

**Investigation into the circumstances surrounding the
death of a man
at HMP & YOI Exeter in December 2008**

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

November 2009

This is the report of an investigation into the death of a man at Derriford Hospital, Plymouth, in December 2008. Aside from a period of nine months in an Approved Premise (a hostel run by the Probation Service) in 2005-2006, he had been in prison since receiving a life sentence in April 1990.

He suffered with diabetes and in March 2008 he developed occasional chest pain. After further investigations he was admitted to Derriford Hospital in November 2008 for heart by-pass surgery. After surgery he initially showed signs of recovery, but he developed respiratory problems and died just over a month later. I would like to offer my sincere condolences to his family and friends for their loss.

One of my investigators conducted the investigation on behalf of the Ombudsman. I thank the Governor of Exeter, and his staff for their co-operation and assistance. In addition, a review of the man's medical care in prison was carried out by Devon Primary Care Trust (PCT). I am grateful to the clinical reviewer for his assistance. I would also like to apologise for the delay in providing this report.

I find that the man was treated well by staff at Exeter, which also included the management of his diabetes, with appropriate and timely referrals to the hospital. I make one recommendation in my report. This concerns the use of restraints when a prisoner is admitted to an outside hospital. I suggest that the use of restraints should be reviewed every 24 hours or when the prisoner experiences a significant change in circumstances. I also support a recommendation made by the clinical reviewer that a review of software used to manage diseases, such as diabetes, takes place in HMP Exeter.

The inquest touching the circumstances surrounding the death of the man was held on 18 September at Torquay Coroner's Court with a jury. They found that he died from natural causes. I am grateful to the Coroner for informing me of this.

Jane Webb
Deputy Prisons and Probation Ombudsman

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CONTENTS

Summary	4
The investigation process	5
HMP & YOI Exeter	6
Key Findings	7
Issues	
Concerning the man's clinical care	10
Use of restraints	10
Recommendation	13

SUMMARY

On 6 April 1990, the man was sentenced to life imprisonment at Exeter Crown Court for an offence of murder. He was assessed by a psychiatrist at the time of his trial who concluded he “shows evidence of a neurotic and volatile personality”. In 1995 he was formally diagnosed with paranoid personality disorder by a psychiatrist in HMP Exeter and was released on licence on 8 September 2005, but he was recalled to HMP Exeter on 16 May 2006. He had regular reviews of his psychiatric state whilst at Exeter, and, following the Parole Board’s decision not to release him in January 2007, he complained of feeling depressed and suicidal. An Assessment, Care in Custody and Teamwork (ACCT) document was opened and reviewed appropriately throughout the year. (ACCT is the Prison Service’s system for supporting and monitoring prisoners in crisis aimed at keeping them safe.)

The man was also diagnosed with diabetes in 1998, a condition which was appropriately managed by the prison healthcare service. However, related to this condition, he suffered some episodes of hypoglycaemia (low blood sugar levels) due to his refusal of food which was seemingly motivated by his feelings of being unable to cope in prison following recall in May 2006.

On 19 March 2008, he experienced chest pain and, following tests, medical staff at the prison suspected this to be angina. On 9 May, he was referred to the local hospital for further tests, which were somewhat delayed due to his reluctance to attend hospital appointments. Following a cardiac catheterisation (a method of gaining detailed information regarding a patient’s heart and coronary arteries) on 16 September, he was diagnosed with triple vessel disease of his heart and referred to Derriford Hospital.

The man was admitted to Derriford Hospital on 20 November and had a heart bypass operation. However, six days later he developed respiratory failure and after further deterioration he died on 28 December 2008.

In this report I endorse one recommendation made by the clinical reviewer in relation to reviewing the software used to manage diseases at HMP Exeter and also make a recommendation of my own concerning the use of restraints.

THE INVESTIGATION PROCESS

1. This investigation was undertaken by one of the investigators from the Ombudsman's office. He first visited HMP Exeter on 12 January 2009 where he was shown around the prison and given access to the man's prison records. The investigator met members of the local branch of the Prison Officers' Association (POA) and the Independent Monitoring Board (IMB). (Each prison has an Independent Monitoring Board. IMB members are independent and unpaid. They monitor day-to-day life in the prison and ensure that proper standards of care and decency are maintained. The IMB produces an annual report on the prison.) Neither the IMB nor the POA had anything specific to bring to the investigator's attention at this time, but both said they would help wherever they could, for which I am grateful. Whilst on this visit, the investigator held informal discussions with a number of prison staff who had known the man. The investigator also had access to the cell which the man had occupied before he was admitted to hospital.
2. Notices to staff and prisoners were displayed by the prison. These invited anybody with information to talk to the investigator. There was only one prisoner to request a meeting and the investigator met with him on 27 April 2009 at HMP Channings Wood. The transcript of this interview was included as an annex to the draft report.
3. Devon County Primary Care Trust (PCT) was asked to undertake a clinical review of the care the man received while in custody. A doctor carried out this review on their behalf for which I am grateful.
4. A family liaison officer from the Ombudsman's office contacted the man's son, as his nominated next of kin, to inform him of the investigation and to give him the opportunity to raise any questions or concerns about the care his father had received in prison custody. At the time of writing this report, he had not raised any specific issues. I hope this report helps to address any concerns the man's family may have and provides them with a better understanding of the events leading to his death.

HMP & YOI EXETER

5. HMP Exeter was built around 1850. It is a local category B prison serving the courts of Cornwall, Devon and West Somerset. This means it holds adult male prisoners and young offenders, both on remand and convicted from the local area. It has a maximum capacity of 533 prisoners.
6. The report of the prison's Independent Monitoring Board that covered the period November 2007 to October 2008 commended the good practice in the Health Care Unit.
7. The most recent inspection by HM Chief Inspector of Prisons, was an unannounced short follow-up inspection carried out from 16 – 18 October 2007. The report noted that health services were "good and improving".
8. Between 2004 (when the Ombudsman's office became responsible for investigating all deaths in prisons) and the man's death in 2008 there had been two other deaths due to natural causes at Exeter. They were due to cancer and a heart attack but there are few similarities between these cases and that of this man.

KEY FINDINGS

9. On 6 April 1990, the man was sentenced to life imprisonment at Exeter Crown Court for an offence of murder. He had been on remand at HMP Exeter since 9 June 1989.
10. A medical assessment completed at the request of his solicitor in 2008 by a consultant psychiatrist, indicates that despite his long history of paranoid thoughts, anxiety and alcohol dependency, he had never been assessed by a psychiatrist until the time of his trial. However, a formal diagnosis of paranoid personality disorder was not made until 1995.
11. In 1998, the man was diagnosed with diabetes and the clinical review concludes that his condition was managed appropriately. He was at various establishments until January 2001 when a panel of the Parole Board recommended transfer to open conditions and he was moved to HMP Leyhill on 7 May 2002. On 8 September 2005, the man was released. During this period in the community he resided in a probation hostel. He was recalled to custody on 16 May 2006 because of alcohol misuse and an allegation of a further offence and returned to Exeter.
12. Medical records show that the man was seen on 16 May and notes were made regarding his personality disorder, diabetes and the need for an alcohol detoxification programme. He was also refusing food due to feeling unable to cope with a further period in custody following his recall to prison. This was of particular concern given his blood sugar levels in relation to his diabetes. On 17 May, an Assessment, Care in Custody and Teamwork (ACCT) document was opened in response to his food refusal.
13. The man subsequently had regular psychiatric reviews of his chronic anxiety and personality disorder by health care staff at HMP Exeter. In January 2007, his application for release from custody was denied by the Parole Board. He subsequently complained of being depressed and experienced thoughts of suicide. The clinical reviewer says that an ACCT was opened appropriately at various times during the year and his antidepressants were changed as necessary. There is no evidence of him attempting suicide apart from some episodes of hypoglycaemia (low blood sugar) brought about by refusal to eat.
14. On 11 June, he was transferred to HMP Gloucester and the following day to Leicester. On 11 July, he was transferred to Bristol and then back to Exeter on 12 July. Despite attempts to clarify the reason for these temporary transfers with both the custody and the Observation, Classification and Allocation departments at Exeter, I have been unable to ascertain the reason for these moves.
15. He was taken to Royal Devon and Exeter Hospital by paramedics on 2 January 2008. He had low blood sugar and had not improved even after nursing staff at the prison gave him some glucose. The healthcare staff called paramedics with a view to administering glucose direct into his veins. They

were unsuccessful and so took him to hospital. He was discharged at 1.30am the following morning and returned to Exeter.

16. On 19 March, the man complained of lower central chest pain that he had been having for one hour. Healthcare staff checked his pulse, listened to his heart and lungs and decided that they were all normal. An entry in the medical record on 20 March says that he may have been suffering from angina. On 25 March, an entry in his clinical record says that he had a slight angina attack, after which he administered his own glyceryl trinitrate (GTN) spray (GTN spray is commonly used to ease and prevent angina pains) and the pain subsided. He was advised to rest.
17. A referral was made to the Royal Devon and Exeter Hospital via the Rapid Access Chest Pain Clinic on 2 May, and he was seen there on 22 May. The clinic concluded he had possible angina and referred him for a cardiac catheterisation which took place on 16 September 2008. This delay was apparently due to his refusing several appointments owing to his concern about the likely prognosis. The man was subsequently diagnosed with triple vessel disease and referred to Derriford Hospital.
18. He was also referred to a consultant neurologist at around this time because of difficulty with his speech. His MRI scan on 29 May 2008 indicated that he might have damage of his brain by excessive alcohol use in the past (a condition called osmotic myelinolysis). His diabetes might also have contributed to this problem.
19. A report prepared on 27 October by the consultant psychiatrist, at the request of the man's legal representative, indicated that he had "recently experienced an acute exacerbation of his paranoia and anxiety which is intertwined with deterioration in his cardio-vascular status". He concluded that the man had a personality disorder which was "exacerbated by various stresses". He said that the man's diabetic and cardio-vascular problems had made his mental health problems worse. His mental health was subsequently stabilised by an increase in his anti-psychotic medication. The consultant psychiatrist described the care the man was receiving as "entirely appropriate".
20. On 20 November, the man was admitted to Derriford Hospital for his heart operation. He was on a bedwatch under restraint. (A bedwatch is where two members of Prison Service staff are present at the bedside of a patient, one of whom will be handcuffed to the patient at all times.) He had heart by-pass surgery the following day which was said to have been successful. On 26 November, he developed respiratory failure and was admitted to intensive care in the cardiology department. His son and other family members visited him on 28 November and other occasions during his stay in hospital.
21. During his time in hospital, staff from the hospital became concerned about the use of restraints on him. On 15 December, for example, they asked that they be removed because the handcuff was causing swelling to his wrist. After checking with the prison and a new risk assessment review being

completed, the Governor agreed that restraints could be removed, but that they should be reapplied if the man was taken off the ventilator.

22. He developed further respiratory problems on 18 December and was admitted to the general intensive therapy unit (ITU). He never recovered from this illness and, on 28 December 2008 at 3.20pm, he died. The post mortem records the cause of death as pneumonia with acute respiratory distress syndrome, coronary artery bypass surgery and Myocardial Ischaemia (which means he died from pneumonia following heart surgery, because he developed breathing difficulties).
23. Before the man had passed away, a member of staff on duty had telephoned his son that he was extremely unwell. His son was on his way to the hospital when his father died. His son was met by nursing staff who broke the news of his death and introduced his son to the prison staff present. These events were followed up by contact with the prison's chaplaincy staff, the Quaker Minister, who helped the man's son through the funeral arrangements (the man was a practicing Quaker).

ISSUES

Concerning the man's clinical care

24. The doctor concludes in his clinical review that the man "was given appropriate medication consistent with the current best practice of how to manage Ischaemic Heart Disease". Although he concludes that the man's medical care was appropriate, he suggests that HMP Exeter use a clinical computer programme called EMIS (or an equivalent system) which contains software with a number of Chronic Disease surveillance programmes. They could be used to manage diseases such as the man's diabetes in a more structured way and so improve the care patients are offered. The Primary Care Trust will wish to consider a review of the current software used at HMP Exeter to manage diseases, such as diabetes, with a view to installing a clinical computer programme such as EMIS.
25. The doctor also says that the man's diabetes was managed appropriately by medical staff at HMP Exeter. However, the man had difficulty complying with the treatment regime, and as indicated earlier, sometimes manipulated his diet to induce hypoglycaemic episodes. There were also times when he did not go for his insulin injections when he was located on the wing rather than the healthcare unit. He therefore had a variety of treatment plans which sometimes included oral medication rather than injections of insulin.
26. There is some evidence from the consultant psychiatrist's report that suggests the man's mental capacity was compromised by either excessive alcohol use or his diabetes. This does not appear to have warranted significant intervention by prison healthcare services, although it was clearly a factor in his personality disorder (according to the consultant psychiatrist). The consultant psychiatrist concludes though, that prison healthcare services managed the man appropriately in terms of his clinical state.

Use of restraints

27. In other reports, the Ombudsman has reflected extensively on the issue of the use of handcuffs for prisoners who are elderly, frail or very unwell. This man was transferred to hospital on 20 November and his condition deteriorated such that he was transferred to Intensive Care on 26 November.
28. I have not had access to the initial risk assessment when he was admitted to hospital, if indeed one was completed. Requests were made by clinical staff at the hospital to loosen or remove the handcuffs due to concerns that they were affecting his circulation. For example on 15 December, an entry in the prison officers 'bedwatch log' at 7.00am says,

"Nurses attended the man. They have again requested the removal of the cuffs due to growing concern about sores to his skin"

and at 9.00am the same day,

“Doctor’s round – again requested the cuffs be removed due to swelling of his arm. Spoke to the governor who stated the cuffs will not be removed until a proper review has been carried out this morning”.

Later on that day the man’s arm was said to be “ballooning” and bandages were applied to his arm. At 3.50pm the decision was made by the governor that the man could have the restraints removed but that they must be replaced if the ventilator was no longer required.

29. It is unclear whether he was restrained again after this date. The management checklist indicates that he was restrained on 17 and 18 December although the observation log makes references that he is not handcuffed.
30. However, it is clear that a risk assessment was carried out on 19 December. An entry in the bedwatch documentation for this date says that the risk assessment was reviewed and recommended that the bedwatch be reduced to a single member of staff. There is no specific mention of restraints in the observation log but the management check list completed at 5.20pm that day indicates that none were being used at that time. Indeed, this seems to have been the case until the man’s death on 28 December 2008.
31. Policy and practice in the Prison Service regarding the use of restraints on prisoners in hospital is extremely cautious, and I am aware that the balance between decency and security can be difficult to find. The nature of the man’s offences would, of course, have needed to be considered, particularly in relation to his risk to the public. Nevertheless, my own sense is that the Service has become too risk averse and that a heavily sedated man was not a likely escapee. (I am certainly not aware of any specific evidence to suggest he was an escape risk.)
32. I do understand the decision taken by HMP Exeter given the prevailing climate and the expectations of the Service as a whole. However, I also wonder whether the staff undertaking the managerial bedwatch checks are able to balance risk and concern for decency at the end of life in a timely manner. I judge that restraints could have been safely removed sooner, and that the presence of two officers, later reduced to one officer would have been an adequate safeguard for the public. I therefore make the following recommendation:

The Governor of Exeter should ensure a full risk assessment, including an assessment of the use of restraints, is prepared by staff and considered by the Duty Governor when a prisoner is admitted to an outside hospital, and should be reviewed at least every 24 hours or when the prisoner experiences a significant change in circumstances.
33. Although I criticise the decision to keep the man restrained for nearly a month while he was sedated in Intensive Care, I also recognise that prison staff were compassionate and caring with regard to other aspects of his care.

34. He unfortunately seems to have been part of the small percentage of people who do not survive heart bypass surgery. HMP Exeter appears to have reacted entirely appropriately to his symptoms and made timely referrals where necessary. I echo the clinical reviewer's conclusion that "I can find no evidence that his (the man's) medical care whilst in custody contributed to his death."

RECOMMENDATION

The following recommendation was partly accepted by the Prison Service:

The Governor of Exeter should ensure a full risk assessment, including an assessment of the use of restraints, is prepared by staff and considered by the Duty Governor when a prisoner is admitted to an outside hospital, and should be reviewed at least every 24 hours or when the prisoner experiences a significant change in circumstances.

They said:

'A daily check is carried out by a Principal Officer with 72 hour check carried out by E grade operational manager. Review of restraints will be carried out at 72 hr reviews or on each change of circumstances.'

The other recommendation I endorsed was from the Clinical Review, and that said:

Healthcare staff to use Chronic Disease surveillance programmes within EMIS to manage patients with chronic disease.

This was accepted and they said:

'System One' being installed into healthcare over the next 3 months. Once installed staff will use appropriate tools.' They also said this would be completed by 30 November, 2009.