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 July 2014 at HMP Exeter

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 pneumonia as a result of cancer of the gullet in July 2014, at HMP Exeter. He was 72 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received at Exeter was undertaken. The prison cooperated fully with the investigation.

The man was sentenced to 10 years in prison in January 2014 and sent to HMP Exeter. He was still recovering from kidney cancer and the removal of one kidney when he arrived at Exeter. Prison healthcare staff were concerned about him and arranged blood tests to check for cancer markers. A few days later, before the blood tests had taken place, he stumbled in his cell and grazed his head. A nurse noted he had a rapid pulse and low blood pressure and called an ambulance.

At hospital, doctors diagnosed the man with cancer of the gullet which had spread to his lungs. The cancer was not treatable and the hospital discharged him to the prison in February 2014 for palliative care.

The clinical review identified some areas for improvement in medication management and in dietary provision, but overall I agree with the clinical reviewer that the man's care at Exeter was good and equivalent to that he could have expected to receive in the community. However, I am concerned that staff restrained him when he went to hospital without healthcare input into the risk assessment.

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 **February 2015**

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SUMMARY

1. In January 2014, the man was sentenced to 10 years in prison for sexual offences and sent to HMP Exeter.

2. Three months before, surgeons had removed one of the man's kidneys after he had been diagnosed with renal cell carcinoma (a type of kidney cancer).

3. Healthcare staff at the prison were aware of the man's recent health problems but noted he seemed less well than expected. A nurse arranged blood tests to check for cancer markers. On 24 January, before he had the blood tests, he stumbled in his cell and grazed his head. A nurse attended and noted he had a rapid pulse and low blood pressure. The nurse was concerned about him and arranged for him to go to hospital as an emergency.

4. The man stayed in hospital for tests and, on 31 January, hospital doctors diagnosed primary cancer of the gullet and secondary cancer in his lungs. Doctors considered they could not actively treat the cancer. On 17 February, he returned to prison for palliative care. His prognosis was under one year.

5. The man lived in a special unit at Exeter for prisoners with complex needs and disabilities. He did not want to move to the prison's palliative care suite, but staff developed appropriate care plans and a hospice nurse became involved in his care. His family were able to use a family room on the unit when they visited him. The clinical reviewer considered his end of life care was good.

6. The man received good care in prison. Staff quickly realised that he was ill and sent him to hospital, where his diagnosis was timely. We agree with the clinical reviewer that his care was equivalent to that he could have expected to receive in the community. However, there was some delay in him receiving special dietary supplements and some errors in medication which should have been investigated. We are also concerned that there was no healthcare input into the risk assessment when he was restrained when taken to hospital. We make three recommendations.

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 records. She informed the Governor of the preliminary findings of the investigation.

9. NHS England commissioned a clinical reviewer 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 gave the cause of death. We have sent the Coroner a copy of this investigation report.

11. One of the Ombudsman's family liaison officers contacted the man's family to explain the investigation process. They did not have any specific concerns for the investigation to take into account. His family received a copy of the draft report and indicated that they were satisfied with the findings.

12. The prison also saw our draft report and raised one factual inaccuracy which we have amended.

13. 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.

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 10 cells on F wing for prisoners who need social care and one cell for end of life palliative care. This opened in March 2013 and has facilities for visiting relatives.

HM Inspectorate of Prisons

15. 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. 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 2013, the IMB said GP cover had been problematic with insufficient numbers and little continuity. However, healthcare generally continued to provide a good service. The IMB noted that F wing had been refurbished and provided good care for terminally ill prisoners and others needing extra support.

Previous deaths at HMP Exeter

17. The man was the third prisoner to die of natural causes at HMP Exeter since January 2012. There were no significant similarities with the circumstances of the previous cases.

ISSUES

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

18. When the man arrived at HMP Exeter on 16 January 2014, a nurse completed a reception health screen. She noted that he was frail, a cigarette smoker and had tightness in his chest from COPD (chronic obstructive pulmonary disorder – lung disease). He had had a diagnosis of kidney cancer and a kidney removed three months before. The remaining kidney was not fully functioning. He was very anxious and upset. He was sentenced to 10 years in prison the next day and given appropriate support.

19. On 18 January, a nurse saw the man at a clinic for prisoners over 70. He said that he had trouble swallowing bulky foods and often vomited after meals. She arranged for staff to monitor his weight weekly and for the elder care clinic to continue to monitor him.

20. On 19 January, a nurse assessed the man, who said he had problems with his memory and with swallowing. She requested full blood tests to check for cancer markers and made an appointment with a doctor for 28 January.

21. On 24 January, wing staff called the healthcare unit's designated emergency responder to see the man. He said that he had kidney pain and felt dizzy and he had stumbled and grazed his head against a wall. The nurse noted he had a rapid pulse but low blood pressure. He considered his medical history and asked for an emergency ambulance to take him to the hospital.

22. Hospital doctors admitted the man and initially suspected he had renal failure. Scans showed this was not the case. On 31 January, doctors diagnosed primary cancer of the gullet which had spread to the lungs. Doctors considered his condition was not treatable and discharged him back to HMP Exeter on 17 February for palliative care. The hospital dietician recommended high calorie drinks to help him retain weight. Hospital doctors informed him of his diagnosis and that his prognosis was under one year.

23. We agree with the clinical reviewer that healthcare staff at the prison referred the man to hospital appropriately and his diagnosis was made in a timely way.

The man's clinical care

24. On 17 February, healthcare staff carried out a full care needs assessment, including an environmental risk assessment, and implemented a support plan for the man. The assessments identified problems with his mobility and his ability to prepare meals and drinks. The support plan noted that input from a palliative care nurse would be helpful and that he needed a soft diet and build-up drinks.

25. On 18 February, a primary care nurse from a hospice and a palliative care nurse met the man. The primary care nurse explained her role and told him he needed to keep staff informed about his pain levels. She noted that the

kitchen needed a form from the doctor to give him build-up drinks and asked staff to arrange this. She arranged to see him again in two weeks and contacted his wife to talk to her about community hospices.

26. On 24 February, a prison GP chaired a care plan meeting. There were no pressing concerns. She wrote to the catering manager about the man's dietary needs and requested an extra pint of full fat milk each day to make up his build-up drinks.

27. Throughout March, records show that nurses saw the man frequently and his palliative care needs were met. On 4 April, the prison GP noted that nothing had been done about her request for additional milk for the man. She wrote to the Governor and the milk was supplied from 10 April.

28. On 8 April, the prison GP held a meeting with the man and his family, the prison family liaison officer and nursing and prison staff. She summarised his illness, symptoms that might occur (including pain and difficulty eating) and how they could help to reduce this. After discussion with his family and the team, he said that he did not want to be resuscitated if he had a cardiac or respiratory arrest and signed an order to confirm this.

29. On 9 April, a pharmacist noticed that staff had given the man amiodarone (a medication to stabilise irregular pulse) at a high dose for longer than was requested on his hospital discharge summary. This was rectified but it is not clear if anyone discussed this with him. The clinical reviewer noted that the side effects of excess amiodarone can be tiredness, nausea and shaking which can also be symptoms of cancer.

30. The team continued to monitor the man closely and to discuss his progress with him and his family. He did not always want the palliative care team to review him and staff respected his wishes.

31. From the end of May, the man began to experience more pain. Clinicians reviewed this regularly and prescribed oromorph (liquid morphine) as well as tramadol (strong pain relief). He was still able to work in the prison workshops at this point, although his condition was deteriorating.

32. On 4 June, the hospital admitted the man for a blood transfusion as his blood count had dropped, but there was no significant impact as a result.

33. On 10 June, the man's drug chart was mislaid and staff wrote a new one. As a result he received a double dose of tramadol. The primary care nurse noticed the error and to level out the dose, he missed his next morning's dose. The clinical reviewer was satisfied this did not cause harm.

34. Over the next weeks the man lost weight, suffered from swollen legs and increasing pain. Nurses saw him daily and doctors prescribed anticipatory drugs (to alleviate pain and nausea at the end of life). After consultation with his family, a syringe driver (which provides continuous pain relief) was used

from 23 July and this reduced his discomfort. He became steadily less responsive. He died a few days later. His family were with him.

35. The clinical reviewer concluded that the man's end of life care was good. The palliative care team saw him regularly and there was frequent liaison between prison healthcare staff and the community palliative care team. His pain was addressed and reviewed regularly. He and his family were involved in decisions. His end of life care was managed well, and this allowed him to spend time with his family without significant pain. We agree with the clinical reviewer that the end of life care given to him was at least equal to that he could have expected to receive in the community.

36. However, the clinical reviewer was concerned that there was a significant delay in the man receiving additional milk for build-up drinks. This is important as palliative care patients often have a poor appetite and it is difficult to provide sufficient calories to avoid weight loss. There were also two errors in medication. Although he came to no harm as a result, this should have been seen as a significant event and reviewed to avoid it happening again. We make the following recommendations:

The Governor and Head of Healthcare should ensure that prisoners needing special dietary supplements for health reasons, receive them without delay.

The Head of Healthcare should ensure that all medication is given in line with the prescription, and that any error is investigated and lessons learned.

The man's location

37. When the man was discharged from hospital in February 2014, he lived in the prison's social care unit, for prisoners with complex needs and disabilities. The unit has 11 places (including rooms with adjustable hospital beds), a garden area, a family room, a workshop and kitchen. The unit is staffed by nurses who provide personal care to prisoners as needed. Prison Officers who are studying for, or have completed, qualifications in social care also work on the unit.

38. There is a palliative care room with a hospital bed and views of the garden area. The man preferred to live in one of the other rooms in the unit and had an adjustable bed to help make him comfortable and aid nursing care.

39. We are satisfied that the man was appropriately located during his illness.

Restraints, security and escorts

40. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital, and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. The level of restraints used should be necessary in all the circumstances and based on a

risk assessment which considers the risk of escape, the risk to the public and which also takes into account factors such as the prisoner's health and mobility.

41. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and the risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment and kept under review as circumstances change. It found that restraining a prisoner by handcuffs when receiving chemotherapy (and by implication, other life saving treatment) was degrading. It would also be regarded as inhumane, unless justified by other relevant considerations.

42. On 24 January 2014, the man was taken to hospital as an emergency. There was no medical input into the risk assessment which rated his risk of escape and hostage taking as 'normal' and his risk to children as both medium and high (both were ticked). An operational manager authorised the use of double handcuffs for the journey and an escort of two officers. This was to be reduced to an escort chain in hospital. Double cuffing entails the prisoner having his hands cuffed in front of him and then having one wrist attached to a prison officer by an additional set of handcuffs. This is usually required for moving category A or category B prisoners in good health. An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.

43. On 28 January, staff at the hospital told the prison that they thought it likely that the man was terminally ill but investigations were still on-going. The duty governor authorised the removal of restraints and he remained unrestrained from then on.

44. On 4 June, the man went to hospital for a blood transfusion, but the prison was not able to provide us with the records relating to this.

45. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances which must be fully considered, taken into account and balanced against the security risks. Although we are pleased that his restraints were removed on 28 January, it is concerning that there was no healthcare input into the risk assessment on 24 January and that double cuffs were used for the journey. The 2007 High Court judgement requires healthcare staff to comment on whether the prisoner's condition impacts on their risk of escape. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

Liaison with the man's family

46. A prison family liaison officer was involved in meetings with the man and his family. He contacted the man's wife and sister to explain his role and to offer support and answer any questions the family had. He kept in regular contact with both throughout the man's illness.

47. The man's family were able to visit as often as they wanted and used the family room in the social care unit. His wife and sister were with him when he died.

48. The funeral was held on 15 August. The prison contributed to the costs in line with national guidance.

49. We are satisfied that there was early and good liaison with the man's family, who were able to visit him often and remained with him when he died.

Compassionate release

50. Prisoners can be released 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.

51. On 6 June, the Governor forwarded an application for the man's early release. On 13 June, an official in the National Offender Management Service Headquarters refused the application on behalf of the Secretary of State on the grounds that he did not wholly fulfil the criteria for release as his most recent prognosis was between three and six months and he was not incapacitated.

52. On 22 July, the Governor applied again and said that the man was unable to move unaided**.** No reply was received and no decision was made before he died.

53. We are satisfied that although unsuccessful, the prison appropriately considered compassionate release and re-submitted an application when the man's health deteriorated.

RECOMMENDATIONS

1. The Governor and Head of Healthcare should ensure that prisoners needing special dietary supplements for health reasons receive them without delay.

2. The Head of Healthcare should ensure that all medication is given in line with the prescription, and that any error is investigated and lessons learned.

3. The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

ACTION PLAN

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible
1	The Governor and Head of Healthcare should ensure that prisoners needing special dietary supplements for health reasons receive them without delay.	Accepted	A system is now in place to order dietary supplements via healthcare. The expected delivery time for products such as 'Ensure supplement drinks' is one day. A request system is in place for any other dietary requirements which require the catering team's input. All requests can be met on the day of request in most cases. All prisoners subject to palliative care are subject to multi-disciplinary reviews. These reviews now include the catering team, and are chaired by the Head of Residence and Safety or the doctor.	Completed The Governor and Head of Healthcare
2	The Head of Healthcare should ensure that all medication is given in line with the prescription, and that any error is investigated and lessons learned.	Accepted	The Head of Healthcare conducts management checks of treatments and observes the issuing and recording of medication. Any errors involving medication are investigated, and lessons are learned according to the medicines management policies and procedures that are in place.	Completed Head of Healthcare
3	The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.	Accepted	All managers will be reminded via a Notice to Staff (with guidance added to local operating instructions) of the 2007 High Court judgment which made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit, and the risks posed by the same prisoner when suffering from a serious medical condition. Duty Governors will ensure the above is considered in all future risk assessments, especially for emergency escorts during patrol times.	February 2015 The Governor and Head of Healthcare