PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the death of a man, in January 2010, at Axminster Hospital whilst in the custody of HMP & YOI Exeter

Report by the Prisons and Probation Ombudsman for England and Wales

October 2012

This is the report of an investigation into the death of a prisoner of HMP Exeter. He died in January 2010. He died of cancer of the throat.

One of my family liaison officers contacted the man's wife to explain the purpose of my investigation. I would like to repeat the family liaison officer's condolences to his family. I hope my report addresses the questions the family may have.

The investigation was undertaken by one of my senior investigators. I would like to thank the Governor of Exeter and his staff for their participation in the investigation.

A clinical reviewer was asked to undertake a review of the man's clinical care. I appreciate his assistance throughout the investigation process and his final report. He found that the man's care whilst in Exeter was good. He highlights some areas around healthcare procedures in HMP Erlestoke that might be improved.

The clinical reviewer also comments on the circumstances of the man's transfer between Erlestoke and Exeter. I agree that the transfer could have been better managed, although fortunately it does not seem to have had an impact on the man's ongoing treatment. I make three recommendations: two to Erlestoke about explaining the procedures for compassionate release and urgent hospital referrals, and one to Exeter ensuring that medical incidents during transfer are noted on the records.

Both prisons sought specialist advice about the man's care and made thoughtful arrangements for his treatment. Compassionate release was considered, but thought inappropriate, and I am pleased to see that minimal use was made of restraints.

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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **October 2012**

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SUMMARY

The man was serving a life sentence, and had been in prison for some 20 years. In June 2009, whilst in Erlestoke, he was diagnosed with cancer of the throat (oesophageal). He developed pain in his foot in August and was referred to hospital but, by the time he was admitted, his leg had to be amputated below the knee.

Staff at Erlestoke realised that the man and his family would require support, and made some changes to his care. They began the process for applying for compassionate release. It is not apparent, though, how clearly this was explained to the man.

By September, the man needed to be in a prison which provided 24 hour healthcare. Exeter was identified as being the most convenient for his partner (whom he went on to marry whilst a hospital patient in Exeter) to visit, and the governors of the two prisons spoke about the transfer and agreed it in principle. However, it seems that there was a misunderstanding over the timing of the transfer. The man arrived at Exeter on 17 September, only to find that the prison was not expecting him so quickly. After urgent discussion with his staff, the Governor agreed that the man could remain. No arrangements had been made for continuity of the man's cancer care with the local hospital, but fortunately they were able to continue with little disruption to his treatment.

The man was initially allocated to a normal prison wing. But by mid-November his health had deteriorated and he had to move to the healthcare centre. Staff worked closely with specialists to ensure that he received the treatment he required. Special arrangements were made for the man's family to visit him in the healthcare centre.

In December, the man developed fluid in his abdomen and was admitted to hospital. His condition deteriorated further and, by the end of December, he was extremely unwell. He moved to the hospice in the Axminster Hospital for end of life care. Arrangements were made so that the prison officers accompanying him did not wear prison uniform. Medical staff at the prison remained in ongoing contact with the hospital to monitor his condition until the man died.

I have found that the care the man received was equitable to what he would have received in the community and some excellent individualised arrangements were made at both prisons. I make two recommendations to Erlestoke, about explaining compassionate release procedures to terminally ill prisoners, and urgent hospital referrals. I also make one recommendation to Exeter about recording medical incidents during escorts. Although I do not make a recommendation, the Governors of both prisons will wish to ensure that any future transfers of prisoners with medical needs are clearly arranged.

THE INVESTIGATION PROCESS

1. My investigator was given full access to all the relevant records relating to the man, including his prison and medical files. During the investigation he visited Exeter and spoke to staff who had cared for the man. He interviewed four members of staff, and these interviews were recorded.

2. The investigator also spoke to the Governor of Exeter. A note of the conversation, which has been agreed by the Governor was also attached. The investigator made himself available to the Prison Officers Association, the Independent Monitoring Board and the chaplaincy had they wished to speak to him. The investigator also corresponded with the Governor of HMP Erlestoke concerning the circumstances of the man's transfer from Erlestoke to Exeter.

3. Notices were posted to staff and prisoners about my investigation, inviting contributions but none were received. The investigator had access to statements made by the staff after the man died.

4. The clinical reviewer was asked to carry out a review of the man's clinical care. I am grateful to him for undertaking this review. My investigator discussed aspects of the man's treatment both with healthcare staff at Exeter and with the reviewer.

5. My investigator contacted Her Majesty's Coroner to inform her of the nature and scope of my investigation and request a copy of the post mortem report. Upon completion, my report will be sent to the Coroner to assist her enquiries into the man's death.

6. One of my family liaison officers (FLOs) contacted the man's wife. She told her of my investigation and invited her and the man's family to ask any questions or raise any issues for consideration. The man's wife said that, in her opinion, her husband received excellent care at HMP Exeter. She asked if my investigation could consider the care that the man had received at HMP Erlestoke prior to his transfer to Exeter. She also asked if I would consider the preparations for her husband's transfer, and the application process for compassionate release. I hope my report addresses the matters which the man's wife is concerned about.

THE MAN

7. The first conviction recorded for the man was in 1973. He had a number of convictions, largely for stealing offences, although he had one conviction for assault in 1981. He was sentenced to life imprisonment in 1989 and was serving this sentence when he died.

8. The man formed several serious relationships with women who corresponded with him during his prison sentence. Following the breakdown of one relationship, his former partner complained that he had threatened her. Security reports suggested that he had arranged for her to be assaulted.

9. The man married towards the end of his life. Having been due to marry in prison, his admission to hospital caused a change of plan, and the wedding took place in the hospital chapel.

HMP & YOI EXETER

10. 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.

11. It has four residential wings, which are in a traditional Victorian layout, emanating from a centre area. A and C wings hold normal prisoners mainly in shared cells, while B wing is the first night accommodation and integrated drug treatment system facility. D wing is a brick built, three-storey building, physically separate from the main prison building, for vulnerable prisoners.

12. Facilities include an outdoor exercise yard, a gym and weights room, a chapel, a library and a large workshop that has recently been partitioned into smaller units for delivering training courses. The visitors' reception centre is just outside the prison walls.

13. The Devon Partnership Trust 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 working 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.

Compassionate release

14. When a prisoner is diagnosed with a terminal illness, an application can be made for release on compassionate grounds. Procedures for applying for compassionate release for prisoners serving indeterminate sentences are contained in Prison Service Order (PSO) 4700. The criteria are as follows:

- "the prisoner is suffering from a terminal illness and death is likely to occur very shortly (although there are no set time limits three months may be considered to be an appropriate period for an application to be made to Lifer Review & Recall Section), or the lifer is bedridden or similarly incapacitated, for example, those paralysed or suffering from a severe stoke; and

- the risk of re-offending (particularly of a sexual or violent nature) is minimal; and

- further imprisonment would reduce the prisoner's life expectancy; and

- there are adequate arrangements for the prisoner's care and treatment outside prison; and

- early release will bring some significant benefit to the prisoner or his/her family."

Previous deaths at Exeter

15. The man was the eleventh prisoner to die at Exeter since 2004, when my office became responsible for investigating deaths in custody. There has since been a further death. There is nothing in any of my previous investigations which is relevant to the circumstances of the man's death.

Her Majesty's Chief Inspector of Prisons

16. The latest report on Exeter by Her Majesty's then Chief Inspector of Prisons, was an announced inspection in October 2009. Although she made some comments about the policies for disabled prisoners, there are no issues in the report which are relevant to the care that the man received.

Independent Monitoring Board (IMB)

17. Each prison in England and Wales has an Independent Monitoring Board responsible for monitoring day-to-day life in the prison and to ensure that proper standards of care and decency are maintained. The report published for Exeter for the year 2008-09 does not raise any issues which are relevant to the man.

KEY FINDINGS

18. The man was sentenced to life imprisonment in 1989 for a domestic murder. He moved through the prison system, and in doing so completed a number of offender courses including anger management, victim awareness, coping skills and a relationship course.

19. Security reports were compiled at various times during the earlier part of the man's sentence that he had threatened staff and prisoners. He also threatened to damage prison property, go on hunger strike, and climb on the roof to make protests. The comment was made that he could "try to manipulate staff to his own advantage".

20. On four occasions, the man was placed on the prison's special measures to support prisoners thought to be at risk of harming themselves. The measures were still in place when he transferred to HMP Erlestoke in May 2008, but were removed the following day and not needed again. The man seemed to settle well at Erlestoke, working in a trusted position as head of quality control within the workshop.

21. After suffering pain in his abdomen, the man saw the prison doctor on 1 December. The doctor examined him and, unable to find any obvious cause, prescribed medication to counteract acid in the stomach. The man needed to see the doctor again on 9 January, and was additionally prescribed painkillers. The abdominal pains did not improve and, on 16 March, he underwent blood tests. The results were normal but by 23 March the man was prescribed a stronger painkiller to take at night, when the pain was worse. On 2 March, he was referred for an ultrasound scan (to provide an image of the internal organs), and prescribed further medication for the pain.

22. By 17 April, the man complained that the pain had become considerably worse. The prison doctor examined him and found a swelling on his right side. He referred him to the hospital, with a comment in the referral letter that the swelling was probably in the muscle. In the meantime, the doctor increased the dosage on the man's painkillers. The papers do not indicate when or if the hospital appointment took place.

23. The man saw a prison doctor on 23 April. More blood tests were carried out, all of which were normal. The out-of-hours doctor had to be called to see the man on 3 May. He was prescribed further pain medication.

24. The Parole Board considered the man's case on 12 May. They noted that, despite concerns from staff, he did not accept that he was at risk of harming his partner (who later became his wife), nor that he had a problem controlling his temper. The Board recommended that he should undertake further offence-related work, including the Controlling Anger and Learning to Manage it (CALM) course, and the Healthy Relationships Programme (HRP). The man's case was to be reviewed again in November 2010.

25. On 21 May, the man told the doctor that he was having difficulty digesting his food and had been losing weight. He was not suffering from any pain, so his medication was adjusted accordingly. The doctor made an urgent referral to Salisbury District Hospital for him to have an endoscopy (a procedure to examine the body internally). However, despite the doctor having adjusted his prescription, he seemed to continue to receive the old dosage.

26. The hospital appointment took place on 17 June. The endoscopy revealed a growth that was narrowing the man's stomach. He was told that the growth was cancerous.

27. The man had an appointment with a consultant orthopaedic surgeon at the hospital on 19 June. The doctor wanted to assess whether the man's back pain was due to the cancer spreading to his spine. He requested an urgent magnetic resource imaging scan (MRI – a scan using radio waves to give a detailed image of the inside of the body). An appointment was made, but subsequently cancelled by the hospital. The records do not show if the scan was rescheduled.

28. As part of the response to his cancer diagnosis, prison and hospital staff liaised over any amendments that ought to be made to the man's diet. A number of changes were made in view of his changing metabolism.

29. In view of the man's prognosis, staff at Erlestoke considered whether he should be given compassionate release. The process was set in motion, and reports from staff who knew and worked with the man were collated. A number of reports recommended against release. Agreeing with the recent Parole Board decision, some staff had concerns about the risk the man might present to his partner.

30. On 15 August, the man complained that his left foot was numb. The out-of-hours doctor attended, and noted that the foot was cold and pale. The doctor prescribed painkillers. The man saw the prison doctor on 17 August, who noted that he had a pulse in his ankle, but not in his foot. The doctor referred the man to the blood clinic, and an appointment was made for 27 August.

31. The man said that he was still in a lot of pain. He spoke to his partner, who contacted the hospital and spoke to the oncology (cancer) team. Notes on the man's prison medical file indicate that the medical team in Erlestoke also spoke to a nurse from the oncology team. According to the notes, the hospital nurse said that she had told the man's partner that the pain in his foot was not a symptom of his cancer treatment, and they were unable to help. She advised that he should contact the doctor where he was (either the prison doctor or the out-of-hours service). The man's partner, however, said that hospital staff advised her that if he was in such pain he should be in hospital. The man felt that this was the case.

32. The following morning the man's foot had gone darker in colour, and a request was put to the hospital for an urgent appointment. This was made for 9.00am the following morning, 19 August.

33. A case conference was held in Erlestoke on 18 August. Attendees included the Governor, healthcare practice manager, chaplain, the man's personal officer, the head of resettlement, the man's probation officer, and a representative from the security team. They agreed that the man and his partner would need a good deal of support in the coming months, and a number of measures were put in place. The man would only be escorted by a single officer when in hospital, and would not be subject to any physical restraints. While he was in hospital for chemotherapy sessions, arrangements were made for his partner and her children to have extended visits with him. The conference also held preliminary discussions as to where he could transfer when his illness progressed and he needed a higher level of care. HMP Winchester could provide continuity of medical treatment but Exeter gave greater proximity to his partner. The papers do not show whether any contact was made with either prison at this stage. A family liaison officer was appointed to provide support and a first point of contact for the man's partner.

34. The following morning, the man attended his hospital appointment. On seeing the man, the hospital admitted him as an in-patient. He had to go into surgery, which resulted in the amputation of his left leg below the knee.

35. On 20 August, the Governor of Erlestoke wrote to the man about the outcome of the case conference. Amongst other issues, he wrote that in view of the man's illness, he had submitted an application for compassionate release. He also wrote to staff in Erlestoke, outlining the man's health problems and explaining the special arrangements that he had put in place. He noted that the man had initially seemed to take the news of his cancer well, but struggled more recently. He did not always speak consistently about his treatment, sometimes seeming to be content, and other times not. He advised that staff needed to be aware of this.

36. Medical records show that, on 11 September, the man was discharged from the hospital back to prison. He was able to move around using a wheelchair, and was waiting for an appointment to have a prosthetic leg fitted. His chemotherapy was placed on hold. The disability officer in the prison considered any issues relating to the man being in a wheelchair, such as access to toilets and showers. The notes indicate that it was now considered to be an appropriate time for the man to move to a prison with 24 hour medical cover.

37. On 16 September, the Governor of Erlestoke telephoned the Governor at Exeter. The Governor of Erlestoke explained that the man had terminal cancer, and had reached the stage where he would need to be in a prison with 24 hour medical cover. Exeter has such cover, and was the most convenient available location for the man's partner, who did not drive, to visit. The Governor of Erlestoke asked whether the Governor of Exeter would be willing, in principle, to accept the man. The Governor of Exeter told the investigator that he replied that he would accept the man in principle, and would speak to the Governor of Erlestoke again about the arrangements.

Exeter had looked after prisoners with cancer in the past, and he was confident that they would be able to do the same for the man. The Governor of Exeter spoke to the Head of Healthcare and she contacted the healthcare centre at Erlestoke to gain an understanding of the level of the man's illness and the extent of the care he required. The Head of Healthcare wanted to ensure continuity of care for the man although, at this stage, she did not know when this might be.

38. However, there was some breakdown in communication between the two establishments about the timing of the transfer. The following day, Erlestoke put into place arrangements for the man to transfer to Exeter. He left Erlestoke at 9.30am in an escort vehicle. The escort papers show that 15 minutes later the car had to return to Erlestoke as the man had passed out. Back in the prison, he was seen by nurses and, having taken some painkillers and a drink, the vehicle left Erlestoke for a second time at 10.15am. The man's medical notes do not contain any reference to this incident. It might be that his papers were packed away to go with him to Exeter but, nevertheless, this should have been entered on the medical record.

39. The vehicle arrived at HMP Exeter at 12.25pm. This was during the lunch period, when staffing levels are reduced and the prison is in a state of lockdown. Staff on the gate and in the reception area were not expecting the man, and he remained in the car in the secure area between the gate and the building while staff tried to clarify what should happen. After some urgent discussion with his staff, the Governor of Exeter agreed that Exeter would accept the man.

40. Prisoners arriving in Exeter will, as routine, go through a reception health screening. As the man arrived in exceptional circumstances and with specific health needs, he did not go to the reception area in the normal way. Instead, he went to the healthcare centre, and one of the prison doctors, Dr A, conducted the reception screening and a medical assessment in a single consultation. The man said that he wanted to remain on a normal wing while he could, and he and the doctor agreed that he did not need to be in the healthcare centre at that stage.

41. In line with normal reception procedures, a cell sharing risk assessment was made (to decide whether there is any potential threat to a cellmate if the prisoner was allocated a double cell). As a lifer, the man had been allocated a single cell for a number of years. It was agreed that this was even more important because of his medical needs. As well, there was considered to be a high risk that he might assault a cellmate.

42. The man was allocated to B wing, which has an ordinary level exit to allow wheelchair users to leave the wing when required, or in an emergency. It is, however, a flight of stairs above the servery (from where meals are collected) and the medical hatch (where medication is given out). The Governor of Exeter explained to the man that he was not happy with a wheelchair user being separated from these facilities by a staircase. He intended to arrange for him to be relocated. However, the man said that he was satisfied where

he was. A "buddy" was collecting his meals and nursing staff brought his medication to him. He did not want to move because of his disability and was happy on B wing. Satisfied that his safety was not compromised, his care was not disadvantaged, and his quality of life was not reduced, the Governor of Exeter agreed that the man could remain on B wing.

43. Being a cancer patient, the man's ongoing medical care had to be transferred to the local hospital. This was the Royal Devon and Exeter Hospital (RD&E). An entry on the man's medical file on 17 September indicates that the RD&E had no details of the man's care. A nurse from the medical team at Erlestoke had contacted the oncology team to say that she would fax the relevant information but none were received.

44. It was during a stay in hospital in September that the man married his fiancée in the hospital chapel.

45. The medical team at Exeter liaised with the RD&E and arranged an appointment to plan the man's ongoing care. However, on the day, he felt too weak to attend and the appointment was rearranged for 5 October. The prison made arrangements to manage the man's security whilst he was attending hospital. He had previously been subject to the standard security procedures when outside the prison, consisting of two members of staff, plus handcuffs. But at this stage, the arrangements were changed, and the man was no longer subject to physical restraints whilst in hospital.

46. After a short period on B wing, the man transferred to A wing. His cell was on the ground floor, opposite the servery and near the staff office.

47. The man went to the outpatients department of the RD&E as planned on 5 October. His treatment was reviewed, and arrangements made to commence his fourth cycle of chemotherapy. On 10 October, he went into hospital to begin this treatment. Having had problems swallowing, a stent (an artificial tube) was inserted into his oesophagus to help him swallow. However, it was removed because of a problem. Further changes were made to his diet, and the man said that swallowing had become easier. He remained in hospital until 22 October. After he had left hospital, the staff contacted the prison to tell them that a scan had shown that the man had a blood clot on his lung. Healthcare staff in the prison provided the appropriate treatment.

48. The man's wife wrote to the Director General of the National Offender Management Service (NOMS) on 15 October about compassionate release for her husband. She said that they had been led to believe that the application had been approved at the first stage, and they were awaiting further news. The papers do not make clear when the Director General of NOMS replied, but the response set out the procedures for compassionate release and explained that his situation remained under review.

49. As the man's pain got worse, staff worked to keep it under control. He developed metastasis (secondary cancer deposits in the bone) and it was

judged necessary for him to move to the healthcare centre on 11 November. Staff in the prison kept in contact with the hospital's hospice care team, which looks after cancer patients. The team regularly visited the prison and provided support, both to staff in their duties of care, and to the man himself. Additionally, the community matron went to the healthcare centre to provide advice and assistance to obtain equipment for the man's care.

50. The man was allocated a double cell, which had been adapted to a single cell for use by disabled prisoners. A hospital bed was obtained. Healthcare staff arranged an open door policy so that they could go in freely at any time day or night, without needing permission to unlock the door. The man was unable to reach the emergency call bell from his bed and a monitor was provided to allow him to be heard in the office.

51. The application for compassionate release remained under consideration. The Public Protection Casework Section (PPCS) of NOMS was responsible for processing the application, and they consulted the Directorate of Health Care. They advised that the man did not yet meet the medical criteria for early release.

52. The regime for prisoners in healthcare differs slightly from that in the main prison. There is no evening association (free time out of their cells for the prisoners to mix and socialise), and smoking is not allowed. The staff did their best to allow the man to maintain some of the things he was missing by not being on normal location. They would escort him back to A wing for evening association, to allow him some social activity, and take him outside for a cigarette. With the agreement of the Governor, special arrangements were put in place to allow the man's wife to visit him in the healthcare centre, without the normal visiting procedures or the normal restrictions on visiting hours. Visits were arranged through the chaplaincy, and held in the interview room in healthcare.

53. Through November, the man suffered from increasing levels of pain, and his medication was adjusted accordingly. Medical records show that on 1 December, staff suspected that he might have fluid on his lung. An x-ray was arranged for the following day, when this was confirmed. The man was admitted to hospital to have the fluid drained and returned to prison on 9 December.

54. The PPCS continued to liaise with Exeter about whether the man met the criteria for compassionate release. There were concerns about releasing the man to any address other than a hospice. However, Axminster Hospital's end of life care section had indicated that they would not be willing to accept the man without support from the prison. The prison could only provide support if the man remained a prisoner, and so he was not released at this stage. This information was passed to the man's solicitors on 2 December.

55. By 19 December, the man was suffering from increased pain in his stomach. He saw Dr A who diagnosed that, as the cancer was spreading, it was causing a build up of fluid in the man's abdomen. He referred him to hospital

to have the fluid drained, and the man went that afternoon. The prison reviewed the security arrangements, and the man was not subject to any physical restraints, and was accompanied by only one prison officer.

56. Whilst the man was in hospital, healthcare staff remained in regular contact with hospital staff. This served to check on his wellbeing, and assess when he was likely to return to prison and whether additional equipment would be required. It became apparent that the man's cancer was spreading, and doctors concluded that surgery was no longer an option. The decision was taken that the only treatment was to alleviate his symptoms and make him as comfortable as possible.

57. A discussion was held on 22 December between prison staff, hospital staff, and the man and his wife about where he would be best placed as his illness progressed. It was agreed that Axminster Hospital was the preferred option because of it was more accessible for the man's wife.

58. The PPCS had continued to keep the man's application for compassionate release under review. On 24 December, the prison were told that approval had been given for him to be released on compassionate grounds when he was no longer considered to pose a risk to others. This information was passed to the prison.

59. The man was taken to Axminster Hospital on 30 December for end of life care. In his notes he was described as comfortable on arrival. A syringe driver (a portable battery-operated pump to administer medicines steadily) was introduced to help control his pain. The application for compassionate release remained under consideration because of the change in the man's circumstances, but approval was not given at this stage. The prison reviewed the security arrangements again, and agreed that the officer accompanying the man should wear civilian clothing. This would give greater privacy and dignity to the man and his family.

60. The duty Governor visited the man in hospital on 30 December, and again on 1 January. He spoke to hospital staff, who gave no indication that the man's condition had deteriorated significantly.

61. Officer A was escorting the man (known as bedwatch duty) on the night shift on 1 to 2 January 2010. He arrived at approximately 9.45pm on 1 January to take over from a colleague, and it was immediately apparent to him that the man was in a poor condition. He did not respond to attempts at conversation, had difficulty breathing, and was grey in colour. Through Officer A's shift, the man did not respond to anything, apart from appearing to find it painful when nurses moved him. At approximately 5.50am, the officer thought that the man had stopped breathing. He summoned nursing staff, and they confirmed that he had died. The officer contacted the prison, while nursing staff contacted the man's wife. She arrived shortly afterwards with her two children, and at 8.00am the officer left the hospital.

62. Notices were posted to staff and to prisoners informing them of the man's death, and reminding them where support was available if required.

63. The man's wife said that her husband's property was returned to her without delay. The prison offered financial assistance with the costs of the funeral, and were represented on the day.

ISSUES

HMP Erlestoke

64. The man was diagnosed with cancer whilst at Erlestoke. Staff held a case conference to discuss his ongoing care, recognising that there were issues that needed to be addressed. The Governor wrote to staff, and separately to the man, explaining the measures to be put into place. The man was subject to less intrusive security during hospital visits, special arrangements were made for extended family visits, and consideration was given to ensuring that he was best placed when his condition became such that he could no longer remain at Erlestoke. Such a sympathetic and proactive approach is to be commended. The clinical reviewer notes that when the man was recorded as losing weight, staff at the prison liaised well with the hospital to effect any necessary changes to the man's diet with his changing condition. I do note, however, that the man's partner mentioned problems with some dietary changes, specifically providing extra full fat milk.

65. More broadly, while the clinical reviewer commends the use of computerised medical notes by staff at Erlestoke, he comments on the general brevity of entries to the record. He recommends that medical notes at Erlestoke should be more clearly documented, using a "Subjective, Objective, Assessment, Plan" format. I draw this to the attention of the Head of Healthcare.

66. When the man was diagnosed with cancer, staff at Erlestoke compiled the papers required for an application for compassionate release. This included reports from the relevant departments with whom he had contact, and who could contribute to the consideration. Some of the report-writers expressed concern at the potential risk to the man's wife and her children. It was noted that the man had been convicted of a domestic murder, and that his current relationship had not been tested outside a prison setting. There was also concern at the man's failure to fully address his thinking and behaviours within relationships, and the triggers that led to his offence. This echoed concerns expressed by the Parole Board at their last consideration of his case, and the man had not undertaken any work on these areas since then. The man's declining health meant that he would be likely to be increasingly dependent on his wife, which would be likely to increase the pressures.

67. But the man and his wife were confused about the process for applying for compassionate release, and as a consequence were not clear how far the application had progressed. It is not clear from the files whether this was a misunderstanding or whether the process was not clearly explained to them. But the man's wife felt it necessary to write to the Director General of the NOMS for clarification. In order to ensure the same confusion does not happen in similar circumstances, I make the following recommendation.

The Governor at HMP Erlestoke should consider how compassionate release procedures can be explained to terminally ill prisoners and their families.

68. Whilst still a prisoner at Erlestoke, after his cancer diagnosis, the man developed problems with his left leg which resulted in a below-knee amputation. The clinical reviewer comments that, prior to the amputation, the man's medical notes do not contain an assessment of his pain. Nor was any working diagnosis recorded. The clinical reviewer observes that he would normally expect an urgent referral to hospital in such circumstances. I similarly would have expected more urgency in dealing with this condition. I note the clinical reviewer's opinion that there is nothing to suggest that the outcome would have been different had things been handled any differently. Nevertheless, I suggest that the Head of Healthcare at Erlestoke considers what happened in this case, to be satisfied that referrals for urgent hospital treatment are made promptly and there are no delays for prisoners requiring treatment.

The Head of Healthcare at HMP Erlestoke should ensure that there is an efficient process for making urgent hospital referrals.

Transfer from HMP Erlestoke to HMP Exeter

69. When the man left Erlestoke to transfer to Exeter, the escort vehicle had to return to Erlestoke when he became unwell. This is recorded on the escort records, but no note is in the medical record. All the records should be complete so that staff at the receiving prison are fully informed.

The Head of Healthcare at Exeter should ensure that any medical incidents during prisoners' transfers are subsequently recorded in the medical file.

70. Erlestoke and Exeter have different views about the circumstances of the man's transfer between the two prisons. Staff at Exeter say that they were taken by surprise at the speed of the man's arrival. My investigator wrote to the Governor at Erlestoke who replied that, from his point of view, there had been prior notice. He considered that the circumstances of the transfer were appropriate and were communicated, although he did not provide any supporting documentation.

71. Whatever the agreement between the Governors, it is clear that the man was not expected at Exeter on the day that he arrived. I am pleased that the Governor there acted swiftly and humanely to avoid unnecessary discomfort and distress for the man and his family. I hope that the confusion on this occasion was unusual and so do not make a recommendation. I am sure that, in future, both Governors will ensure that detailed transfer arrangements are in place before a prisoner is moved.

72. The man's serious condition meant that there should have been a plan to ensure continuity of his cancer care but unfortunately, this was not the case. A member of Erlestoke's healthcare team did contact the RD&E hospital and give advance notice that she would fax some information through. The communication, however, broke down after this. It is not clear where the fault lay, but I would have hoped that, realising the importance of the transaction,

each side would have ensured that the information was exchanged satisfactorily. One of the prison doctors at Exeter did comment in interview that the RD&E continued the man's treatment without any disadvantage.

73. This may well have been the case, and it is fortunate that they were able to do so. But the communications should have been better and the transfer of care should have relied less on good fortune and more on good planning. The clinical reviewer recommends that, bearing in mind the need for a comprehensive care plan, good communications should be maintained between prisons when transferring prisoners for healthcare reasons. I agree, and would hope that the confusion in this case is not repeated.

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74. One of the prison doctors described oesophageal cancer as an aggressive form of the illness. The man was diagnosed in June, transferred to Exeter in September, required full-time healthcare in November, was hospitalised in December, and died in January. This is within the boundaries of what could be expected for such an aggressive form of cancer.

75. The investigator asked whether the man's care followed an end-of-life pathway (a specific level of care devised for those who are terminally ill). The doctor said that the prison has an end of life policy, which follows recognised care pathways and they work closely with specialists in palliative care.

76. The clinical reviewer concludes that the standard of care the man received at Exeter was equivalent to that which he could have expected in the community. Good contact was maintained with specialist agencies, appropriate equipment was provided and records were well-kept .

77. I too believe that the care the man received at Exeter was good. There are many examples of thoughtful and imaginative arrangements which improved his comfort and treatment. When he was unable to reach the emergency call bell in his cell in the healthcare centre, staff provided a monitor which could be heard in the office. I applaud the way that the staff identified the problem and introduced a solution.

78. Staff were willing to engage with him to make him as comfortable as possible. Any expertise required was brought in via the nurses from the hospice care team (which I understand is equivalent to the Macmillan Nurses), and the community matron was engaged to assist in providing any equipment (and further advice) which was needed.

79. After the man transferred to the healthcare centre on 11 November, he was given a large room which could accommodate a hospital bed, which was brought in especially for him.

80. Another example of consideration to the man's wishes was when staff took him back to the wing at association time so that he could spend some "normal" time with other prisoners, and enjoy a cigarette.

81. An open-door policy was put in place so that the staff could go into the man's cell during the night (when under normal circumstances it would be locked), if he needed urgent attention. Family visits were arranged on the healthcare wing.

82. I am also pleased to see the sensitive use of physical restraints and escort officers whilst the man was in hospital. The safety of the public is paramount, and must be the primary consideration. But it seems to me that both prisons sensibly assessed the risk the man could pose and balanced that against his comfort and dignity.

83. I agree with the clinical reviewer that the man received care for his cancer in prison which was equivalent to what he would have received in the wider community.

CONCLUSION

84. The man had been in prison for a long time. During his sentence, he had formed a relationship with the woman who became his wife.

85. In the summer of 2009, whilst in Erlestoke, he was diagnosed as suffering from oesophageal cancer. Erlestoke recognised that the man and his family would need a higher level of support over the coming months, and put some changes into place. They also put into motion the process for applying for compassionate release. The man and his family, however, did not seem to be clear on how the process worked and this caused them a degree of confusion.

86. In August, the man developed problems with pain in his foot. He complained to medical staff in the prison, and was referred to hospital. It was four days before he was seen in the hospital, and ultimately he had to have his left leg amputated below the knee. However, the clinical reviewer judges that the delay is unlikely to have meant that the outcome would have been any different.

87. By September, the man needed to be in a prison which had 24 hour medical care, and Exeter was identified as the easiest place for his wife to visit. The Governor at Erlestoke spoke to the Governor at Exeter and they agreed the transfer in principle. However, there was a misunderstanding over the timing of the transfer, and the man arrived unexpectedly the next day. I am pleased that the Governor at Exeter acted swiftly and agreed to accept him. His medical care was transferred to the local hospital.

88. After initially being on a normal prison wing, the man had eventually to move to the healthcare centre. Staff brought in specialist expertise and equipment as required, and the man was in a specially adapted cell. Staff helped him to continue to live as normally as possible, and special arrangements were made for his wife to visit him.

89. In December, the man went to hospital for treatment but his condition did not improve and, by the end of the month, he was transferred to an end-of-life unit in Axminster Hospital. Compassionate release remained under consideration, but concerns about the risk the man could present to his family meant that it was not granted.

90. Whilst the man received good care at both prisons, I comment on the arrangements at HMP Erlestoke regarding information about compassionate release for prisoners and their families and swift referrals for hospital treatment, and recording events during prison transfers at Exeter.

RECOMMENDATIONS

1. The Governor at HMP Erlestoke should consider how compassionate release procedures can be explained to terminally ill prisoners and their families.

2. The Head of Healthcare at HMP Erlestoke should ensure that there is an efficient process for making urgent hospital referrals.

3. The Head of Healthcare at HMP Exeter should ensure that any medical incidents during prisoners' transfers are subsequently recorded in the medical file.