

**Investigation into the circumstances surrounding the  
death of a man, shortly after his release on compassionate  
grounds from HMP Lincoln, in May 2007**

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

**December 2007**

This is the report of an investigation into the death of a man who was a prisoner at HMP Lincoln, until his release on compassionate grounds in May 2007. He died the day after his release at a local hospital, with his wife at his side. I offer my sincere sympathy and condolences to the man's wife, and to all of those affected by his loss.

A post mortem examination revealed the cause of death to be carcinomatosis due to a squamous carcinoma of the lung (lung cancer).

The investigation was carried out on my behalf by one of my colleagues. An independent review of the man's medical care in prison was carried out by the Lincolnshire Primary Care Trust. I am most grateful to the clinical reviewer for his assistance.

I would also like to thank the Governor and staff of Lincoln for their full and ready co-operation during the course of the investigation. I am particularly indebted to the Governor's secretary for the assistance she provided my investigator in her role as liaison officer.

I make four recommendations and highlight two examples of good practice.

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## SUMMARY

The man who is the subject of this report was sentenced to three years imprisonment on 17 October 2006, and was received at HMP Nottingham on the same day. He had been due to attend a scan at a hospital near to his home on 31 October, following investigations that he had been undergoing for several months. The scan was cancelled, for reasons that were not recorded, and subsequently rebooked for 19 December.

Shortly after his imprisonment, the Consultant Neurologist at the local hospital wrote to the Medical Officer at Nottingham to report that recent investigations had shown a “persisting and enlarging abnormality in [the man’s] right lung”. This was forwarded to HMP Whatton, where the man had transferred to on 25 October. A GP at Whatton discussed the implications of this letter with the man. She found that he knew nothing of the results, and ensured that he was aware that it could mean that he had cancer. The GP made an urgent referral to a hospital local to the prison the same day.

The man attended for the scan on 19 December, and was formally diagnosed with cancer of the lung. An appointment was made for him to have a lung biopsy on 3 January 2007. However, on the day of the biopsy, the man refused to attend. He said that this was because he wanted “to live in optimum comfort for the remainder of my life” and thought that his life would be at risk if he underwent the biopsy.

The man refused all further offers of investigation or treatment, other than pain relief, and said that he wanted no further intervention for his condition. On 5 February, he transferred to HMP Lincoln where there is 24 hour healthcare available. Comprehensive nursing care plans were created for the man on his arrival, and he lived in the healthcare centre’s High Dependency Unit (a room for patients who require more intensive care than is usually provided).

The man was an independent man who was very reluctant to ask for or receive assistance from staff, even as his condition deteriorated. He was regularly encouraged to inform staff when his pain increased or if he was struggling with a task, but continued to avoid doing so whenever possible.

On 18 April, the man was admitted to a local hospital after he developed swelling in his left leg. He was diagnosed with a deep vein thrombosis, and discharged on 24 April following treatment.

The man was again admitted to hospital on 27 April, as his pain was now severe and he was not responding to pain relief. By early May, his condition had deteriorated to the extent that it was recommended that he be released early on compassionate grounds. A licence was issued that day. The man’s condition did not improve, and he died on the following day with his wife at his side.

My report shows that the man received commendable care at Lincoln, although I make one recommendation with regard to the provision of a syringe driver for pain relief. I make four recommendations in total, and highlight two examples of good practice.

## THE INVESTIGATION PROCESS

The investigation was opened on 11 May 2007 when my investigator, issued notices announcing the investigation to staff and to prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known to my investigator. No prisoners came forward as a result.

My investigator was given access to the man's prison files, including the medical record. He visited Lincoln on 18-19 July 2007, and interviewed four members of staff during the course of the investigation. An independent clinical review of the man's health needs whilst he was in custody was carried out by the Lincolnshire Primary Care Trust.

My senior family liaison officer contacted the man's wife on 25 May 2007. She and my investigator subsequently met with the man's wife on 5 June. At the meeting, the man's wife told how she was permitted to visit her husband in his cell and that the prison paid for taxis to take her to and from hospital when he was an inpatient. She also raised the following issues that she wished the investigation to address:

- Whether her husband could have been released earlier?
- That it was difficult to have a private conversation with her husband when he was in hospital in the last few days of his life due to the presence of prison officers in the room.
- A hospital appointment that was arranged prior to her husband's imprisonment was cancelled after he was sentenced.
- Her husband might have agreed to have a biopsy or surgery for his cataracts if she had been allowed to accompany him.
- Her husband struggled to reach the telephone to contact her because he was in a wheelchair.
- When her husband was first diagnosed with cancer nobody from the prison informed her.

## **HMP LINCOLN**

Lincoln is a category B, local adult male prison. Built in 1872, the prison receives prisoners direct from the courts across the East Midlands. It also receives serving prisoners transferred in from other establishments and has an operational capacity of 490.

The prison holds mainly remand and convicted prisoners serving short term sentences and a relatively small number of life sentence prisoners. It is divided into four residential units, a segregation unit, a first night in custody wing and a healthcare unit for both inpatients and outpatients.

The most recent inspection report by Her Majesty's Chief Inspector of Prisons was published in November 2005. It described Lincoln as a prison in recovery, working towards restoration of normal functioning and a good standard of regime. The report found that healthcare provision had improved and that, despite being understaffed, the inpatient facility was a safe and therapeutic environment with a decent standard of care in evidence.

There have been five other deaths at Lincoln since April 2004. This is the first death in this time to have been due to natural causes.

## KEY EVENTS

Prior to his imprisonment, the man who died was undergoing a number of investigations at a hospital close to his home. He had been diagnosed with Chronic Obstructive Pulmonary Disease (COPD, a condition comprising chronic bronchitis and emphysema, the accumulation and slow release of air in the lungs) in 2004. In December 2005, he was referred by his GP to the neurology department at the hospital. The GP noted that the man had gradually lost his mobility over the last three months and now required a wheelchair. The man was also noted to be a heavy drinker and smoker.

The man had two hospital appointments booked at the time of his reception into custody. The first of these was on 31 October 2006 for a CT scan, following a recent x-ray that the Consultant Neurologist at the hospital thought may have shown a lung abnormality. He also had an appointment on 20 November 2006 for an operation to remove cataracts in his eyes.

The man was received at HMP Nottingham on 17 October 2006, having been sentenced to three years imprisonment on the same day. A first reception health screen (a routine health screen for all new arrivals into prison) was completed following his arrival. The reception screen noted that the man suffered from angina, liver damage and emphysema, and the appointment for the CT scan was also noted. The man was also recorded as being wheelchair bound and having poor mobility and poor balance. He stayed in the healthcare centre overnight as an inpatient.

The man was assessed by a prison doctor on 18 October. The doctor considered that, despite his multiple health problems, the man was able to self-care and had no acute problems. He concluded that there was no need for the man to remain in healthcare as an inpatient, but that he needed ground floor accommodation. The doctor also said that the CT scan would need to be cancelled. The reason for this was not recorded.

There is no ground floor accommodation in the Vulnerable Prisoners Unit (VPU) at Nottingham. The man therefore remained as an inpatient in healthcare until 25 October, when it was arranged for him to transfer to HMP Whatton. A further reception health screen was carried out at Whatton at which the man said that he had been experiencing a sharp pain in both sides of his chest that stopped him from sleeping.

On 23 October, the Consultant Neurologist at the man's local hospital wrote to the Medical Officer at Nottingham. He noted that the man had a "persisting and enlarging abnormality in the right lung". He went on to recommend "in the strongest possible terms" that the man undergo the cancelled CT scan as soon as possible.

This letter was forwarded to Whatton from Nottingham, as it arrived after the man's transfer. On 9 November, an urgent referral was made to a hospital local to the prison by a GP at Whatton. An appointment was subsequently made for the CT scan to take place on 19 December 2006.

When she saw the man on 9 November, the GP at Whatton discussed the implications of the Consultant Neurologist's letter with him. The GP noted that the man had no idea about the results of these investigations. She therefore discussed the potential diagnosis with him, and ensured he was aware that it could mean that he had cancer.

Later that afternoon, the man's wife telephoned the healthcare centre at Whatton. The man had spoken to her following his conversation with the GP. The man's wife spoke to a nurse who reassured her that no firm diagnosis had been made as yet.

On 7 December, the man was seen by a nurse on the wing after he complained of pain in his left side. He told the nurse that he was taking all of his diclofenac (medication for pain relief) early in the day. He was therefore running out of pain relief for the night. The nurse discussed this with the prison GP, who suggested that they try the man on codeine and put him down to see a doctor if this was not effective.

The man attended hospital on 19 December for his CT scan. He was reviewed by a doctor who diagnosed a suspected right lung primary with widespread lung metastases (cancer of the lung). The doctor advised that the man undertake a further lung biopsy, and this was arranged for 3 January 2007.

However, on the morning of 3 January the man refused to attend for his biopsy. He completed a disclaimer, in the presence of a nurse, in which the reason for his refusal was given as "potentially too many risks to my life in my opinion". The man saw the nurse again later that morning to discuss his condition further. He told her that he did not want any treatment because he wanted to "live in optimum comfort for the remainder of [my] life". Nevertheless, the man did say that he wished to proceed with his cataract operation (which had been re-booked for 8 January).

The man was reviewed by the prison GP on 5 January. He again said that he was too frightened to have a biopsy. The GP reviewed his pain control, and added tramadol 50mg (a pain killer) to his prescribed medication. He was also written up for oromorph (an opiate based pain killer) as and when he required it.

On 8 January, the man was scheduled to attend hospital for cataract surgery. However, despite saying five days earlier that he wished to proceed, he declined to attend the appointment. He again completed a disclaimer (in the presence of a different nurse). The reason given on the disclaimer was that the man's wife was due to visit him and, as she had already left home, he did not wish to disappoint her and felt that her visit should take precedence. Following the cancellation of his appointment, the man's name was removed from the waiting list at the hospital.

The following day, the man was seen "special sick" (a short notice appointment with a nurse) by a nurse. He said that he had been in pain that morning and that the tramadol was not helping him at present. The nurse therefore gave the man some oromorph.

On 10 January, the man attended a hospital local to the prison for a review of the results of his CT scan. The Consultant noted that the man had previously declined

to undergo a biopsy. He explained the procedure and booked him in for a further biopsy on 16 January.

The man was reviewed by the prison GP on 15 January. He said that his pain was not well controlled and that he was experiencing pain in his left chest wall. The GP therefore decided to try MST, a morphine-based drug for pain relief. The man also complained of shortness of breath when at rest, and this was worse when he exerted himself. He said that it was now hard for him to even potter around his cell. The GP prescribed lorazepam 1mg (a relaxant).

On 16 January, the man again declined to attend his biopsy. He signed another disclaimer, saying that he wanted no further intervention for his condition. On the same day, the Healthcare Manager at Lincoln was contacted with regard to transferring the man to her prison, as it was felt that he needed to be in an environment with 24 hour healthcare (which is not available at Whatton). She visited the man the following day to assess his suitability for transfer.

The man was due to attend an outpatient's appointment at the local hospital's Respiratory Unit on 24 January, but again declined to attend. He was reviewed on the following day by the prison GP, who noted that the man's pain was definitely improving since he had started on MST. On 1 February, the man reported that his pain was now under control.

On 5 February, the man transferred to HMP Lincoln. He was seen on arrival by a nurse, and said that he was pleased at being nearer home. The nurse also noted that the man was fully aware of his condition and prognosis. She devised a number of nursing care plans, including plans for the man's pain control, breathing and sight. The man said that he wanted to be as independent as possible, and the nurse therefore noted that staff might need to approach him before he asked for help. The man was located in the healthcare centre's High Dependency Unit (a room for patients who require more intensive observation, treatment and nursing care than is usually provided).

The man's first night at Lincoln was settled, and he said that his pain was not too bad when he woke. As he was unable to reach his wife on the telephone, the nurse contacted her to tell her of his transfer and give her the prison's address. The man was reviewed later that day by a GP and noted to be stable and coping very well.

Over the following week, the man struggled to maintain his personal hygiene. He said that he felt embarrassed and helpless, and was encouraged to ask for help from staff. He usually declined offers of help, and was able to shower independently on some occasions.

On 19 February, the man was visited and assessed by a MacMillan Nurse. He told her that he had pain on both sides of his chest and the MacMillan Nurse therefore advised him to take paracetamol regularly. She also increased his dose of oromorph to 20mg, although the man continued to take 10mg for a few days as he thought that the increased dose was too much for him.

On 23 February, a Healthcare Support Worker (HCSW) spoke to the man at length. Her impression from speaking to the man was that he did not understand his condition or the likely effects of any treatment. The man appeared to be unwilling to undergo a biopsy because he thought that he would die as a result of the trauma. He also appeared to have little knowledge of his prognosis, and thought it realistic that he would be released in April 2008 and cared for at home by his wife. The man had gone on to say that he was happy to be cared for by healthcare staff at Lincoln, but did not want to participate in investigations at hospital. The HCSW arranged for the man to be visited again by the MacMillan Nurse to discuss his future care and treatment options.

The man was seen by a GP at Lincoln on 26 February. They had a long chat during which the GP reiterated to the man that, if he had no treatment, his life expectancy was severely limited. The GP also explained that if the man had a biopsy they might be able to get a positive diagnosis and therefore offer palliative treatment to extend his life. The man reluctantly agreed to undergo a biopsy on the condition that it was done under anaesthetic. The GP subsequently wrote to the Consultant Respiratory Physician at the hospital that the man had been attending whilst at Whatton, to enquire whether it was feasible for the biopsy to go ahead under anaesthetic.

The MacMillan Nurse visited the man again on 28 February. He said that his pain was now more controlled. The man was also noted on the same day still to be very reluctant to let any of the staff help him with his personal care.

On 1 March, the man's observations were taken and his blood pressure was noted to have fallen. He was extremely breathless, but declined oxygen therapy. He was settled for the next couple of weeks, apart from on 4 March when he complained of pain despite having refused the pain control he was offered.

An application for Early Release on Compassionate Grounds was completed by the Governor on 13 March. This was faxed to the Release and Recall Section (RRS) of the Home Office on 14 March. Unfortunately, the application was faxed to the wrong office and was not received by RRS until 27 March. The application contained a prognosis from a GP at Lincoln who wrote that "current evidence suggests terminal illness (cancer lung) lasting over few months".

The man requested extra oromorph on 17 March as his pain levels increased. On the following day, when asked by staff, he said that he would like to have oromorph every morning on waking. On 19 March, it was agreed that the man could have his visits in healthcare as his condition had now deteriorated to the extent that he could not be taken to the visits hall.

On 22 March, the man told staff that he was beginning to lose dexterity in his fingers. He said that he was still able to self-care, but acknowledged that he might require assistance with this soon.

The man attended a local hospital on 23 March for a chest x-ray. The results showed that there were extensive nodules of cancer throughout both of his lungs. The man had trouble coming to terms with the news that his cancer had spread

excessively. He expressed concern at the thought of dying in prison, and said that he wanted to die at home with his wife.

The man was settled over the course of the next week or so. He was able to eat and sleep well, and was described as being quite cheerful and bright. On 30 March, he was again visited by the MacMillan Nurse. The man told her that he was in pain even when sitting down, and out of breath on exertion. The nurse therefore asked the prison doctor to increase the dose of MST.

In the meantime on 28 March, having received that day a report from a Consultant Respiratory Physician at a hospital local to HMP Lincoln, RRS referred the man's case to an advisor in Prison Health for the Department of Health. On 30 March, having seen the papers, the advisor asked that the Healthcare section at HMP Lincoln provide some additional information in relation to continuity of healthcare post release (as required by paragraph 7.18 of Prison Service Order 3050, the Prison Service guidelines on continuity of healthcare for prisoners). This was supplied that day by the Healthcare Manager at Lincoln. On 3 April, the advisor, having also discussed the case with the Healthcare Manager, expressed the view that compassionate release would need to be recommended at some time, but not immediately as the prognosis at the time did not warrant it. He asked that a further prognosis be provided to consider the outcome if the man decided to accept treatment.

The Consultant Respiratory Physician was therefore asked to write in support of the man's compassionate release application. He replied on 4 April. In his letter he wrote that, "there is no evidence to suggest he would benefit from chemotherapy or radiotherapy". The Consultant also suggested that the man was "likely to deteriorate and die over the next 2-3 months". It does not appear that this information was passed onto RRS. On the same day, the lock was removed from the man's cell door so that staff had easier access.

The man's condition changed little in the next few days. On 8 April, it was again noted that he needed encouragement to inform staff when his pain increased. He was in considerable pain on 10 April, and was given two extra doses of oromorph at his own request. In the afternoon, the MacMillan service was contacted and it was agreed to increase the man's dose of MST. This increase in MST worked well initially, and the man reported on 12 April that his pain control was better. On 15 April, however, he reported pain in the lower part of his chest and was given extra oromorph.

On 16 April, the man was visited by a palliative care specialist from a local hospice to discuss his pain management. The specialist suggested a number of changes to the man's medication. He also suggested that the man's prognosis must be short, possibly four to six weeks. The specialist said that the man might become unable to tolerate oral medication and could be switched to a syringe driver (a plastic syringe that delivers small amounts of a drug continuously through a battery operated pump) when required.

The man was visited by his wife on 18 April. During her visit, the man's wife spoke to the Healthcare Manager about her husband's cataracts and requested that he

have them removed. The Healthcare Manager said that she would make a referral, but that the man might have to go to the bottom of the waiting list. At around 9.00pm, the man asked a nurse to look at his left leg. The nurse noted that his calf was very hard and swollen to almost twice the size of his right leg. The out of hours doctor was contacted and the man was admitted to a local hospital at around 11.00pm. He was accompanied by two officers for the duration of his stay and restraints were not applied.

The man was diagnosed with a deep vein thrombosis (DVT, a blood clot that forms in a vein) in his left leg. He was discharged back to HMP Lincoln on 24 April, and given warfarin (anti-coagulant therapy) for his DVT. The man was very unsteady on his feet over the next couple of days. On one occasion he struggled to get off the toilet and was advised to ask for assistance in future. He replied that he "wouldn't ask anybody for help to get to the toilet and never will".

On 25 April, the man again complained of a painful right leg. He was seen by a prison GP who noted that the man's leg was not tender, inflamed or increased in size. The GP decided to keep the man on the medication that he was taking for his DVT and reassess as necessary. By the following day, the man's right leg had become inflamed. The GP therefore increased his warfarin dosage.

At 5.10am on 27 April, the man rang his call bell and said that he was in severe pain. He was given pain relief to no effect, so the dose was repeated one hour later. This did not help either, and the man continued to be in obvious pain. He also found it difficult to move and was unable to cough. He was visited by a MacMillan Nurse, who suggested hospital admission so that pain relief could be administered via a syringe driver. She discussed this with the palliative care specialist, who agreed with the suggestion. However, the man did not want to go to hospital but was eventually persuaded following further discussions.

The man was admitted to a local hospital in the afternoon of 27 April. He was accompanied by one officer and restraints were again not applied. Later that afternoon, his wife was contacted by the Healthcare Manager and informed of the hospital admission. It was also agreed on the same day that the prison would pay for taxis to take the man's wife to and from the hospital, so that she could visit her husband every day.

The same day, RRS received a revised prognosis of four to six weeks. A Casework Manager in RRS told my investigator that it was also not clear to them at this stage whether this prognosis might change were the man to accept treatment.

On 30 April, RRS were informed that the man had transferred to hospital and that his condition had deteriorated significantly. RRS also received confirmation that day from the Governor's secretary at Lincoln that the only regime now available to the man was palliative care. As such, they recommended to Ministers that early release should be granted. This was agreed on 1 May.

However, that very day the man's condition improved somewhat. RRS therefore decided to delay release until they had a clearer picture of his condition. The escort was also increased to two officers. Sadly, his improvement did not last long and, a

few days later, the man's condition had deteriorated again. For this reason, his release on compassionate grounds was agreed and the licence was issued that day.

The man showed no further signs of improvement. He died at 12.45am on the following day, with his wife at his side. The cause of death was recorded as carcinomatosis due to a squamous carcinoma of the lung (lung cancer). The man's funeral was held on two weeks later, and the prison acted appropriately in accordance with PSO 2710, the Prison Service guidelines for dealing with a death in custody.

## ISSUES

### *Issues raised in the clinical review*

The clinical review was conducted by the Lincolnshire Primary Care Trust. The clinical reviewer comments that he is “impressed with the level of care that the man received whilst in HMP Lincoln”. He goes on to say that, “I don’t believe that staff could have done more to make his last weeks and months more comfortable.”

The clinical reviewer notes that, towards the end of his life, the man was in considerable pain, as is common for lung cancer patients. He says that the man was “appropriately assessed” by external staff from a local hospice and the MacMillan service. However, the clinical reviewer notes that, when these specialist staff advised that the man should receive his medication via a syringe driver, he had to be admitted to hospital.

At interview, the Healthcare Manager at Lincoln said that they were going to get a syringe driver for morphine at the prison to try to bring the man’s pain under control. The syringe driver was initiated at the local hospital, and the man did not return to the prison after this.

The clinical reviewer goes on to say that, in the community, “palliative care patients frequently have their controlled drug medications administered by a syringe driver as this allows for large quantities of drugs to be administered more easily.” He concludes that the man’s “level of pain relief might have been greater had he been treated in the community – it would certainly have been easier to ensure that he received adequate doses of controlled drugs.”

The clinical reviewer therefore makes the following recommendation:

**HMP Lincoln should review the provision of pain relief for prisoners who require palliative care. This should include consideration of whether it is practicable to provide controlled drugs via a syringe driver for such prisoners, thus preventing unnecessary hospital admissions.**

### *Issues raised by the man’s wife*

As noted earlier, my investigator and senior family liaison officer met with the man’s wife on 5 June 2007. The issues raised were outlined on page 5 of this report.

- ***Compassionate release***

The man was released early on compassionate grounds. His wife thought that the man’s release could have been agreed much earlier.

Chapter 12 of Prison Service Order 6000 sets out the following criteria for compassionate release on medical grounds:

- the prisoner is suffering from a terminal illness and death is likely to occur soon; or the prisoner is bedridden or similarly incapacitated; and

- the risk of re-offending is past; 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.

An application for the man's early release on compassionate grounds was completed on 13 March 2007 and faxed to the Home Office for consideration on the following day. Unfortunately, due to an administrative error, the application was faxed to the wrong department and was not received by the Release and Recall Section (RRS) until 27 March.

The application was then referred to an advisor in prison health at the Department of Health for his advice. The advisor said that it was likely that release would need to be recommended at some point, but not immediately as the man's prognosis was only "poor" at the time. He also thought that a further prognosis should be obtained were the man to accept treatment.

This was fed back to HMP Lincoln who sought the advice of a Consultant Respiratory Physician at the local hospital, on 3 April. The Consultant replied the following day and said that "there is no evidence to suggest he would benefit from chemotherapy or radiotherapy". The Consultant also suggested that "he is likely to deteriorate and die over the next 2-3 months". A further update was sent to RRS on 27 April which gave a revised prognosis of four to six weeks.

My investigator contacted a Casework Manager in the Pre-Release Team of RRS. He said that, "the first principle that has to be observed in these cases is that the release of the prisoner will not put the public at risk." The Casework Manager went on to say that, "risk was the major factor in deciding when to recommend release in this case." At the time of the man's revised prognosis (27 April), the Casework Manager said that "we were not persuaded that the risk of harm had yet reduced to an acceptable level."

The Casework Manager also said that, at this point in time, it was not known to RRS whether the revised prognosis might be changed were the man to accept treatment. It does not therefore appear that the note prepared by the Consultant Respiratory Physician on 4 April had been received at RRS. However, given the emphasis on the level of risk presented by the man, it is unlikely that such information would have made any difference to the outcome.

On 30 April, RRS were informed that the man had been transferred to hospital, that he could now only receive palliative care, and that his condition had deteriorated significantly. The Casework Manager said that, at this point, they considered that the man's risk was reduced to the point where his early release could be recommended to Ministers. On 1 May, Ministers agreed to the release. However, the Casework Manager was then informed that the man's condition had improved and that the prison had clear concerns about him being released on licence at that

point owing to his risk. At interview the Healthcare Manager at Lincoln said that one of the reasons that these concerns had been raised was because the man had been well enough to be taken to the hospital car park by the escorting officers for a cigarette. The Casework Manager therefore made the decision to delay issuing the licence for early release until there was a clearer picture of the man's condition.

A few days later, the Casework Manager was informed that the man's condition had deteriorated further. He therefore issued the licence for early release on compassionate grounds on the same day.

The decision as to when a prisoner's condition has deteriorated to the extent that his risk of re-offending is past, as required by the terms of PSO 6000, is self-evidently a difficult one to make. If the man was well enough to be taken outside of hospital for a cigarette then the decision that there was still some risk of re-offending, however slight, was probably an appropriate one. On this basis, I do not think that the decision to release him on compassionate grounds could have been made any earlier. I therefore consider the timing of the man's release on licence to be reasonable and appropriate.

The seconded offender manager who had completed the risk assessment on the original application for early release told my investigator that she had no involvement with the case after she had completed her section of the application. She said that she was not aware that the man's risk had been reassessed on 1 May, but that it would have been helpful if she had been consulted. I agree.

**The Governor should ensure that the seconded offender manager is consulted when a prisoner's risk is reassessed at any stage of an application for early release on compassionate grounds.**

- ***Privacy in the last days of the man's life***

The man's wife was complimentary about the conduct of the prison officers who were on escort duty during his time in hospital. However, she said that she was unable to have a private conversation with her husband in the last few days of his life due to their presence in the room. My investigator discussed this with the Head of Security at Lincoln. The Head of Security said that it was a case of finding a balance between compassion and security. He did not think that the officers could be blamed for exercising caution, but thought that if the man's wife had made a request to the duty governor then her wish might have been agreed.

However, it seems to me unlikely that the man's wife, or any relative of a terminally ill prisoner, would be sufficiently familiar with the workings of a prison to know that she could make such a request to the duty governor. It may be appropriate in future to offer such an opportunity to the next of kin of a terminal patient, subject to a suitable risk assessment.

**The Governor should consider amending the Hospital Risk Assessment Form to give the opportunity for the next of kin to have some private time alone with a terminally ill patient, subject to an appropriate risk assessment.**

- ***Cancellation of outstanding hospital appointments following the man's reception into custody***

When the man was first received into custody on 17 October 2006, he had two outstanding hospital appointments. The first of these was on 31 October for a CT scan; the second was on 20 November for an operation to remove his cataracts.

The reason for the cancellation of these appointments was not recorded at HMP Nottingham. However, it is standard practice to reschedule any outstanding hospital appointments that are booked when a prisoner is received into custody. This is for reasons of security, as a prisoner is not permitted to know in advance of any time outside of prison.

My investigator spoke to the clinical lead at Nottingham. She said that the man's appointments were not recorded in their diary and that they could not therefore say for certain why they had been cancelled. She said that there are a number of reasons why the appointments might have been cancelled. First, if the appointment was booked at a hospital outside of their area then they would try to rebook it closer to the prison. Secondly, if there were already two hospital appointments booked on the same day then it would have to be cancelled as they do not have the staff numbers to do the escorts.

When the Consultant Neurologist's letter of 23 October 2007 was received at Whatton, healthcare staff at the prison had to make an urgent referral to the a local hospital to re-book the scan. As I have said, there was no record of the man's appointment in the diary at Nottingham. Whilst it was noted in his medical record by staff at Nottingham that the appointment had been cancelled, there was no record made of the reason for the cancellation or a note of any attempt to re-book on a different date. The likely conclusion is that the man's appointment was not re-booked. This is worrying, given the content of the Consultant's letter.

**The Head of Healthcare at HMP Nottingham should review procedures for recording and rebooking any hospital appointments that have to be cancelled.**

- ***The man's refusal to have a biopsy or surgery***

The man's wife thought that her husband might have agreed to have a biopsy or further investigation or surgery on his cataracts, if she had been allowed to accompany him. The clinical reviewer notes that the man was offered numerous opportunities to accept investigation and treatment. He declined on each occasion (as was his right).

My investigator discussed with the Head of Security at Lincoln the possibility of the man's wife accompanying him on hospital appointments. The Head of Security said that he had never heard of the next of kin attending a hospital appointment with a prisoner and, for reasons of security, did not think that it would ever go ahead. Indeed, he added that if a prisoner finds out in advance about a hospital appointment then it is automatically cancelled.

It is clear from earlier discussion that, at the time of any of these appointments, the man would have been considered to be at risk of re-offending. I do not therefore consider it unreasonable that he was not offered the opportunity to be accompanied by his next of kin.

- ***The man's ability to use the telephone***

The man's wife was concerned that her husband struggled to reach the telephone to contact her because he had to use a wheelchair. She said that she raised this with the prison and was told that "if he asks, they'll help". However, the man's wife said that he was not the sort of man to ask for assistance.

Prison Service Order (PSO) 2855, the Prison Service guidelines on Prisoners with Disabilities, sets out the Prison Service Standard for Disabled Prisoners. Paragraph 1.2.1 states:

"The Prison Service ensures that all prisoners are able, with reasonable adjustment, to participate equally in all aspects of prison life without discrimination."

It is clear from the records that the man was a very independent man. He wanted to preserve this independence for as long as he could and was very reluctant to ask for help from staff. There are numerous entries in his records of staff offering to help him with daily tasks, including accessing the telephone. It is clear that staff were aware of the man's reluctance to ask for help and, for this reason, offered assistance on a more regular basis than might otherwise have been the case. I am satisfied that staff at Lincoln made appropriate efforts to help the man with his daily tasks and to encourage him to ask for help when he needed it. Indeed, the clinical reviewer comments that, "staff could not have done more in his last weeks and months to make him more comfortable".

**The Governor should commend healthcare staff for the efforts that they made to look after the man in the last weeks of his life.**

- ***The man's wife was not informed when her husband was first diagnosed with cancer***

The man's wife told my investigator that, when her husband was first diagnosed with cancer, she was not told by anyone at the prison.

The possibility that the man had cancer was first discussed with him by a GP at Whatton on 9 November 2006. From his medical record, it is clear that the man telephoned his wife later that day to discuss the news with her as she spoke to healthcare staff at Whatton on the same day to discuss the situation further.

My investigator spoke to a Senior Nurse at Whatton. The Senior Nurse said that it is not the prison's place to inform the next of kin of the diagnosis of a serious illness, as they do not know any details of the relationship between the prisoner and the next of kin. It might be that the prisoner does not want their next of kin to be informed, and it is not the prison's place to assume their intentions. The Senior Nurse said that they

would not therefore inform the next of kin as standard practice, but would do so if specifically requested by the prisoner.

When the man's wife telephoned healthcare at Whatton on 9 November, staff were willing to discuss her husband's condition with her. It is noted in the man's medical record that his wife was "reassured that no firm diagnosis as yet". As such, I am satisfied that healthcare staff at Whatton acted appropriately when it was first revealed that the man might have contracted cancer.

## **Family response to the draft report**

On 15 November 2007, I received comments on my draft report from the man's wife. Having read the draft report, one of the main issues for the man's wife was that she wanted to better understand how the application form for her husband's early release could have been faxed to the wrong office, and whether this meant that he could have been released and come home earlier?

As I have discussed on pages 14-16 of this report, I do not consider that the decision to release the man on compassionate grounds could have been made any earlier. I am not therefore of the opinion that it would have made any difference to the outcome had the man's application form been faxed to the correct office of the Recall and Release Section (RRS).

However, there may be occasions in future where a quick decision on an application for compassionate release is imperative. In such circumstances, it is essential that RRS receive the relevant paperwork as quickly as possible. Whilst I do not consider it necessary to make a formal recommendation, it may be appropriate in future for staff to request an acknowledgement of receipt when sending an application form for compassionate release to RRS.

## **RECOMMENDATIONS AND GOOD PRACTICE**

**HMP Lincoln should review the provision of pain relief for prisoners who require palliative care. This should include consideration of whether it is practicable to provide controlled drugs via a syringe driver for such prisoners, thus preventing unnecessary hospital admissions.**

Accepted – subject to security risk assessment. All patient's care plans reflect their pain management. HMP Lincoln now has a named palliative care link nurse. Expertise is available from the MacMillan team.

The PCT advise that pain relief administered through a syringe driver would be available to future patients within prison healthcare, subject to its deployment passing the necessary risk assessment.

**The Governor should ensure that the seconded offender manager is consulted when a prisoner's risk is reassessed at any stage of an application for early release on compassionate grounds.**

Accepted locally – the seconded offender manager will be consulted when a prisoner is reassessed for early release on compassionate grounds.

Partially accepted nationally – Security Policy Unit will consider this recommendation as part of a wider review of NSF national policy in relation to seriously and terminally ill prisoners/patients.

**The Governor should consider amending the Hospital Risk Assessment Form to give the opportunity for the next of kin to have some private time alone with a terminally ill patient, subject to an appropriate risk assessment.**

Accepted – Hospital Risk Assessment Form to be amended to include this option subject to an appropriate risk assessment.

**The Head of Healthcare at HMP Nottingham should review procedures for recording and rebooking any hospital appointments that have to be cancelled.**

Accepted – HMP Nottingham healthcare have reviewed procedures to ensure that all receiving healthcare are aware of outstanding hospital appointments.

## **GOOD PRACTICE**

**HMP Lincoln paid for taxis to take the man's wife to and from hospital in the last week of his life.**

**The Governor should commend healthcare staff for the efforts that they made to look after the man in the last weeks of his life.**