A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Exeter in July 2013

Our Vision

'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution
to safer, fairer custody and offender supervision'

This is the investigation report into the death of a man, who died in July at HMP Exeter. He was 44 years old. He died of T cell lymphoma (a form of leukaemia). I offer my condolences to his family and friends.

The man was remanded into custody at HMP Wormwood Scrubs in November 2012 and transferred to HMP The Verne on 15 February 2013, after he had been sentenced to three years four months imprisonment in January. When he arrived at The Verne, he told a nurse that he had a swollen cheek and blocked nose. He was treated for sinusitis but, when he still had the symptoms a week later, he was referred to a specialist. He was diagnosed with T cell lymphoma and began a course of chemotherapy. Sadly, the treatment did not work and, in June, he was told his illness was terminal. In July, it became clear that he was approaching the end of his life and he transferred to the palliative care unit at HMP Exeter for end of life care. He arrived at Exeter on 23 July and died just over a week later.

I agree with the clinical reviewer that the man received a very high standard of care at both The Verne and Exeter. The care planning at The Verne in particular was excellent. Staff contacted his family at an early stage and remained in frequent contact. While an application for compassionate release was not agreed, he was able to spend several days with his sister, who had travelled from the USA to see him, out of the prison on temporary licence. His level of escort and restraints during his admissions to hospital was appropriately reviewed and reduced as his health deteriorated. His end of life care was anticipated and well planned.

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 **January 2014**

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SUMMARY

1. The man was born and grew up in St Lucia. In November 2012, he was charged with importation of class A drugs and remanded into custody at HMP Wormwood Scrubs. He was convicted on 17 January 2013 and sentenced to three years four months imprisonment.

2. The man had dental treatment on several occasions at Wormwood Scrubs between November 2012 and February 2013 but otherwise appeared fit and well. On 11 February, he had a tooth taken out.

3. The man transferred to HMP The Verne in Dorset on 15 February 2013. During his first reception health screen he told the nurse that his left cheek was swollen and his nose was blocked. He was referred to the prison GP the same day, who diagnosed sinusitis and prescribed painkillers.

4. The man's symptoms persisted and he saw the doctor again on 27 February. The doctor thought the swelling in his sinus was unusual and referred him to an ear nose and throat specialist at hospital. He was admitted the same day and a scan revealed a large aggressive mass in his left sinus. The next day, a residential manager at The Verne telephoned the man's sister in New York to tell her he had been admitted to hospital for further tests.

5. The man was diagnosed with T cell lymphoma and returned to The Verne on 13 March. He began a course of chemotherapy and required several hospital admissions. He also developed several infections after chemotherapy as a result of an immune system disorder. The lymphoma did not respond to chemotherapy and curative treatment was stopped in June.

6. The man received palliative radiotherapy as an inpatient in hospital between 3 and 22 July. He transferred to the palliative care suite at HMP Exeter for end of life care on 23 July and died several days later.

7. Staff contacted the man's next of kin at an early stage of his illness. Although an application for compassionate release was rejected, he was able to spend several days with his sister out of the prison on temporary licence. His level of escort and restraints during his admissions to hospital were appropriately reviewed and reduced as his health deteriorated. His end of life care was anticipated and well planned.

8. Overall, we consider that the man received a very good standard of care at both The Verne and Exeter.

THE INVESTIGATION PROCESS

9. The investigator issued notices to staff and prisoners at HMP Exeter informing them of the investigation and inviting anyone who had relevant information to contact her. No one responded.

10. In line with our arrangements for investigating reasonably foreseeable deaths which ensure an appropriate degree of proportionality, the investigator obtained copies of the man's prison medical records and relevant aspects of his prison records. She spoke at length by telephone to an operational manager at HMP Exeter about the circumstances of the man's death.

11. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison. The investigator and clinical reviewer reviewed the records and after discussion decided that it was not necessary to interview staff. The investigator spoke by telephone to a doctor from a hospice to obtain further information.

12. HM Coroner for Exeter and Greater Devon was informed of the investigation. The Coroner has been sent this report.

13. One of the Ombudsman's family liaison officers contacted the man's sister, his nominated next of kin, on 10 September, to explain the investigation. She said she did not have any concerns about her brother's care for the investigator to consider. She confirmed that the prison had assisted her with funeral expenses and had returned all of her brother's personal possessions.

14. The investigation has assessed the main issues involved in the man's care, including his diagnosis and treatment, whether appropriate palliative care was provided, liaison with his family, his location and whether compassionate release was considered.

HMP EXETER

15. HMP Exeter is local prison holding about 500 remand and sentenced adult men. Since April 2013, health services at the prison have been provided by Dorset NHS University Foundation Trust. Primary healthcare services are located on B wing. Prisoners in need of social care are located in two cells on F wing. An end of life palliative care suite, also on F wing, opened in March 2013 with a suite for visiting relatives.

HM Inspectorate of Prisons

16. The man died during the first week of the most recent inspection of Exeter. At the time of writing, the full inspection report has not been published. However, inspectors have told us that the palliative care suite was a very good environment and that the staff and prisoners who were close to him were cared for appropriately after his death. Inspectors found that the healthcare department was well managed and provided a very good level of care for patients. The department had good working relations within the prison and with Dorset University Foundation Trust, which had recently been commissioned to provide the services. Healthcare services were well staffed with a good skill mix.

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. The latest published report from Exeter IMB pre-dates the opening of the palliative care suite but it welcomed the plans. The IMB commented that the healthcare unit had undergone significant change since 2010. The overall size of the department had been reduced but primary care facilities had been refurbished and facilities to care for two prisoners requiring social care had been added.

Previous deaths at HMP Exeter

18. There have been 15 deaths at Exeter since 2004, three of them, including the man's, since 2011. None of the circumstances were similar to his.

ISSUES

The diagnosis of the man's terminal illness and informing him of his condition

19. The man was remanded to prison on 12 November 2012 and taken to HMP Wormwood Scrubs. On 17 January 2013, he was convicted of importing class A drugs and sentenced to three years and four months imprisonment. His medical record shows that he was fit and well and had no concerns about his health. He was not taking any medication and gave no history of previous illness or chronic conditions. He saw the dentist five times between 27 November and 22 January. The nature of this treatment is not specified but he had a tooth removed on 11 February.

20. On 15 February, the man transferred to HMP The Verne in Dorset. A nurse completed a full health screen on 18 February. The nurse recorded that he appeared healthy and well but had told him that his left cheek was swollen and his nose was blocked. The nurse referred him to the prison GP. A doctor examined him the same day and noted his cheek was tender and that he had had a tooth removed on 11 February. He diagnosed sinusitis, prescribed pain killers and planned to review him if he was no better in a few days.

21. The doctor saw the man again on 27 February and recorded that he had a gross swelling of the left sinus and a nasal obstruction. He thought this was unusual and rang the maxillofacial surgery department at the hospital. They advised him to refer him to the ear, nose and throat department for a scan. He was taken to hospital the same day and admitted for tests.

22. The next day on 28 February, the man had a scan which showed that he had a large aggressive mass in his sinus which was described as extending into his eye. The healthcare manager telephoned the hospital to check his condition and was told that it was regarded as serious but not imminently life threatening.

23. Biopsies of the mass in the man's sinus were taken on 1 March. He had another scan on 6 March. The same day, he gave his consent for prison staff to be given all information about his health and for them to pass this on to his sister, his next of kin, who had been informed he was in hospital. On 7 March, he was diagnosed with T Cell lymphoma. There is no specific record in the notes but it is clear from entries on his medical record and prison record that he was informed of the diagnosis and planned treatment by the hospital consultant. A residential manager told his sister the news the same day. He returned to The Verne on 8 March.

24. The clinical reviewer concludes that diagnosing a nasopharyngeal cancer can be difficult because the condition is relatively rare in general practice. Given the man's history of dental treatment and his presentation, the clinical reviewer considers that the prison doctor's initial diagnosis of sinus infection was reasonable and the treatment given appropriate. When his symptoms persisted for a week, the doctor acted appropriately by seeking a specialist opinion. The clinical reviewer writes that many doctors would have completed

a “two week” referral, but in this case the doctor acted more quickly and arranged immediate specialist help.

The man’s medical treatment

25. The man received most of his medical care at hospital. A course of chemotherapy was planned for mid-April but this was brought forward to the end of March after his condition deteriorated. There is no evidence that any of his treatments were delayed for administrative reasons.

26. On 7 May, the man was readmitted to hospital for tests on a lump in his neck. This was found to be another tumour. On 10 May, the man’s named nurse at The Verne was told by the consultant haematologist at hospital that the man’s lymphoma had worsened despite chemotherapy and he had developed human T cell lymphotropic virus. He began a course of antiretroviral medication and remained in hospital until 16 May.

27. On 15 May, the nurse manager was told by the ward sister that they were considering transferring the man to another hospital for more intensive chemotherapy. She asked whether palliative care was now appropriate and the Sister told her that the hospital palliative care team were aware of him but he remained under the care of the haemotology department and had not yet been referred. She contacted a hospice in Dorchester that day to explore the possibility of him moving there if necessary.

28. The man returned to The Verne on 16 May. On 5 June, he was readmitted to hospital by emergency ambulance when he developed a high temperature and his condition deteriorated. On 11 June, a doctor told him that his condition was terminal. He began a cycle of palliative chemotherapy the same day. He returned to The Verne in between treatments. The chemotherapy finished on 22 June and he was then referred to a hospital for palliative radiotherapy.

29. On 1 July, the man signed A Do Not Attempt Resuscitation (DNAR) order, which meant that he did not want to be resuscitated in the event of cardiac or respiratory arrest. He was admitted to hospital on 3 July and remained there until his radiotherapy finished on 22 July. On 23 July, he moved to the palliative care suite at HMP Exeter.

30. By this time, the man was very weak and needed help getting in and out of bed. He had a catheter to drain his urine. He found it increasingly hard to take his medication and slept a lot. Staff from a local hospice visited him and advised healthcare staff on his care and pain relief medication. He died a few days later.

31. The records show that a member of the nursing team spoke to the man and his escorting officer each time he came back to The Verne from hospital. He was assessed and the record updated with new requirements such as extra food to help him with the side effects of the chemotherapy. The nurse manager, residential manager and others tried to maintain good

communication with the hospital, although they were not always able to contact the consultant directly. The nurse manager, the named nurse and residential manager visited him in hospital and kept in touch by telephone during each admission.

32. The clinical reviewer concludes there was detailed recording of good care planning before and after each hospital admission. He highlights the nurse manager and named nurse's very active involvement in the man's care planning and their obvious commitment to obtaining the best care for him.

33. An emotional and physical support care plan was written for the man after his diagnosis in March. The plan was reviewed regularly and the medical record shows that staff discussed welfare, special needs and treatment with him. He had daily one-to-one visits from nurses during healthcare hours and received support when he found his illness difficult to come to terms with. The clinical reviewer concludes that he was involved in his care planning and was appropriately supported.

34. The man needed significant pain relief at The Verne and Exeter. The clinical reviewer writes that he was largely managed with oral analgesics until July 2013. Initially he was given ibuprofen and paracetamol for his dental pain, but when the diagnosis became clear he was started on oral opiates (tramadol) at an appropriate dose. On 25 July, a syringe driver was considered when he was in some pain, but by the next day the pain had settled. His oral analgesics had been increased in strength to oral morphine. His pain levels were reviewed and recorded at least four times a day at Exeter. The clinical reviewer concludes that his pain relief was reviewed frequently and that the medication was adequate for his condition.

35. The clinical reviewer concludes that the level of care received by the man from his initial presentation to the time of his death was more than adequate and was at least as good if not better than he would have received had he not been in prison. Appropriate palliative care plans were agreed and followed. Decisions on resuscitation and escalation of his treatment were made appropriately and with his consent. At The Verne this information was made available to out of hours care and the Ambulance Service, to ensure compliance with his wishes.

The man's location

36. The Verne does not have 24 hour healthcare. Out of hours care is provided by an on-call service overnight and at weekends. From the time of his diagnosis the residential manager liaised closely with the healthcare manager to ensure that The Verne remained the best location for the man. He lived in a single cell on a standard wing. Wing staff were given fact sheets about his condition and were provided with the number of a 24 hour hospital based telephone service who would triage his condition and provide advice. On several occasions, night staff had to call the out of hours medical service or phone the helpline. A pack containing his medication and a summary of his condition was kept at the gate to be given to out of hours medical staff or

ambulance staff. Over the Easter weekend, he was moved to HMP Dorchester because they have 24 hour healthcare and staff at The Verne were concerned that it was a long time for him to be without access to a nurse. While he was at Dorchester, he asked several times to go back to The Verne.

37. Healthcare staff visited the man daily on the wing at The Verne. The records show that there was good communication between healthcare and wing staff. There are almost daily entries on his prison record from his personal officer and other wing staff recording how he was and updating colleagues on his needs. During his admissions to hospital, the healthcare manager and residential manager visited him and spoke to him by telephone. His cell was kept for him and checked by the residential manager to make sure it was ready for him each time he returned from treatment. On one occasion, when she found it to be in an unacceptable condition, permission was sought from him for it to be cleared and cleaned for his return.

38. The man was given a thermometer to help manage the fever resulting from chemotherapy. At each stage of his illness he was assessed by the disability liaison officer. He was provided with a special pillow and staff borrowed a back rest from hospital in May when he found it difficult to lie down. He was given a prison carer (another prisoner trained as a carer by St John's Ambulance Service) to help him collect meals, clean his cell and attend appointments. He was allowed frequent showers as the steam helped relieve the blockage in his nose and the pain in his face. He was reviewed every four hours and often every two hours after he moved to Exeter to ensure he was comfortable.

39. As the man's condition deteriorated in June, he was given a specially adapted cell with an en-suite bathroom on the ground floor at The Verne. His carer moved wings to be with him. When his needs increased, the number of carers was increased to three who worked on a rota basis. Special food and build-up drinks were provided as he found it increasingly difficult to eat. In late June, the healthcare manager and residential manager became concerned that he needed 24 hour health care. Exeter agreed in principle that he would transfer there pending the consultant's decision about further chemotherapy, as moving him from the catchment area of the hospital would have been detrimental to his treatment. He was told about his proposed move to Exeter before he moved to the hospital for radiotherapy in July. He was given the opportunity to go to the chapel and say goodbye to his friends on his last day in The Verne. As soon as his treatment in Poole finished, he was moved by ambulance to the palliative care suite at Exeter for end of life care.

40. The healthcare manager had originally contacted a hospice in Dorchester about the man on 15 May to see if it would be suitable in the event of him becoming terminally ill. The consultant from the hospice visited him in hospital and also spoke to his sister. The investigator spoke to the consultant, who confirmed that because he was either undergoing treatment or had a life expectancy of months, he was not eligible for admission to the hospice.

When he was discharged from hospital on 23 July, his life expectancy was six to fourteen weeks. The criteria for admission to the hospice is a life expectancy of less than two weeks, so he transferred to Exeter as had been arranged.

41. The clinical reviewer concludes that the care planning at The Verne and the thinking behind it was excellent. The man was appropriately transferred to Exeter when he needed a different level of care and we are satisfied that appropriate consideration was given to his best location throughout his illness.

Restraints, security and escorts

42. When prisoners travel outside prison to a hospital or hospice, a risk assessment is conducted to determine the nature and level of any security arrangements, including any restraints. NOMS has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity and maintain their dignity. The level of restraints used should be necessary in the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes account of factors such as the prisoner's health and mobility.

43. Between 27 February and 20 May the man was escorted to hospital appointments in handcuffs accompanied by two officers. The handcuffs were removed during consultations and for treatment including chemotherapy. The same level of escort and restraint applied for hospital stays. The risk assessments were brief and contained little explanation apart from "standard cat C risk to staff and public". No concerns about this level of restraint were raised by healthcare staff who also signed the risk assessment forms. From 20 May, the escort was dropped to one officer and no restraints were applied.

44. While we would have expected to see more detailed consideration in the earlier risk assessments, we are satisfied that the initial level of escort and restraint was appropriate taking into account the man's age and the fact that in the early stage of his illness he appeared relatively fit and well. By 20 May, his condition had worsened and he was suffering from the side effects of his treatment. The decision to reduce the escort and dispense with restraints was therefore appropriate at that stage.

Liaison with the man's family

45. The residential manager took responsibility for liaising with the man's family. She called his sister (his nominated next of kin) on 28 February when he was first admitted to hospital and remained in frequent telephone contact with her. She gave his sister the hospital contact numbers for both hospitals and his sister was able to telephone her brother and hospital staff during his admissions.

46. The man's only relative in the UK was his nephew. He was able to visit his uncle in his specially adapted cell on 16 June. His sister flew from New York for an extended visit between 17 and 23 June. She was allowed to see her

brother for long periods in his cell. On 19, 20 and 21 June, he was allowed daily temporary release from the prison so he could spend some days together with his sister outside the prison.

47. On 22 July, the residential manager visited the man in hospital. He became very distressed about his situation and asked to speak to his sister. She called her immediately and he was able to talk to her, his other sister and his father. A family liaison officer (FLO) was appointed at Exeter. She met him on his arrival there and also spoke to his sister and cousin by telephone.

48. The man's sister was flying from New York to visit him in Exeter when he died. The FLO met her at her hotel. She visited the palliative care suite to meet staff and prisoners who had spent time with her brother in his last week. The prison offered financial assistance with the funeral. We consider that liaison with his family was caring and compassionate.

Compassionate release

49. Prisoners can be considered for early release on compassionate grounds for medical reasons. In order to be released on these grounds, a prisoner must have been diagnosed with a terminal illness and there must be an indication that death is likely to occur soon (usually within three months).

50. On 3 July, an application for the man's release on compassionate grounds was submitted to the pre-release section of the Public Protection and Casework Section (PPCS) in the National Offender Management Service (NOMS). On 10 July, his application was turned down on the grounds that he did not fit the criteria because at that stage he was expected to live longer than three months and was still receiving treatment. The prison was advised to inform PPCS if his circumstances changed. When he was discharged from hospital on 23 July, the residential manager was told that his life expectancy was six to fourteen weeks. While it does not appear that a new application for release on compassionate grounds was made at Exeter, his condition deteriorated very rapidly and he died only a week later.