PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Exeter on 13 February 2014

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 of liver disease on 13 February 2014 at HMP Exeter. He was 88 years old. I offer my condolences to the man's family and friends.

A clinical review was commissioned to investigate the man's clinical care. HMP Bristol and HMP Exeter cooperated fully with the investigation.

The man was sentenced to nine years in prison in 2010 and went to HMP Bristol. He was very frail and experienced ill health throughout his time in prison. In July 2013, he was diagnosed with liver failure as a result of previously undiagnosed cirrhosis of the liver. His condition gradually deteriorated and he became confined to bed.

In January 2014, hospital staff said that further active intervention would be of no benefit and, on 7 February 2014, the man moved to the palliative care unit at HMP Exeter where he was given pain relief and supportive care until he died on 13 February.

I agree with the clinical reviewer that the standard of care the man received in prison was equivalent to that he could have expected in the community. However, some points of learning arise from the investigation. When the man arrived at Bristol the prison did not request his community medical records which might have helped healthcare staff identify some underlying problems earlier. I am also concerned to note that he missed a hospital appointment when he was at Bristol because prison officers refused to push his wheelchair. The Governor needs to ensure that this does not happen in future.

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 **August 2014**

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SUMMARY

1. On 15 April 2010, when he was 84, the man was sentenced to nine years in prison for sexual offences and went to HMP Bristol. He was partially sighted, hard of hearing, had restricted mobility and had diabetes. Despite his poor health, the prison did not request his community GP records. Initially he lived on a standard residential wing, but, as his health deteriorated, he moved to the prison's healthcare unit in August 2011.

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2. In January 2012, he was treated for a urine infection and was investigated for possible prostate cancer, which proved not to be the case. The man had an ultrasound scan which showed that he was retaining urine, possibly due to poor muscle function

3. On 10 May 2012, the man missed a hospital appointment because prison officers refused to push his wheelchair, which they considered was a job for healthcare staff.

4. The man continued to be cared for in the healthcare unit and his health steadily declined. In June 2013, a doctor noted the man was unwell and had a swollen abdomen, but he refused any treatment. His health became worse and he was taken to hospital on 6 July. The hospital diagnosed him with liver failure as a result of previously undiagnosed cirrhosis of the liver, ascites (a build up of fluid) and a blood disorder. They treated him and discharged him on 16 July. He returned to hospital in August and September to have fluid drained. In January 2014, hospital staff considered he was too weak for any future drainage of his ascites. .

5. The man's health continued to deteriorate. On 23 January 2014, he was taken to hospital for end of life care. As the hospital was not able to offer any treatment other than pain relief, he was discharged back to HMP Bristol on 27 January with a plan to move to the palliative care unit at HMP Exeter. He moved there on 7 February and was cared for at Exeter until he died on 13 February, 2014.

6. We agree with the clinical reviewer that the standard of clinical care the man received in prison was equivalent to that he could have expected in the community. However HMP Bristol should have requested his community medical records when he arrived to help continuity of care. We are concerned that he missed a hospital appointment because prison officers at Bristol refused to push his wheelchair. We have been unable to comment on security arrangements when the man went to hospital as the prison told us they were unable to find the records. Liaison with the man's family when he was discovered to be very seriously ill with liver failure could have been more effective. We make three recommendations to HMP Bristol.

THE INVESTIGATION PROCESS

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

8. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison record. She informed the Governor in writing of the preliminary findings of the investigation.

9. NHS England commissioned a doctor to review the man's clinical care at the prison.

10. We informed HM Coroner for Exeter and Greater Devon District of the investigation, who provided the post-mortem report. We have sent the Coroner a copy of this investigation report.

11. One of the Ombudsman's family liaison officers contacted the man's son, his nominated next of kin, to explain the investigation. The man's son did not have any specific issues or concerns for the investigation to consider.

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

13. The man's family received a copy of the draft report and indicated that they were satisfied with the findings.

HMP EXETER

14. HMP Exeter is a local prison holding about 500 men. Health services are provided by Dorset NHS University Foundation Trust. Primary healthcare services are delivered from B wing. There are ten cells on F wing for prisoners who need social care and one cell for end of life palliative care which opened in March 2013 with facilities for visiting relatives.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Exeter was in August 2013. The Inspectorate found that care for prisoners on F wing with complex needs and disabilities was impressive. Health services were available 24-hours a day with a wide range of clinics, including for chronic diseases. Two nurses led the care of older prisoners.

Independent Monitoring Board

16. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that prisoners are treated fairly and decently. In its most recently published report for the year to December 2012, the Exeter IMB noted that the increasing number of prisoners over the age of 55 was causing changes to the prison regime. A palliative care suite was still being completed at the time.

Previous deaths at HMP Exeter

17. The man is the second prisoner to die of natural causes at HMP Exeter since January 2012. The other prisoner also transferred to Exeter for end of life care.

HMP BRISTOL

18. HMP Bristol is a local prison holding more than 600 men. The prison no longer has a healthcare inpatient unit which became the Brunel Unit for prisoners with complex mental and physical needs in February 2012. Mental health nurses are on duty in the unit between 8.00am-8.00pm.

19. The man was cared for in the previous healthcare inpatient unit, and remained in the Brunel Unit once it opened.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Bristol was in May 2013. The Inspectorate found that the needs of older prisoners were generally well met. Chronic disease management was assessed as poor and care planning for prisoners with complex needs was weak with poor coordination between prison and health services. Medicines management was reasonable.

Independent Monitoring Board

21. In the most recent annual report for the year to July 2013 the Bristol Independent Monitoring Board (IMB) noted that more healthcare staff were employed flexibly and primary care resources on residential wings met the needs of prisoners. The IMB was satisfied with the standard of healthcare given to prisoners.

ISSUES

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

22. The man was sentenced to nine years in prison in April 2010 when he was 84 years old and had been at HMP Bristol since then. He was very frail, had difficulty hearing, was partially blind, had restricted mobility and type two diabetes. When he arrived at the prison, he declined the offer of hepatitis screening and a vaccination. During his reception health screen he said he did not have a problem with alcohol or drugs. Despite his extensive health problems, the prison did not request his community GP records.

23. In January 2012, the man was treated for a urine infection and was investigated for possible prostate cancer, which proved not to be the case. He had begun to have some urinary incontinence and had an ultrasound scan which showed that he was retaining urine, possibly due to poor muscle function.

24. For the next year, records show healthcare staff saw him frequently and he became generally more frail and poorly. On 25 June 2013, a prison GP noted he had a tight and swollen abdomen and difficulty going to the toilet. However, the man refused treatment and said there was nothing wrong. On 27 June, he was doubly incontinent but did not complain of any pain or sickness to staff.

25. Healthcare staff monitored the man and he became increasingly unwell. On 6 July, a locum doctor examined the man and noted his abdomen was distended and he was breathless. He arranged for him to be admitted to Bristol Hospital where he had a CT scan and ultrasound examination. He was diagnosed with liver failure as a result of cirrhosis of the liver (long term liver damage). The man also had ascites (a build up of fluid), hyponatraemia (a blood disorder) and urinary retention. He was treated and returned to the healthcare unit at Bristol on 16 July. Prison managers agreed an open door policy for the man, to make access and caring for him easier. Hospital staff informed him of his diagnosis and records indicate that when he returned to the prison he was well informed about his daily care and fully aware of his condition.

26. The clinical reviewer said that the diagnosis of liver failure was difficult to make, and was as a result of cirrhosis of the liver which had not been diagnosed earlier. He obtained the man's community medical record from before he was sent to prison. This showed that blood tests in 2009 indicated low sodium and raised liver enzymes. While the results were not necessarily a cause of concern in themselves, the clinical reviewer says that consideration of these could have prompted subsequent blood tests and any further abnormal results might have given a clue to poor liver function. As the prison had not requested the man's GP records, this was not considered. For continuity of care, Prison Service Order 3050 states that prisons should request information from GP or relevant services prisoners have recently

been in contact with when they arrive. We make the following recommendation:

The Head of Healthcare at HMP Bristol should ensure that staff routinely request community GP records and other relevant records for newly arrived prisoners.

The man's medical treatment

27. On 10 May 2012, the man was due to attend a hospital appointment. It is unclear from the records what this appointment was for. Prison officers refused to push his wheelchair and said they required a medical escort to do so. A member of healthcare staff was not available at short notice and so the appointment had to be cancelled and rebooked. The clinical services manager told us this is an ongoing issue at the prison. Officers say they are unable to push wheelchairs because they have not had training, although healthcare staff do not have specific training to push wheelchairs either. It is unacceptable that prisoners should miss hospital appointments for this reason and we make the following recommendation:

    The Governor of HMP Bristol should ensure that there are appropriate arrangements to take prisoners to hospital appointments and that appointments are not missed because of the actions of prison officers.

28. After his diagnosis of liver failure, the man was admitted to Bristol Hospital on 18 July 2014, because his abdomen needed draining of a build up of fluid. He was discharged back to the prison on 6 August, with medication to treat fluid retention.

29. A prison GP reviewed the man on 7 August. He noted his medications, that he had developed pressure sores and that he had a catheter. A care plan created on 9 August, required staff to take the man his meals, monitor his fluid and food intake, monitor his diabetes daily and turn him every two to four hours to prevent more pressure sores. He was unable to get out of bed by this time.

30. Healthcare staff monitored the man daily. On 18 August, a prison GP saw the man because he had low blood pressure (85/50). He appeared very sleepy and unresponsive and an ECG test showed an irregular heartbeat. The doctor sent him to hospital and hospital doctors drained excess fluid from his abdomen. He returned to the prison two days later. On 18 September, he went for a day clinic appointment to have fluid drained again.

31. On 9 October, a doctor discussed end of life care with the man and told him that resuscitation was unlikely to succeed because of his severe liver disease. The man signed a do not attempt cardiopulmonary resuscitation order which meant that in the event of cardiac or respiratory arrest no attempt at resuscitation would be made. This was reviewed with him each month.

32. On 7 January 2014, records show that a hospital heptology nurse (specialist in liver disease) was concerned that the man would be too weak for any future drainage of his ascites and might need palliative care instead. (Palliative care is longer term care that is not curative for people with life-threatening illnesses. It includes symptom control and pain relief.)

33. On 23 January, a prison GP examined the man. She considered that he was in the end stages of life and prescribed antibiotics for a chest infection. A nurse noted later in the day that the man's oxygen levels were very low at 35 percent. Two doctors agreed the man needed to be admitted to hospital for end of life care. He was admitted to Bristol hospital and diagnosed with pneumonia and complications secondary to ascites. As he was no longer receiving any active treatment, other than pain relief medication, the hospital staff wanted to discharge him to the prison for end of life care. The prison held a multidisciplinary team meeting to plan his care and agreed with HMP Exeter that he would move to their palliative care unit when he was fit to do so. On 27 January, the hospital discharged the man to Bristol and he moved to the palliative care suite at Exeter on 7 February.

34. Healthcare staff at Exeter cared for the man in the palliative care suite. He received regular pain relief and records show he was comfortable. The clinical reviewer found that the man did not suffer from unnecessary pain or distress. His condition continued to deteriorate and he died at 6.55pm on 13 February.

35. The post-mortem found that the man died of decompensated liver failure with ascites caused by cirrhosis. The report stated he had a large amount of ascites, as a result of complications from cirrhosis of the liver. There was also evidence of heart disease and old strokes, but no symptoms of this before he died.

36. Overall, the clinical reviewer found that the man received a good standard of clinical care, equivalent to that he could have expected to receive in the community and we are satisfied that this was the case. However, the clinical reviewer found room for improvement in some aspects of his care at Bristol, such as the management of his diabetes, and makes recommendations which the head of healthcare will need to address. They are not covered in this report as they are not directly related to the circumstances of his death.

The man's location

37. The man lived on a standard residential wing at Bristol until August 2011. After his health deteriorated, he moved to the inpatient unit at the prison in August 2011. The inpatient unit changed its function in February 2012, but he continued to live on the same unit with a healthcare assistant employed between 8.00am-8.00pm to look after him and other patients who needed social care. At night, the Brunel Unit, as the inpatient unit became, is staffed by prison officers. On 28 February 2012, extra support rails were fitted in his cell to assist him to move about safely.

38. When the man became more unwell he was appropriately admitted to hospital as necessary, and when it became clear that end of life care was needed, he moved to the palliative care suite at Exeter. The clinical reviewer considered that it might have been better to have moved the man to Exeter in January, rather than to hospital first, but overall we are satisfied that the man's care was provided in suitable locations.

Restraints, security and escorts

39. When prisoners have to travel outside prison such as to a hospital, a risk assessment is conducted to determine the nature and level of any security arrangements, including any restraints.

40. The National Offender Management Service (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.

41. Bristol was unable to find any of the escort risk assessments or escort logs for the man's hospital visits and stays except for his last hospital admission on 23 January when he was accompanied by one officer and not restrained. Nor was he restrained when he transferred to Exeter. Although it is unsatisfactory that the records for other hospital visits cannot be found, the prison has assured us that restraints were not used. It would be difficult to see how restraints could have been justified and we accept the prison's assurances.

Liaison with the man's family

42. It is not clear from the records whether the man's family was informed of his condition when he was first diagnosed with liver failure. On 23 January 2014, a nurse noted that a message had been left for the man's son when the man was taken to hospital. A prison manager contacted the man's son on 25 January, to inform him that the man's health had deteriorated and that he was not expected to live much longer. The prison manager explained how to organise a visit to the hospital and we understand that the man's family were able to visit him there.

43. The prison manager spoke to the man's son again on 6 February, to let him know that the man was moving to Exeter's palliative care unit the next day. The prison manager gave the man's son some information about the palliative care unit and visit arrangements and told him another officer would take over as family liaison officer at Exeter. The Exeter family liaison officer contacted the man's son on 7 February to confirm that the man had arrived there and was comfortable. He also introduced a deputy family liaison officer. The officers began a log of contact with the man's family and noted that his son planned to visit him the next week.

44. On 11 February, the deputy family liaison officer telephoned the man's son to give him an update on his father's condition. On 13 February, when the man's health deteriorated rapidly, an officer called the man's son at around 2.00pm. The man's son and granddaughter set off to see him but unfortunately arrived at 7.00pm, shortly after he died. They met officers and discussed the man's funeral arrangements. The prison offered funeral expenses in line with national guidance.

45. We are concerned that there was no recorded contact with the man's family during his illness, until 23 January. Prison Service Instruction (PSI) 64/2011 states that arrangements should be in place for an appropriate member of staff to engage with the next of kin of prisoners who are either terminally or seriously ill and that it is good practice for a log of contact with the family to be maintained. We make the following recommendations:

The Governor of HMP Bristol should ensure that when a prisoner is seriously ill, an appropriate member of staff is appointed at the earliest opportunity to support the prisoner and his family and keeps a log of such contact.

Compassionate release

46. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months.

47. An application for compassionate release was made on behalf of the man on 31 January. The Public Protection Casework Section (PPCS) of the National Offender Management Service (NOMS) requested further information from the Governor, who responded on 5 February. NOMS refused the application the same day because the man did not meet the criteria as there was no clear prognosis that he had three months or less left to live and he had no release address.

65. We are satisfied that the prison appropriately processed the man's application for compassionate release.

RECOMMENDATIONS

1. The Head of Healthcare at HMP Bristol should ensure that staff routinely request community GP records and other relevant records for newly arrived prisoners.

2. The Governor of HMP Bristol should ensure that there are appropriate arrangements to take prisoners to hospital appointments and that appointments are not missed because of the actions of prison officers.

3. The Governor of HMP Bristol should ensure that when a prisoner is seriously ill, an appropriate member of staff is appointed at the earliest opportunity to support the prisoner and his family and keeps a log of such contact.

ACTION PLAN: The man

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and Function Responsible
1	The Head of Healthcare at HMP Bristol should ensure that staff routinely request community GP records and other relevant records for newly arrived prisoners.	Accepted	A standard pro-forma is now used for all new reception health screens and healthcare staff can request a brief high level medical summary (known as a "front sheet") from the registered GP practice for each prisoner. Admin staff pass the received front sheets to the duty GP each day to make a summary of the key clinical information (including read codes) in the SystmOne clinical notes. More detailed information will be requested when the complexity of the patient's condition requires it, and each step of the information gathering process is entered onto the patient's electronic record.	Completed Head of Healthcare
2	The Governor of HMP Bristol should ensure that there are appropriate arrangements to take prisoners to hospital appointments and that appointments are not missed because of the actions of prison officers.	Accepted	The Orderly Officer or Duty Governor will be informed if there is a shortfall of staff, to ensure that cover is provided and appropriate arrangements are in place so that appointments are not missed.	Completed Governor
3	The Governor of HMP Bristol should ensure that when a prisoner is seriously ill, an appropriate member of staff is appointed at the earliest	Accepted	A family liaison officer will now be appointed when a prisoner is diagnosed with a serious or terminal illness.	Completed Governor

	opportunity to support the prisoner and his family and keeps a log of such contact.			