Section 3 – Progress record

This application for early release on health grounds includes assessments from:

Section 4	-	The Medical Officer
Section 5	-	The Prison Social Work Unit
Section 6	-	The Governor

Section 4 – To be completed by the Medical Officer

(a) [redacted] examined the prisoner most recently on 3 August 2009.

(b) The consultants involved in the case are:

[redacted] (Consultant Oncologist - [redacted] Hospital)

[redacted] (Consultant Urologist - [redacted] Hospital)

[redacted] (Consultant Oncologist - [redacted] provision of second opinion/external reviewer)

[redacted] (Consultant Urologist [redacted] - [redacted] Hospital - undertook initial investigations resulting in diagnosis.

The palliative care team from [redacted] and a number of other specialists from other countries, have reviewed, commented and contributed to clinical management of the patient.

(c) The prisoner is suffering from metastatic prostate cancer.

(d) Mr Megrahi suffers from general debility, and several symptoms directly relating to his condition. Clinicians who have assessed Mr Megrahi have commented on his relative lack of symptoms when considering the severity and stage of his underlying disease. However, over the last month or so, his pain, previously restricted to his lower back, has increased and new foci have developed. As a result, his sleep pattern is disturbed. He appears tired and drawn. His recent consumption of appropriate medicines to assist him has increased.

(e) Mr Megrahi has undergone specialist consultations with a variety of medical consultants from across the UK and Libya. There has been, throughout the course of his illness, substantial consensus between both visiting and "home" specialists on matters of diagnosis, treatment and prognosis.

It is very difficult to be precise on matters of prognosis for any disease and Mr Megrahi's condition is no different. Factors in favour of a good prognosis in Mr Megrahi's case centre around his background of general good health, quality of health care and overall lifestyle, involvement in his care and compliance with treatment. Factors suggesting a

poorer prognosis are more numerous and weigh more heavily - the histological type of his tumour, the stage of his cancer at diagnosis, his psychological wellbeing, the passage of treatments which have been appropriate but have offered only transient success. Bio-chemical markers of disease once again indicate high activity and likely progression of his disease. However, no other marker or investigation would offer a more accurate barometer of prognosis to assess his clinical condition.

On diagnosis in autumn 2008, specialist clinical consensus gave this prognosis: and in the absence of a good response to treatment, survival could be in the order of months to many months rather than years.' Pressed to offer a more specific estimate, there was an informal mid-estimate of 18-24 months.

In May 2009, a Prisoner Transfer Agreement application was submitted by the Libyan Government on the patient's behalf. Whilst not structured to focus on health matters, it contained a number of key documents and assessments of Mr Megrahi's health. They describe the pattern and course of rapid development of the disease and its resistance to treatment. A key excerpt from the application documentation (April 2009, [redacted] states on the course of Mr Megrahi's disease course in the following 6 months: 'people who respond to hormonal treatment can hope for many years of disease suppression and even in the worst case scenario, one would have hoped for 2 years or more of disease control with hormone therapy. Unfortunately the patient did not even reach six months of disease control, which is another point in favour of the aggressive nature of his disease.' We would regard this assessment as a fair reflection of Mr Megrahi's clinical course at that time.

In June and July 2009, assessment by a range of specialists reached firm consensus that the disease was, after several different trials of treatment, "hormone resistant" - that is, resistant to any treatment options of known effectiveness. Consensus on prognosis, therefore, has now moved to the lower end of expectations from 10 months ago. Reviewing the total picture, the concluding specialist view is that, in the absence of a good response to treatment, survival could be in the order of 'months' and, no longer 'many months'. Whether or not prognosis is more or less than 3 months, no specialist "would be willing to say".

In the opinion of his [redacted] who has dealt with him prior to, during and following the diagnosis of metastatic prostate cancer, and having seen him during each of these stages, his clinical condition has declined significantly over the last week (period 26 July-3 August). The clinical assessment, therefore, is that a 3 month prognosis is now a reasonable estimate for this patient.

(f) Early release should be considered for the following reasons (Medical Officers should have in mind the following question: Does the condition of health render the prisoner incapable of committing further criminal acts, particularly of violence?)

Mr Megrahi is suffering from terminal cancer. The rationale for treatment is symptom-control and both he and his family are aware cure is not an option. He has, since first

consulting, reported a feeling of isolation - cultural, religious, social and language. He has a strong sense of family duty. The diagnosis of a terminal condition had heightened his sense of isolation and undoubtedly has substantial psychological impact. Mr Megrahi himself has a strong belief of the physical state impacting on the psychological and vice versa. He simply wishes to return home to be with his family, including his elderly mother.

In addition to considering the requirements of the patient, we had also discussed consideration of the family. His return to Libya would, we feel, not only benefit the patient, but would also be advantageous for the family. Mr Megrahi has several children of varying age. If he was returned home, his family could become more involved in his health-care needs. We would anticipate this would benefit them, not only in the short-term, but also when considering any potential longer-term psychological impact.

Whilst his condition does not restrict or remove Mr Megrahi's ability to carry out any particular tasks, we do not believe he would represent a risk to himself or anyone else.

We would anticipate a continued decline in his physical condition and increased dependence in external help. We understand plans for transfer of care to Libyan health service have been made (although we are not aware of specific details).

(g) We attach relevant medical reports in a sealed envelope.

(h) If released, medical care would be available from:

As noted previously, we are not aware of the specific details of treatment locations and treating physicians on return to Libya, though [redacted], MB, FRCPEd, Professor Medicine (Endocrinology), [redacted] Libya, has been involved in his care.

Having worked closely with clinicians from Libya over the past 10 months, there is real commitment to offering Mr Megrahi high quality health care following transfer or release. Our clinical staff will continue to work with Libyan clinicians to manage any transitional arrangements. No aspect of his illness or health care needs would constitute a barrier to compassionate release.

NAME ..... [redacted] .....
(Block capitals)

Signature ..... [redacted] .....

Date ..... 10 August 2009 .....