Investigation into the circumstances surrounding the death of a man in October 2010 in hospital whilst in the custody of HMP Exeter

Report by the Prisons and Probation Ombudsman for England and Wales

January 2012

This is the report of an investigation into the death of a man. He died in hospital in October 2010. He had been suffering from cancer, and had been in and out of hospital for some weeks.

One of our family liaison officers contacted the man's brother to explain the purposes of the investigation. We offer condolences to the family, and apologise for any distress caused by the delay in issuing our report. The man's brother had no comments to make on the draft of this report other than to thank our office for conducting the investigation.

The investigation was undertaken by a senior investigator. We would like to thank the previous and current governors of HMP Exeter and their staff for their participation. The local Primary Care Trust (PCT) commissioned a clinical reviewer to undertake a review of the man's clinical care, whose assistance is greatly appreciated.

The man was a 78 year old man, who had been in prison for nearly two years. He had a number of underlying health problems, including heart disease. He was transferred to HMP Exeter because it was felt that he needed the 24-hour healthcare offered in their in-patient unit. In August 2010 he was taken to hospital, and whilst there it was agreed that his heart disease had reached the stage where it was regarded as terminal. He returned to prison, and staff did their best to ensure that he was made as comfortable as possible. After a fall in early October, he was taken to hospital and whilst there was diagnosed with cancer in his lung. He remained in hospital until he died.

We are satisfied that the man received a good level of care in HMP Exeter. There are three recommendations as a result of this investigation, relating to medical records, visiting arrangements, and to the holding of debriefs in light of a death in custody. I am pleased to see that the National Offender Management Service has accepted these recommendations. The clinical reviewer makes one recommendation in relation to a risk assessment of the healthcare centre, and we draw this to the Head of Healthcare's attention.

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.

Thea Walton
Acting Deputy Ombudsman **January 2012**

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SUMMARY

1. The man was an elderly man, who had underlying health problems, including congestive heart disease and diabetes, before arriving in prison. Once in custody, his medical problems were noted and treated appropriately. Nevertheless, he was frail, and suffered from more than one fall. As a result, he was referred by HMP Channings Wood to the falls clinic at the hospital. His diabetes was well managed.

2. After a spell in hospital in December 2009, the man spent a week recuperating in HMP Exeter's healthcare centre (as Channings Wood does not have an inpatient unit). He returned to Channings Wood and continued to engage with healthcare. In July, his behaviour began to change, and he was becoming confused. He saw a prison doctor, who noted that he was having trouble breathing. The doctor referred him to hospital, and he was admitted.

3. Whilst in hospital, tests indicated that the man's heart condition had now reached an acute stage. His condition was now regarded as terminal. It was agreed that on release from hospital he would need the 24-hour care that was offered by the in-patient centre at HMP Exeter. He left hospital and went to Exeter on 3 August.

4. The man was admitted to the healthcare unit on arrival. His immediate healthcare needs were met, and the prison made adjustments to ensure his care and comfort. Contact was made with a local hospice, and his family were informed of his illness. Following discussion between the prison doctor and the hospital consultant, it was agreed that should the situation arise, it would not be in his best interests for him to be resuscitated. This was discussed with the man himself, and subsequently with his family.

5. On 26 September he suffered a fall and had to once again go to hospital. It was discovered that he had broken his hip, and he remained in hospital until he had had an operation to insert a pin. He returned to prison on 1 October.

6. When he returned, hospital staff had provided an air mattress to ensure the man was as comfortable as possible. He stayed in a cell with CCTV so he could be monitored, and an aural monitor was placed in the cell so staff could hear him if he fell or if he called for help. Arrangements were made so that staff could access his cell 24 hours a day, including during the night when cells are usually locked except in emergencies.

7. On 6 October the man suffered another fall. Once again he was admitted to hospital. Whilst in hospital, further tests revealed cancerous cells in his lung. His family were told, and were kept informed throughout his stay in hospital. The prison made preliminary preparations to ensure they could care for him should he return, but his condition deteriorated. He remained in hospital until he died.

8. We recommend that the Head of Healthcare monitor prisoners' medical records to ensure that they are being well maintained, and that locations for visits are consistently considered. We also recommend that the Governor should ensure that debriefs are held following a death in custody.

THE INVESTIGATION PROCESS

9. The Ombudsman's investigator formally opened the case at HMP Exeter on 21 October. He met with the Deputy Governor and the Head of Corporate Development. He also spoke to the Heads of Healthcare responsible for both in-patients and other prisoners. The prison provided him with the man's prison record. He also obtained the man's prison medical records.

10. Notices were issued to staff and prisoners informing them of the investigation and inviting anyone with relevant information to contact the investigator. No such contact was received.

11. The local Primary Care Trust (PCT) conducted a clinical review of the man's care and treatment. This was undertaken by a clinical reviewer. The investigator discussed the report with him.

12. The investigator formally interviewed three members of staff, and those interviews were recorded. The interviews were transcribed and interviewees invited to sign and return copies, confirming their accuracy. Unfortunately, a delay in the prison being able to arrange the interviews has led to a delay in issuing this report.

13. One of our Family Liaison Officers contacted the man's brother to explain the investigation and offer the opportunity to contribute. His daughter had indicated that she was content for her uncle to act as next of kin. The family were content with how the prison had handled the circumstances arising from his death.

14. The man's brother raised two specific points. When he visited his brother, the visit had taken place in the healthcare centre. When he next visited, however, the visit took place in the visitors' centre. His brother was obviously in poor health, and was in a wheelchair. The centre was busy and noisy, and the brothers had difficulty in hearing each other. He asked why he could not have visited in the healthcare centre once again.

15. The second point related to when the man returned from hospital after an operation on his hip. Whilst in hospital he had had restraining bars on his bed, yet when he came back to prison he did not. His brother asked if an assessment had been made as to whether he should have had something similar on his bed in prison.

16. The investigator wrote to HM Coroner to inform her of the nature and scope of our investigation and to request a copy of the post mortem report. Throughout the course of the investigation, the investigator remained in contact with the Coroner's office. Upon completion, this report will be sent to the Coroner to assist her enquiries into the man's death.

HMP EXETER

17. HMP Exeter was originally built in the 1850s as Devon County Jail. It has an operational capacity of 537 and accepts adults and young offenders from courts in Cornwall, Devon and West Somerset.

18. The local PCT provides healthcare in the prison in the separate healthcare unit. The unit has 15 beds for in-patients, and serves the three prisons in Devon (HMP Dartmoor, HMP Channings Wood, and Exeter itself). Two cells are suitable for disabled prisoners, with adapted shower and toilet facilities. Doctors are on duty in the prison during daytime hours, and nurses are on duty 24 hours a day. Outside the normal working day, doctors are available through the standard out-of-hours service in Devon.

Previous deaths at Exeter

19. In the last two years, five prisoners have died at HMP Exeter (three deaths occurred prior to the man's death and one since). One other death was due to natural causes and none of the circumstances of these other deaths are relevant to the circumstances of his death.

Her Majesty's Inspectorate of Prisons' report

20. The latest report on Exeter by Her Majesty's then Chief Inspector of Prisons followed an announced inspection in October 2009. There are no issues in the report which are relevant to the circumstances of the man's death.

Independent Monitoring Board (IMB) report

21. Each prison in England and Wales has an Independent Monitoring Board made up of unpaid volunteers from the local community appointed by the Secretary of State for Justice. The IMB are responsible for monitoring day-to-day life in the prison and to ensure that proper standards of care and decency are maintained. The last report published by the IMB for Exeter is the annual report for the year ending 31 October 2010. There are no issues reported upon which are directly relevant to the circumstances of the man's death.

KEY EVENTS

22. The man was born in November 1931. He had been married, but was divorced in 1964. He had a son and a daughter from this marriage.

23. He had been employed through his adult life, but had been retired since 1992. He suffered from some health problems, including diabetes, and said that he had suffered a heart attack some seven years prior to coming into prison. He reported a family history of heart disease and diabetes. He had stopped smoking after his heart attack, and said that he did not drink alcohol.

24. On 12 December 2008, the man was remanded to HMP Exeter. He underwent a reception health screening, and said that he had a history of heart problems, as well as suffering from diabetes. He was given appropriate medication and arrangements were made for ongoing monitoring of his conditions. Because of the nature of his offence, for his own protection he was not located on an ordinary prison wing. This was his first time in prison, and he had no previous convictions.

25. Convicted of several offences on 11 February 2009, the man was sentenced at Crown Court to seven years imprisonment. On 29 May he was transferred to HMP Channings Wood.

26. In view of his health problems a prison doctor requested advice regarding the man's needs. On 23 June 2009 he wrote to the Occupational Therapy Department at hospital and said that because of his age, and the fact that he had type 2 diabetes, osteoporosis (where bones easily fracture), hypertension (high blood pressure), a history of ischaemic heart disease (related to narrowing of the coronary arteries), and myxoedema (problems with his thyroid gland), his needs had to be assessed. He had already suffered a fall, damaging his hand.

27. During his time in Channings Wood, the man suffered a number of falls. These caused some minor bone fractures, including to his hands and fingers. As a result, he was referred to hospital, where he attended the falls clinic. The clinic provided advice on minimising the risk of falling, and reducing the risk of damage if he did fall. He did, however, suffer a further fall on 21 December, which resulted in him being admitted to hospital. He was unable to bear weight on his right leg, and had fluid on his lung. It was suspected that he might also have bleeding in his brain. He was also noted to have in the past suffered from erratic heart rhythm, ventricular failure on both sides of the heart, and an under-active thyroid gland (which can affect energy levels).

28. On his discharge from hospital, it was felt that the man would require 24 hour care for a period of rehabilitation. He was therefore transferred to the healthcare in-patient unit at HMP Exeter on 25 December, before being discharged and returned to Channings Wood on 31 December.

29. The man had ongoing contact with healthcare. His diabetes was monitored, and he was referred for physiotherapy. His care was reviewed in the Elder Care Clinic in the prison on 23 February 2010. His diabetes was managed with tablets, and he took daily blood sugar readings. He was fully compliant with his medication. Since his last return to prison, he had been using a walking frame. Although he had initially been anxious about using the shower, he was capable of looking after himself in terms of washing and dressing. There were no concerns over his mental state.

30. In July 2010, the man began to appear confused, and prison staff were concerned at his behaviour. He suffered from a number of panic attacks. On 16 July, he reported to the medical hatch for his weekly medication a day early, and he was noted to be having difficulty breathing. That same day he had a panic attack, and his scheduled appointment with the prison doctor the following week was brought forward. He saw a doctor, the medical lead for prisons in Devon, that afternoon.

31. The doctor noted that he had a build up of fluid in his chest, was having difficulty breathing, and was suffering with fluid retention. He was taken to hospital as an emergency patient. He was admitted and moved to a ward.

32. His records show that the man did not have a smooth stay in hospital. During the early hours of 19 July he suffered a fall, but did not cause himself injury. During his time in hospital he became confused and occasionally aggressive. There were occasions when he refused to co-operate with medical investigations into his health, declining to have his observations taken, to be taken for x-rays, refusing medication, and on one occasion attacking a nurse trying to treat him.

33. Medical staff from Channings Wood had remained in contact with the hospital during the man's stay. The hospital decided that there was little more that they could offer him, and the prison doctor discussed his condition with medical staff in the hospital. It was accepted that his heart condition was now entering the acute phase and should be classed as terminal. On 22 July, taking into account the extent of his heart condition and his generally poor health, it was recommended that when discharged, he should go to the healthcare unit in HMP Exeter. He transferred to the in-patient unit there on 3 August. His notes at this stage indicate that, in addition to his heart problems, he was suffering from cerebral atrophy (loss of cells in the brain) and atrial fibrillation (erratic heartbeat).

34. On his return to Exeter, an admission assessment was made. The man's medical notes show that he was suffering from terminal heart failure and that the prognosis was poor. He had a build up of fluid on the right side of his chest, but the hospital consultant said that this should not be drained as it would be too distressing for him. Prison staff aimed to provide support for him as his condition deteriorated. It was identified

that advice should be sought from a local hospice, and that the possibility of compassionate release should be investigated. He was noted to settle fairly well and was comfortable. He sometimes appeared confused, but was not observed to be short of breath.

35. The prison doctor saw him on 4 August. During his examination, he discussed the issue of resuscitation with him. The doctor confirmed in interview that he understood the discussion. Following further discussion between the doctor and the man's hospital consultant, it was agreed that, should the situation arise, he would not be resuscitated. The consultant said that due to the level of his illness, attempts to resuscitate him would be unlikely to succeed. A notice informing staff that resuscitation should not be attempted (a do not resuscitate, or DNR, notice) was added to his medical notes on 5 August.

36. One of the prison doctors examined the man on 7 August. He was confused and unaware of where he was. The doctor noted that this was likely to be due to his heart condition meaning that a reduced amount of oxygen was being distributed round his body (hypoxia). This would be an expected effect of his illness. The doctor noted that staff would discuss with a psychiatrist whether a full assessment would be appropriate.

37. The man was reviewed daily by the duty medical officer. On 9 August he was again noted to be confused, which the doctor attributed to his cerebral atrophy. He was however comfortable, and said that he felt that his breathing had improved.

38. On 9 August, the man's nurse discussed compassionate release with the doctor. The issue was referred to the Healthcare Manager, who was asked to begin the process to apply for his release on compassionate grounds.

39. The man continued to be regularly monitored by healthcare staff. He was generally mobile and able to move about without assistance. He sometimes slept for long periods, and continued to have episodes when he was confused, though on 11 August the doctor noted that his mental health seemed better.

40. Following a visit, the man's brother met with his brother's nurse on 12 August. They discussed the issue of resuscitation, and the nurse explained that it was not felt to be in his best interests to be resuscitated. The doctor subsequently spoke to the man's daughter on 17 August, and similarly explained the DNR process and their decision.

41. Records show that the man continued to suffer confusion and occasionally appeared unstable when walking. He also had trouble sleeping at night, as he struggled to breathe when lying down, so he continued to sleep at various unusual times. His mobility mainly remained good and he continued to take his medication as prescribed.

He fell on 3 September and hurt his finger, which needed a splint. He wrote to his brother on 10 September, asking him to visit.

42. Medical notes show that on 21 September, the doctor wrote to the local hospice for advice on how to best manage the man's increasing breathlessness. However, in the afternoon of 22 September, he fell on the prison landing. He suffered a cut above his eye, and complained of pain in his left thigh. He was admitted to hospital, where his hip was found to be fractured.

43. He was scheduled to have an operation on 24 September, but this was cancelled when he removed an intravenous drip that had been providing fluid to him, and withdrew his consent. Although he went on to change his mind, the hospital anaesthetist did not think the man was well enough to be put under anaesthetic, so the fluid was drained from his chest without general anaesthetic, and on analysis was found not to contain any cancerous cells. He was subsequently judged well enough to be operated on and the prison chaplain contacted the man's brother to inform him. A pin was inserted into his hip on 27 September. The chaplain visited him and later informed the man's brother that he was comfortable. Staff from the local hospice had spoken to him, and would contact healthcare at the prison to follow this up.

44. The man was discharged from hospital and returned to prison on 1 October. Staff from the local hospice had been in touch with him, and on his return to prison, staff made a number of adjustments to assist their care of him. A hospital bed with adjustable height to help him get in and out of bed was provided. He was accommodated in a cell with CCTV, and staff were told that in addition to normal observations, they should check on him at least five times per hour. During the night, cells in the healthcare centre are locked and staff on the unit carry keys in sealed pouches only to be used in cases of emergency. The lock on his cell door was changed, so staff could gain access if required 24 hours a day. The hospital also provided an air mattress, along with the necessary pump. He would be largely bedbound, and the air mattress would help his comfort and reduce the risk of him developing bedsores. Staff also put an aural monitor in his cell, which fed to a speaker in the office, so they could hear if he fell or called for help.

45. On 3 October the man fell in his cell. He knocked his head, but did not seem to have injured himself. He continued to be closely monitored by staff. However, on 6 October, he suffered a further fall in his cell. A doctor assessed him, and was concerned that pain in his hip could be a bone injury. He referred him to hospital, and he was once again taken to hospital. As with all prisoners going to outside hospital he was risk assessed, and it was agreed that he did not need any physical restraints. He was accompanied by one prison officer. (This is known as bedwatch, and the duties were shared between staff from Exeter as well as from other prisons.) Hospital staff assessed him, and he was admitted. The

following day, the chaplain informed the man's brother that he was back in hospital.

46. The chaplain visited the man on 10 October. He was eating his meal when the chaplain arrived, and seemed pleased to see him. After a little while, though, his concentration faded. The chaplain telephoned the man's brother the following day to update him.

47. Whilst the man was in hospital, healthcare staff in Exeter maintained daily contact with the hospital. This was both to remain aware of his condition, and to assess whether any specialist equipment or changes to processes would be required on his return. It was agreed that when he came back to prison, a healthcare assistant would be employed specifically to provide full-time care for him. However, during his hospital stay, he underwent x-rays that showed some shadowing on his chest, and further tests were ordered. These tests confirmed that he was suffering from cancer in his right lung. The diagnosis was that it was inoperable.

48. The man's brother telephoned the chaplain on 16 October to ask after his brother. The chaplain said that he would be visiting him the following day, and would report back the day after that. He did so, but when he telephoned on 18 October he had to report that he had deteriorated. He had pulled out his intravenous drip, and was unable to receive antibiotics for a chest infection. He was becoming frail, and his brother said that he would visit later in the week. During 18 October, hospital staff recommended that no further surgery should be performed on him. Later that evening, the chaplain visited him. He told hospital staff that he would liaise with the family over his condition, to which the hospital staff agreed. The chaplain contacted the partner of the man's daughter and told them how ill he was. He asked the chaplain to inform him if he died. The chaplain then telephoned the man's brother and again passed on the news that he was seriously ill.

49. On 19 October, staff put the man on the Liverpool Care Pathway. (This is a protocol to care for patients who are close to dying.) A syringe driver (a machine to ensure a measured but constant application of medication) was brought in to allow him to be given painkilling medication continuously: this had to be corrected at one point when found not to be operating correctly. The chaplain visited, but he was asleep. He telephoned the man's daughter's partner, and subsequently his brother, and told them of his condition, but that he was comfortable.

50. At 5.15am the following day nursing staff told the prison staff on bedwatch that the man had died. He informed the prison, and the procedures following a death in custody were put into operation. He was officially pronounced dead at 6.05am by a hospital doctor.

51. The hospital had been liaising with the chaplain on behalf of the man's family. They telephoned him and told him that the man had died. The

chaplain spoke to the prison duty governor, and then telephoned the man's brother and daughter to inform them.

Support for staff

52. All staff who had worked with the man were contacted and reminded of the support that was available to them if needed.

53. The chaplain contacted HMP Portland and HMP The Verne, who had provided staff for bedwatches for the man in hospital, to inform them of his death. He asked them to ensure that support was offered to staff who may feel that they needed it.

Support for prisoners

54. The day the man died, all prisoners in Exeter who were on special measures to support those thought to be at risk of harming themselves were reviewed in case his death had an adverse effect on them. Notices were posted in the prison informing prisoners of his death and advising them where to request support if they felt they needed it.

Debrief

55. It is usual for prisons to hold a debrief in light of a death in custody. These are usually held as soon as possible on the same day after a death in custody to ensure that staff involved have an opportunity to discuss any issues arising.

56. The man was known to be terminally ill, and died after spending some time in hospital. Staff were offered support. Notices were issued to staff informing them of the debrief, but following a number of them declining to attend, the debrief was cancelled.

Post Mortem

57. A post mortem was carried out on 21 October 2010. The doctor noted that the man had two separate diseases, either of which could have caused his death. The doctor thought it likely, though, that it had been the cancer in his lung, rather than his heart disease, which had proved fatal. The heart disease did, however, contribute. The cause of death was given as:

Ia	Bronchopneumonia
Ib	Squamous cell carcinoma of right lung
II	Ischaemic heart disease.

Funeral

58. The prison made arrangements for the funeral and this was held on 28 October. The service was conducted by the prison chaplain and attended by the Governor, along with members of the man's family.

ISSUES

Medical care

59. The man was an elderly man, who was in poor health. The clinical reviewer concludes that he received appropriate care for his many medical problems. He highlights good practice around his diabetic care and his referral to the falls clinic whilst in Channings Wood.

60. The man's brother asked why he had not had protective bars on the side of his bed to protect him from falling. The investigator raised this with the prison's medical lead and with the deputy healthcare manager. They both confirmed that current advice was that for patients such as the man, beds with raised side bars were considered dangerous. If a patient suffers from confusion, as he sometimes did, in conjunction with being physically frail, there is a risk that in trying to get out of bed over the bars a more serious fall can ensue. It seems reasonable that he should not have had such bars on his bed in the prison's healthcare unit.

61. The investigator considered whether the man should have undergone a mental health assessment. He had episodes of confusion, and when in hospital was not always compliant with his treatment. The investigator raised this with both the hospital doctor and clinical reviewer. His episodes of confusion were a consequence of his illness. The problems with both his heart and his lungs meant that his body was not functioning properly, and his brain was not receiving sufficient oxygen. This is known as hypoxia. When this happens, the person can become confused. There would only be a need for a mental health assessment if symptoms persisted once the hypoxia had been treated. He did not get to that stage. We therefore regard the decision not to refer him for a mental health assessment as reasonable.

62. The clinical reviewer makes one recommendation, to which we draw to the Head of Healthcare's attention. He recommends that a risk assessment be made on the facilities in the healthcare unit in Exeter, focussing on reducing the risk of falling by prisoners who are frail. The investigator raised this issue. In light of the man's death, the healthcare manager obtained some material on risk assessments, which were considered by staff. It was found that the majority of the suggested best practice in the provided material was already incorporated into nursing assessments which staff undertook. It was agreed that risks should continue to be assessed on a case-by-case basis.

63. We also point out to the Head of Healthcare that the man's medical notes were poorly maintained. We understand that since he has died, the prison has moved to an electronic record-keeping system. It is hoped that this will improve the situation. However, this will require monitoring to ensure improvements are made.

The Head of Healthcare should conduct checks to ensure that prisoners' medical notes are fully and properly maintained.

Family liaison

64. The man had been estranged from his family, but when it became clear that his illness was terminal, the chaplain made contact with his brother, and subsequently with his daughter. The chaplain handled an extremely sensitive situation well, ensuring that he received visits from his family in his last weeks.

65. When the man died, the chaplain informed the family by telephone. It is usually recommended that such news is broken to families face-to-face. In this instance, however, he had formed a good relationship with the man's brother and daughter. They were aware that he was gravely ill, and had indicated that they were content for the chaplain to contact them by telephone. The chaplain arranged and conducted the funeral, with the family's consent, and they subsequently contacted him, thanking him for all he had done. Taking into consideration the exceptional family circumstances, we are satisfied that his liaison with the family was appropriate and compassionate.

Compassionate release

66. When the man returned from hospital with a diagnosis that his illness was terminal, the possibility of applying for compassionate release was raised. This was referred to the healthcare manager to explore. As events transpired, however, he had to return to hospital after a fall and whilst there his cancer was discovered. He did not return to prison. He had been in contact with the local hospice, but the onset of his illness did not allow time for him to go there. With his exceptional family circumstances, there were no obvious places to where he could be released with full-time care. In these circumstances, we consider it reasonable that his application for compassionate release was not progressed.

Restraints

67. When prisoners are taken to outside hospital, consideration must be given to the level of security applied to them. Safety of the public is paramount, but must be balanced against the likely risk presented and the dignity of the individual. The security department at Exeter conducted risk assessments for the man during his times in hospital. In his final stay, it was agreed that he did not require any physical restraints. He would be accompanied by a single prison officer, and restraint chains could be used if the escorting officer felt them to be necessary. We are satisfied that this was a sensible and humane decision.

Visits

68. The man's brother asked about visits. When he visited him on one occasion, they met in the healthcare centre. When he visited on a subsequent occasion, however, the visit took place in the visitors' centre. This was a busy environment with a degree of noise that made the visit difficult.

69. The investigator raised this issue. Staff in the healthcare centre will generally consider the circumstances of visits in view of the health of the prisoner. This will be considered on a case-by-case basis. If the prisoner is particularly unwell, staff will usually arrange for the visit to take place in the healthcare centre. This will afford more privacy. There are, though, other issues to consider. The visitors' centre does, for example, offer the facility to buy food and drinks, and is specifically set up to facilitate prisoners and their visitors. It is not clear why the man had two visits in two different areas. Therefore we make the following recommendation.

    The Head of Healthcare should ensure that arrangements for visits are consistently considered and recorded in view of individuals' circumstances.

Debrief

70. No debrief was held in light of the man's death. It was scheduled but most staff invited declined to accept the invitation. As a consequence the debrief was cancelled. Staff were contacted to inform them of this decision, and to remind them that support remained available if necessary.

71. It is good practice for prisons to hold a meeting to consider the circumstances of a death in custody. This is outlined in Prison Service Order 2710 (which provides guidance following deaths in custody). In this case Exeter did try to do so. Because the man had not died unexpectedly and had not died in the prison, the need may have been slightly lessened. The meeting was cancelled after staff had largely declined to attend. They were still offered support.

72. Nevertheless, even if staff involved in dealing with a death in custody do not wish to attend a debrief, it is still prudent to hold one. A death in custody, even a foreseen death where the circumstances have been well-managed, is a serious incident. There should be some consideration as to whether there was anything that could have been done in a different way if it would have improved the prisoner's care. Staff should not have the option of simply opting out: although it is partly for their benefit, it is also for the benefit of the overall system of care custody.

The Governor should ensure that debriefs are held in light of a death in custody

CONCLUSION

73. The man arrived in prison with some serious health problems. These included a serious problem with his heart, as well as diabetes. Prison healthcare staff kept him under assessment, and treated his problems. He was elderly and frail, and suffered from a number of falls, for which he was appropriately referred to the falls clinic at hospital.

74. The care he received seems to have been appropriate, and at least equitable to that which he could have expected in the community. Indeed, he was given a level of observation that he would have been unlikely to have received had he not been in Exeter with the 24-hour care provided there. When it was accepted that his illness was terminal, staff began the process to apply for compassionate release. He died, however, before the application had been progressed.

75. The man's lung cancer seemed to develop quickly. It was not detected when he was in hospital in September 2010, but was present the following month. It is possible that the tests he underwent in hospital in August and September did not reveal the cancer even though it was present. The post mortem indicated, though, that had the cancer not developed, he is likely to have died from his heart failure. This did play a contributory role in his death.

76. Family circumstances were difficult, but the prison chaplain managed communications with the man's family. He did receive visits from his brother and from his daughter, and the chaplain kept them in touch with his health. When he died, the chaplain informed the family, as they had previously discussed.

77. Overall, we judge that the man received a good level of care. As his health failed, he was regularly assessed and, when necessary, sent to hospital. When in prison he was located in the healthcare centre, with 24-hour care. Staff made a number of adjustments to allow them to better look after him. A hospital bed was brought in, and an air mattress, to improve his comfort. Arrangements were put in place so that staff could access his cell 24 hours a day. He was allocated a cell with CCTV coverage, and staff were told to observe him regularly. (He was aware he was being observed.) An aural monitor was placed in his cell, so that staff could hear if he fell, and he could call for assistance if required.

78. We make three recommendations, relating to the clarity of medical records, location of visits, and the holding of debriefs in light of a death in custody. The clinical reviewer makes one recommendation in relation to a risk assessment of the healthcare centre and we draw the Head of Healthcare's attention to this.

RECOMMENDATIONS

1. The Head of Healthcare should conduct checks to ensure that prisoners' medical notes are fully and properly maintained.

   NOMS have accepted this recommendation. They commented:

   "A weekly check of a patient's care plan is conducted at the care review meeting for all prisoners located in the HCU. In addition a monthly management check will be implemented on a minimum of 5% of all patient records via System 1."

2. The Head of Healthcare should ensure that arrangements for visits are consistently considered and recorded in view of individuals' circumstances.

   NOMS also accepted this recommendation. They commented:

   "The weekly care review meeting ensures that all patients' needs are catered for on an individual basis. This meeting will take into consideration a patient's ability to access main visits and plan accordingly."

3. The Governor should ensure that debriefs are held in light of a death in custody.

   NOMS also accepted this recommendation. They commented:

   "Local Death in Custody policy to be updated to ensure that all deaths in custody are followed by a de-brief, regardless of whether these are Self Inflicted or Natural Causes."