is a regular agenda item on partnership board, operational and modernisation and prison healthcare operational group meetings.

7. Prison healthcare should introduce as soon as possible Patient Group Directives (PGDs)/nurse prescribing to increase prisoners' access to medication, including antibiotics.

Partially accepted - Patient Group Directives are in place. At this moment in time no staff are able to access the non-medical prescribing course. However, access to prescription of medication out of hours will improve on 1st April when the new GP contract commences.