Investigation into the circumstances surrounding the death of a man at HMP & YOI Norwich in August 2008

Report by the Prisons and Probation Ombudsman for England and Wales

June 2009

This is the report into the death of a man. The man died at HMP Norwich in August 2008, having been transferred from HMP Exeter the previous day. The Coroner for Norfolk did not request a post mortem as the man had been diagnosed with cancer of the lung two months earlier.

Although he was terminally ill when he transferred to Norwich, his death was not expected to occur so suddenly. I extend my sincere condolences to the man's family and friends.

The investigation into the circumstances of the man's was conducted on my behalf by two of my investigators. My thanks go to the Governor of Norwich, the Governor of HMP Exeter, and the Governor of HMP Dartmoor, and their respective groups of staff, for their help and assistance.

Although the man's death occurred within the area covered by Norfolk Primary Care Trust, in light of the fact that he had been so recently transferred from Exeter it was agreed that Devon Primary Care Trust (PCT) should commission the review of his healthcare. The PCT appointed somebody to conduct a clinical review of the care afforded to the man whilst he was in Dartmoor and Exeter. I am most grateful for her review.

In this final report the Ministry of Justice and Department of Health have accepted one of the recommendations. The second recommendation to the Head of Healthcare Services is noted pending a response. The man's family were contacted and did not wish to make any further comment.

Stephen Shaw CBE
Prisons and Probation Ombudsman **June 2009**

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SUMMARY

In September 2007 the man was remanded to HMP Dorchester. He was seen by a reception nurse who noted that he was not receiving any regular medication. The man was generally well but told the nurse that he had lost weight, which he attributed to anxiety about his court appearance. The man was sentenced to six years imprisonment on 10 October, and returned to Dorchester. He was transferred to HMP Dartmoor on 2 November.

In June 2008 he was examined by a doctor following a referral from a nurse. The man had told the nurse he had a cough, was short of breath, and still losing weight. The doctor noted the man's symptoms and suspected a cancer related illness. He immediately referred the man for urgent further investigations, and an x-ray hospital. Four days later, the doctor told him that it was highly probable he had a tumour on his lung. Arrangements were made to support the man and for him to be assessed regularly by healthcare staff. He was moved to a ground floor cell.

On 31 June the man was admitted to hospital as his condition had deteriorated. Three days later, he started a course of radiotherapy (a treatment for cancer symptoms). Consideration was given to his prison allocation given his medical condition, and discussion took place between healthcare staff at Dartmoor and HMP Exeter. Other enquiries were made with the Nelson Unit in HMP Norwich. (This unit is resourced to provide nursing care for older prisoners with age related and terminal illnesses.) On 23 August the man was diagnosed with a chest infection and his prognosis was poor. Six days later, on discharge from hospital, he was transferred to Exeter as the healthcare facilities there were more appropriate for his immediate needs.

However the man's condition deteriorated further, and on 20 August it was decided that he should be transferred to Norwich. He was assessed by the palliative care team and the prison doctor who agreed that he was well enough to withstand the long drive from the West Country to East Anglia. An ambulance was arranged and paramedics accompanied him on the journey.

The man arrived at Norwich in the afternoon of 21 August, and he was seen by a nurse from the palliative care team. He was tired after the journey but seemed to settle and relax in his new surroundings. During the night he was observed regularly by healthcare staff on the Nelson Unit and appeared to be sleeping peacefully. He was checked on 22 August at 5.20am, and was sleeping. However, at 5.35am the healthcare assistant noticed that he was not breathing. The paramedics were called but it was found that the man had died.

The man was transferred to the Nelson Unit as it was judged that this was in his best interests. However, my investigation draws attention to an apparent lack of communication between Dartmoor and Exeter and I make a related recommendation. My second recommendation relates to the lack of suitable facilities for long-term sick and terminally ill prisoners across the country.

THE INVESTIGATION PROCESS

1. The investigation into the man's death was opened on 28 August 2008 when my colleagues visited HMP Norwich. (Notices and the Ombudsman's terms of reference had been sent to the prison in advance.) My investigators met with the Head of Safer Custody, reviewed the man's prison file and medical notes, and took copies of all relevant documents. No members of the local Independent Monitoring Board nor the Norwich branch of the Prison Officers' Association wished to meet with my investigators, as they are well aware of the procedures for a death in custody investigation.

2. Later my two investigators visited the Nelson Unit. My investigators met the Head of Healthcare and the Deputy Governor.

3. One of my Family Liaison Officers spoke to the man's daughter by telephone on 2 September 2008. The man's daughter raised several matters for the investigation to consider. They included her father's transfer to Norwich, and his application for a compassionate discharge.

4. On the morning of 9 October my two investigators visited Exeter and spoke to the Head of Healthcare and a doctor. Later that day, they visited Dartmoor and spoke to the Head of Healthcare.

HMP & YOI NORWICH

5. Norwich is a city centre prison, predominantly serving the courts of East Anglia. It has an operational capacity (maximum crowded capacity) of 557, holding remand and sentenced adult men and young offenders. The prison is divided into two sections. One area accommodates young offenders and the healthcare centre, and the other is for all other prisoners.

6. The healthcare centre provides 24-hour healthcare cover and has space for a maximum of 23 in-patients. On the ground floor of the centre is the Nelson Unit. This unit has been designed and equipped to enable older and less able prisoners to be supported and cared for within the confines of the prison environment.

7. HM Chief Inspector of Prisons last inspected HMP Norwich in November 2006. An extract from that inspection noted:

> "Health services had improved under management by Norfolk PCT. There had been considerable investment in an electronic clinical management system, and clinical governance arrangements were linked with the PCT's clinical governance strategy."

8. Two extracts from the Independent Monitoring Board (IMB) Annual Report for 2007 noted as follows:

> "Over the last year there has been no difficulty recruiting nurses with the right experiences. Lessons have been learnt from death in custody reviews, which have been included in protocols, risk assessments and action plans. Risk assessments have been completed on a range of issues from infection control, the misuse of medication and bullying to 'flu outbreaks and staff shortages. There is a good working relationship with the PCT with the sharing of emergency on-call."

> "The Nelson Unit for elderly prisoners has introduced an innovative 'open door' policy to deal with deaths, of which there have been four this year. It has also used the voluntary sector to develop various social activities which are being developed. A handrail has now been fixed and the prisoners will at last be able to use a specially made garden."

9. There have been 17 deaths at Norwich due to natural causes since my office took responsibility for investigating all deaths in prison custody in 2004. (Given its function, it is inevitable that the Nelson Unit experiences a high number of deaths.) Since 2007, seven prisoners have been transferred to the Nelson Unit from outside the Norfolk PCT area for terminal care. Four of those prisoners travelled over 100 miles to receive this specialist support as none was available locally. In all four cases the prisoners were only in the Nelson Unit for a relatively short period of time before they died.

10. In previous reports into deaths at Norwich I have highlighted many areas of good practice. The staff of the Nelson Unit are highly experienced in providing care for the elderly and for those who are terminally ill.

HMP & YOI EXETER

11. Exeter prison is located within the city of Exeter and was built around 1850. It currently has four accommodation units with a healthcare facility in support. The certified normal accommodation is 314 and the operational capacity 533. The prison holds both adult male remand and convicted prisoners committed to custody from Cornwall, Devon, and south west Somerset.

12. The HM Inspectorate of Prisons conducted an unannounced inspection of Exeter in October 2007. The report said of healthcare services:

> "Health services had maintained much of the progress previously reported. There was only a short waiting list for the dentist. Pharmacy arrangements were basically satisfactory, although there were still problems with arrangements for in-possession medications. Mental health work was good and developing. The inpatient regime remained poor, and secondary health screening for new arrivals was voluntary, which was inappropriate."

13. The Independent Monitoring Board's Annual Report for 2007 said of the prison:

> "There are some very dedicated, professional staff working in Exeter Prison. Relationships between staff and prisoners are very good. Prisoners generally feel safe in custody. However, we would like to see a more purposeful and constructive use of prisoners' time through the extension of education, skills and leisure opportunities. The challenges of operating within predominantly Victorian buildings designed for another age are immense. The pressure of very high prisoner numbers adds to the difficulties and requires continuous attention to the maintenance of clean and safe living and working environments. As monitors, we expect to see creative management solutions to these problems in the coming year."

14. One of my investigators recently investigated a death at Exeter. My subsequent investigation report included concerns regarding the nursing of prisoners with palliative care needs. All my recommendations were accepted by the Primary Care Trust and the Prison Service, and I am pleased to report here that the investigation into the man's death found that some of those recommendations had already been addressed.

HMP DARTMOOR

15. Dartmoor is a category C training prison located in the village of Princetown, Devon, with an operating capacity of 625. The prison was last subject to a full inspection by HM Chief Inspector of Prisons in February 2003. An unannounced follow up in February 2006 revealed a prison that had improved

16. Dartmoor works collaboratively with HMP Channings Wood and HMP Exeter as part of the Devon Prisons Health Partnership (DPHP). Healthcare at the prison is commissioned by Devon PCT. The prison's healthcare department has a doctor available every weekday. Overnight and weekend cover is provided by Devon Docs, an out of hours service commissioned by the PCT. There is no in-patient facility within the healthcare unit. A dedicated nurse is based in the Vulnerable Prisoners Unit on F wing.

KEY FINDINGS

17. In September 2007 the man was received into HMP Dorchester following a court appearance. It was noted in the first reception screening that he had lost a stone in weight which he attributed to anxiety about his court case. His weight was recorded as 57.5kg. No further information was recorded in his medical notes other than a history of a hernia and a skin graft to his nose. The man was not receiving any regular medication.

18. The following month the man was sentenced to six years imprisonment by a Crown Court. On 2 November he was transferred to Dartmoor and was seen by a nurse on arrival. He told the nurse that he had lost two stone in weight, which again he attributed to stress. The nurse advised him to make an appointment with the doctor if his weight loss continued. There is no record of his weight on this occasion. The man declined the offer of an appointment to see the doctor.

19. The man had no further contact with any healthcare staff until 16 May 2008 when he complained of abdominal cramps and diarrhoea. His temperature had risen to 38 degrees and he was mildly dehydrated. (A normal temperature reading is 36.5 degrees.) He was advised to dissolve a teaspoon of sugar and a pinch of salt into boiled water to sip. He was also given paracetamol for his raised temperature and Gaviscon for stomach cramps. The symptoms settled the following day.

20. On the evening of 23 June 2008, a nurse was called to visit the man in his cell as he was complaining of shortness of breath. He said that he had had a cough for three weeks and continued to lose weight, now weighing 55kg. The man was examined by a doctor the following morning who suspected cancer of the lung. He was referred for an urgent x-ray and a request was made for a priority appointment at hospital under the two week referral. (When there is suspicion of a cancer related illness, a doctor can request further urgent investigations to take place within two weeks of their referral.)

21. On 27 June, the doctor advised the man that he might well have a malignancy (moreover, a cancerous tumour). He seemed to take the news well and was moved to a more appropriate cell on the ground floor to reduce the need for climbing stairs. Food supplements were prescribed and a computerised tomography (CT) scan was booked for the following week. (A CT scan is an x-ray procedure that takes images of the whole body.) On the same day thee man signed a waiver declining to attend the Court of Appeal for a hearing the following week as he did not feel fit to travel.

22. The man was seen in his cell on 30 June by a nurse who noted that he was breathless and who gave oxygen. His breathing settled down and the nurse advised him to rest. Later, he was seen again by a nurse. His medical notes show that he was now located on the ground floor and his meals were being brought to him. The nurse encouraged him to ask for help whenever he needed it.

23. The following day the man was seen by a nurse in his cell at the request of wing staff. He was extremely breathless, which settled when he rested. He was given some oxygen. The nurse noted that he would need a wheelchair when his daughter visited the prison in a few days time. (The prison's disability liaison officer would arrange a wheelchair to aid the man's mobility.) Lastly, the nurse recorded she would make contact with the Red Cross for the loan of a more suitable and comfortable chair for him.

24. Later that day, the doctor visited him in his cell. He noted that the man was unwell and it was not safe for him to stay in his cell due to his deteriorating health. The man was transferred to hospital by ambulance with two officers. He was restrained by an escort chain. (An escort chain is a 1.8 metres length of chain with a cuff attached to the prisoner and the other to an officer.)

25. On 2 July, healthcare staff made contact with the hospital for an update on the man's condition. He was having a CT scan and feeling much better. The following day, the man's medical notes record that a diagnosis of lung cancer had been made. Further tests were underway and he was to remain in hospital for the time being.

26. The man started a course of radiotherapy, and a course of chemotherapy (a treatment for cancer using intravenous medication) was being considered. On 8 July, his appeal against conviction was turned down.

27. During this time healthcare staff at Dartmoor maintained contact with the hospital. It was agreed to transfer the man to HMP Exeter when he was ready for discharge because Exeter has 24-hour healthcare facilities. Healthcare staff at Dartmoor staff contacted the MacMillan nurse to discuss his ongoing cancer nursing support, and liaison systems were put in place.

28. It was further recorded that a transfer to another health authority would not be appropriate as the man was continuing receiving treatment for his cancer from hospital. A compassionate discharge would not be possible at this time as he was at an early stage into his sentence.

29. Meanwhile, in response to a request from a doctor, a senior officer from the security department at Dartmoor began to look into the possibility of the man being transferred to a prison nearer to his daughter in South East London. The officer was unable to identify anywhere more suitable. However, in this process the senior officer became aware of the specialist facilities for older prisoners in the Nelson Unit at Norwich. The officer emailed the Head of Healthcare at Norwich to explore the possibility of transferring him to their care in the near future. She replied, sending a copy of the admission criteria and asking for further medical information.

30. The information sent from Norwich said:

> "In order to provide an appropriate service it is necessary to outline those for whom the service would be inappropriate to provide admission for:
> - those who require admission to the Acute NHS Trust services

- those who require continuous services of a specialist NHS team
- those who require continuous observation due to an acute psychiatric illness or disturbed behaviour
- those who require specialist treatments or investigations that cannot be met within this care setting
- those who are applying for early release on compassionate grounds."

31. The doctor at Exeter concluded that the man did not meet these criteria, and on 18 July wrote in the medical notes that he was still in hospital and would not be suitable for transfer to Norwich.

32. On 23 July, the man developed a chest infection and it was decided that he was too ill for the course of chemotherapy. The hospital nurse said that the man would need palliative care (specialist nursing care for terminal illness). The doctor recorded in his medical notes that he would need nursing care on his discharge from hospital, with oxygen available when required. The hospital said he did not need hospice care at that time. (Hospices provide nursing care for terminally ill patients.) The doctor noted that the man would be discharged to Exeter for 24-hour nursing care, and his transfer from hospital to Exeter had to be by ambulance and not by a prison vehicle.

33. Six days later the man was discharged from hospital to Exeter. He was admitted to the healthcare centre and seen by the doctor. It was noted that he was frail with obvious weight loss. Oramorph (a morphine based medication) was prescribed for pain relief along with further medication to control his symptoms. The doctor started the process to apply for early release for medical reasons. He discussed this with the man's daughter with a view to getting him registered with her family doctor.

34. A probation officer based in the prison assessed that there was a low risk of the man re-offending and a medium risk of harm to children. There were some concerns about him being released to his daughter's address, but the probation officer thought that they could be managed with the help of Social Services. She said that she would have no concerns about risk if the man's condition deteriorated and he was cared for in a hospice.

35. However, the Governor noted on the application form that the man should not be released. The main reason was that it would result in him residing in the family home, and this would breach his court order. In addition, he was in denial of his offences and was at an early stage of his sentence.

36. On 30 July, in tandem with the application for early release, a multidisciplinary meeting took place at Exeter to discuss the man's care. Amongst those present was a nurse from a local service for care and support of people with terminal illness. It was agreed to seek permission to leave his cell door unlocked 24 hours a day to allow easier access by the staff providing care and support. The hospice nurse agreed to arrange for a hospice bed to be provided when the man needed it, and weekly visits by palliative care nurses were planned.

37. Over the next few days the man's pain control appeared to be well managed and a community matron visited him. Following this visit, a profile bed with a pressure-relieving mattress was ordered to help reduce the risk of him developing pressure sores. The man was seen daily by the doctor and a nursing care plan was put in place.

38. The man's daughter visited him on 2 August. An entry in his personal file the next day noted that staff had a follow-up telephone conversation with her. The entry said, "she was extremely pleased with everything – it had all gone better than she expected and she thought he looked very well considering and found staff to be very kind and helpful."

39. The profile bed and pressure-relieving mattress were delivered on 5 August, and the man appeared to be more comfortable as a consequence.

40. The hospice nurse and community matrons visited the man again on 6 August. On 9 August, the doctor increased the dose of slow-release morphine prescribed for pain control.

41. The man's family visited him again on 11 August. Although he was now in the care of the healthcare team at Exeter, it would seem that staff at Dartmoor had maintained contact with Norwich and it had been agreed to transfer him. They emailed Exeter to inform them of this, and an entry was made in the man's clinical record to this effect. By this time all active treatment and clinical investigations had been stopped and he was just being treated with symptomatic palliative care.

42. On 19 August, a nurse noted that steroid treatment was now less effective and that "the transfer to Norwich was very timely". The man remained comfortable and, following a discussion with the doctor it was noted that he was "not for resuscitation". (Not for resuscitation indicates that, should the patient go into heart failure, resuscitation would not be deemed appropriate.)

43. The man was examined by the doctor on the morning of 20 August and was assessed as well enough to travel. He was frail and unable to walk, but he was able to feed himself and take fluids. The following day at 8.00am he was transferred by ambulance from Exeter to Norwich, accompanied by two officers and a nurse. The man was not restrained. He arrived at Norwich at 2.00pm.

44. On the same day, a letter written on behalf of the Secretary of State for Justice was faxed to the Governor of Exeter advising that the Secretary of State had refused to grant early release.

45. The man was admitted to the healthcare unit for older prisoners and assessed by the palliative care team. A comprehensive clinical assessment was carried out, and he was assessed by a Consultant in Palliative Care. The man was breathless on exertion and had a persistent cough. He complained of a dull ache across his lower chest which was associated with eating food. It was noted that he had significant weight loss and reduced mobility although he

46. The man was described as low in mood, tearful and exhausted after his journey from Exeter. The palliative care nurse discussed his resuscitation status with him. The related paperwork was completed and he made it clear that he did not wish to discuss this any further. It was agreed to continue with the medication that he had been receiving.

47. A member of nursing staff telephoned the man's daughter to inform her that her father had arrived safely at Norwich and was resting. The man settled into his new surroundings and was noted to be sleeping comfortably that night.

48. On 22 August, the night staff observed the man at 5.20 am when he was said to be peaceful. However, when he was checked by the healthcare assistant at 5.35am he was not moving and not responding, although was still warm to touch. An emergency ambulance team was contacted in accordance with the prison's procedure. At 5.58am, the man's death was confirmed by the paramedics.

49. The man's next of kin (his daughter) lives some distance from Norwich. The Duty Governor at HMP Reading was contacted and he agreed to visit her to inform her of her father's passing. Following the visit, his daughter telephoned Norwich and spoke to the Head of Healthcare.

50. As a post mortem examination was not undertaken. It is not possible to say anything in more detail about the cause of death other than that it was a result of cancer.

51. The man's daughter was offered support and assistance from the Head of Healthcare at Norwich. The Governor of Dartmoor made a financial contribution towards the man's funeral expenses.

ISSUES

Clinical care

52. A review of the man's health care was commissioned by Devon NHS Primary Care Trust. A panel of clinicians met to consider the report and its findings.

53. The review has found many examples of good clinical practice whilst the man was in the healthcare unit at Exeter and recognises the contribution of the multidisciplinary team towards his care. I note the clinical review panel's commendation of healthcare staff for the care they gave the man. No recommendations were made in relation to healthcare procedures and services. The review did not include his short time at Norwich.

Care of terminally ill prisoners

54. As soon as the man was diagnosed with cancer and admitted to hospital, healthcare staff at Dartmoor and Exeter discussed the options for his nursing care when he was discharged.

55. The man's daughter was able to speak directly to a doctor about her thoughts and wishes to support her father at the end of his life. Hospice care was considered, as well as compassionate discharge that would have allowed him to stay with his daughter. The compassionate discharge was unsuccessful and hospice care was inappropriate at that stage of his illness. Options for his palliative care lay firmly with Exeter.

56. The man's daughter lived a considerable distance from Exeter and visiting her father during these difficult times was stressful. The Nelson Unit at Norwich, whilst still a long distance from her home, did offer suitable palliative care.

57. The palliative care of prisoners who cannot be released from prison is problematic, and family involvement is subject to the policies and procedures of each prison.

58. The Nelson Unit is one of the few prison health centres in the country that has a dedicated service for terminally ill prisoners. Until funding becomes available to provide more appropriate facilities elsewhere, the Nelson Unit will continue to be under pressure to offer places to prisoners who have to travel considerable distances to get there. As the number of elderly prisoner's increases, the need for additional units like Nelson Unit becomes more and more obvious.

59. I have raised this issue in a number of my reports. It is my firm view that there needs to be a better geographical spread of specialist units for elderly, long-term sick, and terminally ill prisoners. I therefore make the following recommendation:

    The Department of Health and Ministry of Justice should jointly review the provision of healthcare facilities for elderly, long-term sick and terminally ill prisoners to ensure a better geographical spread.

Compassionate Release

60. Approximately five weeks before the man died, his daughter had a conversation with the doctor at Exeter and discussed the possibility of the man being granted compassionate release and moved to her home. She said that the doctor advised her that this would not be possible because her father was too ill to make the two a half hour journey home at that stage of his treatment. In addition, the transfer of treatment from hospital to hospital would be inappropriate at that time.

61. Later, the doctor approached the man's daughter's family doctor to see if her father could be transferred to the practice. The man would be nursed by his daughter in her home if an application for compassionate release was successful. The man was now receiving palliative care nursing, and medical treatments had ceased. The family doctor agreed and so the doctor who the daughter had spoken with started the process of applying for compassionate release.

62. Exeter's probation officer thought that there was a medium risk of harm to the man's daughter's family, and it would be better if he was cared for in a hospice. However, the Governor felt that, in any event, release would be inappropriate as it was early in the man's sentence; he denied that he had committed the offence, and release would breach a court order. The application for a compassionate release was submitted to the Ministry of Justice for consideration. The Secretary of State subsequently turned down the application on 21 August 2008.

Communication between Dartmoor and Exeter

63. Health services for prisoners in Dartmoor and Exeter are commissioned by Devon NHS Primary Care Trust and provided by Devon Prisons Health Partnership. While the man was in hospital, Dartmoor continued to take responsibility for his care by daily contact with the hospital.

64. When he moved to Exeter from hospital, the lead responsibility for his care was transferred to healthcare staff at HMP Exeter. In spite of this it would appear that staff at Dartmoor continued to liaise with Norwich over the possibility of transferring the man to the Nelson Unit. Exeter was not informed of this.

65. It is likely that the doctor would not have pursued the possibility of compassionate release had he been aware that a transfer to Norwich was still being sought by Dartmoor. This would have avoided raising false hopes in the man's daughter that her father might have been released to her care.

    The Head of Healthcare Services should remind staff of the importance of good communications between all services covered by Devon Prisons Health Partnership when prisoners are transferred from one to the other.

The man's transfer to Norwich

66. The man's daughter was concerned that her father was too ill to be moved from Exeter to Norwich. He had spoken to his daughter about a week before the transfer and told her that he had been advised to go to Norwich where there were better facilities. His daughter was keen for him to have the best available care.

67. A member of staff at Dartmoor had told the man about the facilities at Norwich following his diagnosis of lung cancer. As he expressed an interest, the staff made enquiries with the Nelson Unit to see if he would be accepted.

68. The Head of Healthcare at Norwich provided Dartmoor with information about the Nelson Unit, including the admission criteria and the situations when admission is inappropriate. The doctor at Dartmoor, once he became aware of this information, concluded that the man was not eligible for transfer as he did not meet the unit's criteria at that stage of his illness.

69. Whilst the enquiries were made with the best interests of the man in mind, they did cause some confusion for both healthcare staff at Exeter and the man's family.

70. In the meantime, the man was admitted to hospital for lengthy treatment and it was agreed that he would need to be discharged to Exeter because of the 24-hour healthcare facilities that are unavailable at Dartmoor.

71. As I have noted on many occasions, the facilities at the Nelson Unit in Norwich provide excellent palliative care for terminally ill prisoners. Whilst Exeter and Norwich could scarcely be further apart, the facilities that the Nelson Unit could offer to the man were far better than those at Exeter. He had been told about the Nelson Unit and opted to go there.

72. Hospice care is available to prisoners in Exeter through good links with the local palliative care services. At the stage of his illness when he elected to go to Norwich, hospice care was not appropriate to meet his nursing and therapeutic needs. The palliative care team considered it right that the man should be transferred to Norwich. At the time of his transfer, whilst he was very ill, it was not thought that his death was imminent.

73. Immediately prior to his transfer, a doctor examined the man. It was agreed that he was fit to undertake the journey. On the journey a qualified nurse and two officers accompanied him in a private ambulance, fitted for medical emergencies. Whilst a journey lasting six hours was clearly not ideal, the practical arrangements for his transfer were good practice.

74. The fact that the man died so soon after his transfer was unexpected. However, his death was dignified and in much better surroundings in the Nelson Unit than would have been the case at Exeter.

75. Given that this report covers three prisons (Norwich, Exeter and Dartmoor), I suggest that copies are shared with the Governors and Heads of Healthcare in all three establishments.

RECOMMENDATIONS

The Department of Health and Ministry of Justice should jointly review the provision of healthcare facilities for elderly, long-term sick and terminally ill prisoners to ensure a better geographical spread.

Accepted – "Work is already underway to review the level of need, and develop a strategy for the delivery of healthcare to chronic and terminally ill prisoners. This work is being done in partnership between Offender Health and NOMs."

The Head of Healthcare Services should remind staff of the importance of good communications between all services covered by Devon Prisons Health Partnership when prisoners are transferred from one to the other.

Pending – A response from the Head of Healthcare Services has not been received at the time of circulation of this final report