Prisons & Probation Ombudsman
Independent Investigations

Investigation into the death of a man, a prisoner at HMP Exeter, in February 2015

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future

This is the investigation report into the death of a man from kidney cancer in February 2015, at HMP Exeter. He was 50 years old. I offer my condolences to his family and friends.

The clinical reviewer concluded that the overall level of care the man received in prison was equivalent to that he could have expected to receive in the community. During the terminal stages of his disease, he had excellent end of life care at Exeter. However, before he transferred to Exeter in November 2014, his care at HMP Portland was not as good. I commend the high standard of palliative care that he received at Exeter, but it is apparent that Portland needs to develop services for terminally ill prisoners.

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 2015

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Summary

Events

1. The man was remanded to HMP Dorchester in February 2013, and sentenced to six years in prison in July. He had a history of kidney stones, high blood pressure and depression for which doctors prescribed medication.

2. On 12 September, while at Dorchester, a prison doctor referred the man for test, which identified he had kidney cancer. In October, he had one of his kidneys removed. The cancer subsequently spread to his bones and lungs. On 26 November 2013, he moved to HMP Portland and his condition gradually deteriorated. On 22 July 2014, doctors confirmed the cancer had progressed to his brain.

3. On 25 November 2014, the man transferred to Exeter for end of life care in the prison's palliative care suite. He died at Exeter in February 2015.

Findings

4. The clinical reviewer concluded that, overall, the man's care was equivalent to that he could have expected to receive in the community. The kidney cancer was promptly diagnosed and treated. During the final stage of his illness, he was cared for in a specialist palliative care unit at Exeter, where healthcare and prison staff addressed his needs to a high standard. However, at Portland some aspects of the man's end of life

Recommendations

- The Governor and Head of Healthcare at Portland should develop a multidisciplinary end of life care pathway and ensure that relevant staff are trained to provide appropriate care in line with national guidelines.

The Investigation Process

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

6. The investigator obtained copies of relevant extracts from the man's prison and medical records. He interviewed seven members of staff at HMP Exeter and Portland on 23 and 24 March 2015.

7. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison. The clinical reviewer took into consideration the investigator's interviews.

8. We informed HM Coroner for Exeter and Greater Devon of the investigation who sent the results of the post-mortem examination. We have sent the coroner a copy of this report.

9. One of the Ombudsman's family liaison officers contacted the man's partner to explain the investigation. She did not have any specific issues for the investigation to consider.

10. The man's family received a copy of the draft report. His father raised a number of issues that do not impact on the factual accuracy of this report and have been addressed in separate correspondence. The prison also received a copy of the draft report.

11. 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 escorts, liaison with his family, and whether compassionate release was considered.

Background Information

HMP Exeter

12. HMP Exeter is a local prison holding about 500 men. Dorset NHS University Foundation Trust provides health services. There are 12 cells on F Wing for prisoners who need social care and one cell for end of life palliative care. The wing has facilities for visiting relatives.

HM Inspectorate of Prisons

13. The most recent inspection of Exeter was in August 2013. The Inspectorate found that care for prisoners on F Wing with complex needs and disabilities was impressive. There were 24-hour health services and a wide range of clinics, including for chronic diseases. Two nurses led the care of older prisoners. Palliative care was supported through an excellent new suite which had been created for the care of terminally ill prisoners

Independent Monitoring Board

14. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its most recently published annual report for 2013, the IMB said GP cover had been problematic with little continuity. However, health services were generally good. The IMB noted that F Wing provided good care for terminally ill prisoners.

Previous deaths at HMP Exeter

15. The man was the sixth prisoner to die of natural causes at Exeter since 2012. In other end of life cases we found that Exeter provided good care.

HMP Portland

16. HMP & YOI Portland holds up to 580 men, including young adults between 18 and 21. NHS Dorset Community Healthcare Services are the healthcare providers. There are no nurses on duty at the prison overnight.

HM Inspectorate of Prisons

17. HM Inspectorate of Prisons most recently inspected Portland in July 2014. Inspectors were not assured that recommendations from previous Prisons and Probation Ombudsman's investigations into deaths at Portland had been properly implemented. Primary mental health services were affected by staff shortages at the time, but inspectors noted that secondary mental health services were very good.

Independent Monitoring Board

18. In its annual report for the year to 31 March 2014, the IMB at Portland was concerned about the impact of the change of categorisation at Portland, which meant that more than half the population were now adults.

Findings

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

19. The man was remanded to HMP Dorchester in February 2013 (and was sentenced to six years in prison in July 2013). He had a medical history of kidney stones, high blood pressure and depression, for which he was prescribed medication.

20. In July 2013, a prison doctor noted the man had mild anaemia and had reported having pain in his abdomen. The doctor arranged an ultrasound scan. The scan, in August, showed a mass in his left kidney. On 12 September, a consultant urologist at the hospital told him he had a very large tumour in his left kidney, which appeared cancerous, and the kidney needed to be removed. It appeared that the cancer had spread to his lungs. When he got back to the prison, a nurse talked to him about the urologist's findings. The nurse noted that he spoke to his family and was in a positive mood.

21. On 1 October, surgeons removed the man's left kidney. He was discharged back to the prison on 8 October. The next day, a prison GP reviewed him and noted that he wanted to get back to his job in the prison kitchen.

22. The clinical reviewer concluded that the initial diagnosis of the man's cancer was prompt and in line with practice in the wider community. We are satisfied that the prison doctor acted quickly in referring him to a specialist. He was appropriately informed of his diagnosis and healthcare staff at the prison supported him.

The man's clinical care

23. On 9 October, immediately after the man was discharged from hospital, a prison GP noted had had recovered very well from the operation and arranged an appointment with the urologist for November. She implemented a care plan and continued a prescription for an iron supplement and paracetamol. Healthcare staff saw him almost every day.

24. On 25 November, a nurse reviewed the man and noted he remained well and was working in the prison kitchen. He said his medication was helping and he was sleeping well.

HMP Portland

25. On 26 November 2013, the man transferred to Portland. At an initial health screen, a nurse noted he had a history of high blood pressure and recorded he had kidney cancer, for which he had undergone recent surgery. A prison GP reviewed him the next day and noted that he had an advanced cancer, which had spread to his lungs. He re-prescribed his medications.

26. In May 2014, a consultant urologist examined the man and found his condition had deteriorated. A CT scan confirmed the cancer had spread to his bone and lungs and identified a lesion in his remaining kidney. He was now regarded as terminally ill. The urologist recommended that he should begin palliative treatment (which relieves symptoms but is not curative). He did not give a clear

prognosis. He had four cycles of chemotherapy but this did not stop progress of his illness. In July 2014, doctors found that his cancer had spread to his brain.

27. A prison GP said that from this period, the man suffered more pain and became less mobile. Doctors prescribed oramorph (liquid morphine) and fentanyl patches (another opiod pain relief) for his pain, but he continued to complain of pain. In November 2014, the GP discussed his condition and a possible move to Exeter with him. The GP was concerned that his care was not optimal at Portland and he needed 24-hour healthcare, which the prison was unable to provide. He and a nurse discussed his wishes about resuscitation if his breathing or heart stopped. He did not want to be resuscitated and signed an order to that effect.

28. The clinical reviewer found that nurses at Portland had a high level of empathy and care for the man, but they had concerns about their ability to manage his condition well. The clinical reviewer found that some aspects of his care at Portland fell below standard. There was insufficient GP contact and follow up and no proactive approach to managing his condition. Some GP consultations appeared rushed. His pain was not well managed and information about his ongoing care was not clearly recorded to inform the clinical team. There was little in his clinical record to indicate that he was fully consulted and involved with decisions about his ongoing care.

29. A prison GP accepted that they had not managed the man's pain well at Portland. He told us that the man was the first terminally ill patient he had treated at Portland. Nurses at the prison did not have any specialist palliative care experience and officers had not managed end of life care before. Staff explained that this was because Portland had previously been solely a young offender institution and had only begun to take adults gradually over the previous four years.

30. The NHS document 'The route to success in end of life care – achieving quality in prisons and for prisoners' sets out how an end of life care pathway might be implemented in prisons. Among the benefits of an end of life pathway are that it helps carers plan when and how care will be delivered and helps patients make choices about how they are cared for towards the end of their lives. Although we recognise that healthcare and prison staff at Portland tried to respond as best as they could, the prison did not have a holistic approach to end of life care, which is now necessary to reflect its changed population. We make the following recommendation:

    The Governor and Head of Healthcare at Portland should develop a multidisciplinary end of life care pathway and ensure that relevant staff are trained to provide appropriate care in line with national guidelines.

HMP Exeter

31. On 25 November 2014, the man moved to HMP Exeter for palliative care. He was cared for in a specialist palliative care room where healthcare staff addressed his needs to a high standard. A prison GP examined him as soon as he arrived and referred him to the local palliative care team. The GP created a care plan for him, which included a review of his dietary needs, family visits and

contact with a local hospice. Healthcare staff updated the care plan regularly, and reviewed and adjusted his pain relief medication. On 12 January, he discussed his care plan with two GPs at the prison, and said his pain relief was good.

32. On 16 January, at a multidisciplinary meeting, which the man and his ex- partner attended, he said he now wanted resuscitation to be attempted if his heart or breathing stopped. On 21 January, doctors told him his life expectancy was between three and six months.

33. On 28 January, a prison GP spoke to a palliative care consultant about resuscitation when the chances of success are very low. The next day she met the man, his ex-partner and daughter, and discussed his terminal condition with them. She explained that in view of the deterioration in his condition, resuscitation would not be successful and would not be in his best interest. They agreed that resuscitation would not be attempted.

34. Records show the prison GP was actively involved in the man's end of life care. When he arrived at Exeter he was under the care of a consultant oncologist, who continued to see him while he was at the prison. He attended outpatient appointments and had radiotherapy. Healthcare staff liaised with the local palliative care team who visited him. In February 2015, he died peacefully in his cell.

35. The clinical reviewer concluded that the man received good care at Exeter. There were well-documented care plans, which GPs and nurses actively followed up and reviewed. We agree with the clinical reviewer that he had a good standard of care at Exeter and commend the prison's approach to end of life care.

The man's location

36. The man moved to Portland from Dorchester because Dorchester was closing. As soon as he arrived at Portland, healthcare staff arranged for him to be allocated to the Beaufort Wing, which accommodates older prisoners. He had a single ground floor cell with a small bathroom and a toilet. We are satisfied that staff at Portland specifically considered his comfort and ensured he had an appropriate cell with adequate facilities. However, as his condition deteriorated it was apparent that the healthcare provision at the prison was inadequate for his needs and he transferred to Exeter for end of life care. We consider that a holistic end of life care plan might have resulted in an earlier transfer.

37. The man was accommodated in the palliative suite at Exeter, which has suitable facilities, including an en-suite shower and toilet. The room has enough space for a wheelchair and for easy access and nursing. We are satisfied that this was an appropriate location for his end of life care.

Restraints, security and escorts

38. When prisoners have to travel outside prison, such as to hospital, a risk assessment is conducted to determine the nature and level of any security arrangements, including the use of restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. 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.

39. The man had a number of hospital appointments when at Portland. For his earlier appointments, he was handcuffed to an officer. A prison GP told us that the man was mobile at the time and presented fairly well. We are satisfied that the use of restraints was appropriate at the time, as his condition did not affect his risk of escape. From October, the risk assessments clearly show that when his condition deteriorated, he was not restrained.

40. The man attended hospital for radiotherapy a number of times, while at Exeter. The risk assessments were clear and show that staff took into consideration his condition and its impact on his risk of escape. Managers appropriately assessed him in line with Prison Service and legal guidance and did not restrain him for any of these appointments.

41. We are satisfied that prison staff carrying out risk assessments for hospital visits appropriately considered the man's medical condition and how it affected his risk of escape.

Liaison with the man's family

42. On 13 September 2014, at Portland, a Supervising Officer (SO) took on the role of the man's family liaison officer as she recognised the importance of facilitating family contact as he was terminally ill. She said that other managers and staff acknowledged her role and the prison supported her, but this was not part of a formal end of life plan, which they did not have at Portland.

43. The SO attended two hospital appointments with the man, and arranged visits for his ex-partner and father. The prison allowed his ex-partner to visit him at any time.

44. An officer was appointed the man's family liaison officer as soon as he arrived at Exeter. He had named his ex-partner as his next of kin and the officer telephoned her on 27 November, to introduce herself and to help arrange visits.

45. The officer kept in regular contact with the man's ex-partner, his father, sister and daughters. She helped arrange visits and kept a comprehensive log of family contact. She told us she built up a good rapport with his family. When he died in February, his ex-partner was with him at the time. She offered support and agreed to phone his sister to inform her. She drove his ex-partner home and helped her organise the funeral.

46. The funeral was on 25 February and the prison contributed towards the cost, in line with national guidelines. We are satisfied there was very good family liaison at both prisons.

Compassionate release

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

48. The man's offender supervisor at Portland, told us an application for compassionate release was not considered before June 2014 because he did not have a clear prognosis and was still considered a high risk to the public at the time, the application was not progressed. An application for compassionate release however was made to the Public Protection Casework Section (PPCS) of the National Offender Management Service (NOMS) in October 2014; however this could not progress because no resettlement options had been identified.

49. As soon as the man transferred to Exeter in November 2014, the Head of Residence and Safer Custody at the prison enquired about the possibility of compassionate release for him. Initially, there was no suitable release address or clear prognosis. On 21 January 2015, doctors said his life expectancy was now three to six months and the prison submitted an application for compassionate release, which PPCS recorded as receiving on 30 January. A decision was not reached before he died.

50. We are satisfied that both prisons appropriately considered compassionate release.

Action plan

Action Plan: Ian Paul Emsley at HMP Exeter on 1/2/15					
No	**Recommendation**	**Accepted/Not Accepted**	**Response**	**Target date for completion and function responsible**	**Progress (to be updated after 6 months)**
1	The Governor and Head of Healthcare at Portland should develop a multidisciplinary end of life care pathway and ensure that relevant staff are trained to provide appropriate care in line with national guidelines	Accepted	A formal plan for an end of life pathway between Portland Prison and the Dorset Health University Foundation Trust (DHUFT) will be produced in September 2015 and implemented to reflect the change in the prison population. This will take a holistic and multi-disciplinary approach to end of life care as recommended.	Target date for completion: 30th September 2015. Head of Safer Prisons and Equality. Health Care Manager Completed.	
			Specialist equipment and domiciliary care will be provided to HMP Portland through Dorset County Council under arrangements that came into effect following the change in the Care Act in April 2015.	Head of Safer Prisons & Equality. Head of Adult Social Services.	
			Training for prison staff at HMP Portland on end of life care in line with national guidelines will be provided by 30 September 2015 through the Dorset Health University Trust (DHUFT)	Target date for completion: 30th September 2015. Head of Safer Prisons and Equality. Health Care Manager.	