Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Best a prisoner at HMP Exeter on 22 February 2019

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*

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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.

Mr David Best died of urosepsis (a severe urinary tract infection) caused by bladder cancer on 22 February 2019 at HMP Exeter. He was 48 years old. I offer my condolences to his family and friends.

Mr Best was at HMP Channings Wood from August 2017 before he transferred to Exeter in July 2018. I share the clinical reviewer's concern that a prison GP at Channings Wood did not refer Mr Best to see a hospital doctor urgently under the suspected cancer pathway when he repeatedly presented with blood in his urine, and did not follow up a referral to the urology department at hospital. This was not equivalent to the care Mr Best could have expected in the community.

The clinical reviewer found that, overall, the care that Mr Best received at Exeter was equivalent to that which he could have expected to receive in the community.

I am concerned, however, that although staff at Exeter initiated a compassionate release application for Mr Best, it was never completed.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Sue McAllister CB
Prisons and Probation Ombudsman **October 2019**

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Summary

Events

1. On 12 July 2016, Mr David Best was sentenced to three years and six months in prison for sexual assault and was sent to HMP Exeter. On 5 August 2016, he was transferred to HMP Dartmoor.

2. On 2 May 2017, Mr Best saw a nurse because he had blood in his urine and tests showed that he had a urinary tract infection (UTI). A prison GP prescribed him with antibiotics. On 22 May, Mr Best told a nurse that he still had blood in his urine. Another test showed that he still had an infection and a prison GP prescribed him with more antibiotics.

3. On 11 July, Mr Best was released on licence but two days later, his licence was revoked after he breached its terms and he was sent to HMP Bristol. On 2 August, he was transferred to HMP Channings Wood.

4. On 19 September, Mr Best saw a prison GP because he had pain and was passing urine more frequently. He frequently saw healthcare staff because he continued to have blood in his urine. He was diagnosed with a UTI which prison GPs treated with antibiotics. However, other tests did not confirm that he had a UTI.

5. On 20 April 2018, a prison GP reviewed Mr Best and sent him to hospital for suspected severe kidney injury (kidney failure). Hospital staff examined him and found a large tumour in his bladder. A consultant urologist said that Mr Best would be offered palliative chemotherapy because the cancer had spread.

6. On 11 July 2018, Mr Best was transferred to Exeter. He had his chemotherapy sessions at a hospital.

7. On 25 October, a consultant oncologist told Mr Best that they had stopped his chemotherapy because he was not responding to it. On 29 October, Mr Best signed an order to confirm that he did not want to be resuscitated if his heart or breathing stopped. A prison GP said that Mr Best's prognosis was about six to nine months.

8. At 9.45pm on 22 February, an on-call prison GP certified that Mr Best had died. His parents and a Catholic priest were with him when he died.

Findings

Clinical care

9. The clinical reviewer found that it was 'arguable' that healthcare staff at Dartmoor should have considered referring Mr Best to a specialist under the suspected cancer pathway after he presented twice with blood in his urine in May 2017.

10. After Mr Best transferred to Channings Wood, a prison GP frequently reviewed him. Although Mr Best frequently presented with blood in his urine, the prison GP missed numerous opportunities to refer him to a hospital specialist under the suspected cancer pathway. The clinical reviewer found that this aspect of his

care was not equivalent to what Mr Best could have expected in the community and has referred the GP's actions to NHS England and NHS Improvement South West, a regulatory body of clinical professionals.

11. A prison GP at Channings Wood referred Mr Best to the hospital's urology department in September 2017 but there is no record that the appointment was made.

12. The clinical reviewer found that the care that Mr Best received at Exeter was equivalent to that which he could have expected to receive in the community. Healthcare staff put in place care plans to meet his needs, held multidisciplinary meetings to discuss his care, referred him to specialists when he was incontinent of urine and prescribed him anticipatory pain relief medication.

Compassionate release

13. Records indicate that staff initiated a compassionate release application for Mr Best. However, it was not completed and there are no records to explain why not.

Recommendations

- The Head of Healthcare at Channings Wood should ensure that a copy of this report is shared with a prison GP and that they discuss the Ombudsman's findings to address the issues raised.
- The Head of Healthcare at Channings Wood should ensure that a robust process is in place to monitor referrals made by healthcare staff and ensure that they are promptly and appropriately actioned.
- The Governor at Exeter should ensure that when a prisoner is diagnosed with a terminal illness, a clear system is in place to complete compassionate release paperwork in a timely manner.

The Investigation Process

14. 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.

15. The investigator obtained copies of relevant extracts from Mr Best's prison and medical records.

16. NHS England commissioned a clinical reviewer to review Mr Best's clinical care at the prison.

17. We informed HM Coroner for Exeter and Greater Devon of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

18. The Ombudsman's family liaison officers wrote to Mr Best's brother to explain the investigation and to ask if he had any matters that he wanted us to consider. He did not respond.

19. The investigation has assessed the main issues involved in Mr Best'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.

20. We shared the initial report with the Prison Service. There was one factual inaccuracy.

Background Information

HMP Exeter

21. HMP Exeter is a Victorian city-centre prison which covers the courts of Devon, Cornwall and Somerset. It currently holds up to 545 adult men and young offenders. Care UK provides primary and mental health care.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Exeter was in May 2018. Inspectors found that, despite a significant increase in staffing since the last inspection in August 2016, there had been a sharp deterioration in the outcomes for prisoners. They noted that many of their previous recommendations had been ignored. They were particularly concerned to find that the key area of prisoner safety attracted their lowest possible grading. Inspectors reported that two-thirds of prisoners did not feel safe, there had been a 40% increase in incidents of self-harm and six self-inflicted deaths since their last inspection. They noted that prisoner-on-prisoner assaults were at the highest levels seen in the past three years, and the availability of illicit drugs continued to be prevalent. The inspectors were also concerned about poor living conditions.

23. Following the inspection, HM Chief Inspector of Prisons invoked the Urgent Notification protocol and wrote to the Secretary of State on 30 May 2018, setting out his significant concerns about the treatment of prisoners and the conditions in which they are held.

Independent Monitoring Board

24. 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 latest annual report for Exeter for the year to December 2017, the IMB reported that prisoners were treated fairly and humanely. They recognised that there had been an improvement in staffing numbers since their last report but felt more needed to be done to increase staffing to the required levels. The IMB were concerned about delays in appropriate mental health provision for some prisoners as well as poor living conditions.

Previous deaths at HMP Exeter

25. Mr Best was the twelfth prisoner to die at Exeter since February 2017. Four of the previous deaths were from natural causes and seven were self-inflicted. There are no significant similarities with the previous cases.

HMP Channings Wood

26. HMP Channings Wood is a medium security prison near Newton Abbot in Devon. It holds over 700 men. Care UK provides health services at the prison. There is one permanent GP, with locum GPs running additional clinics. Nurses are on duty every day and there is an out of hours GP service.

HM Inspectorate of Prisons

27. The most recent inspection of HMP Channings Wood was conducted in October 2018. Inspectors reported that, overall, the prison had deteriorated since their last inspection. They noted that the healthcare unit was clean and tidy and that staff were caring and professional. They said that there were gaps in record-keeping and a lack of care-planning for prisoners with complex health needs. Inspectors noted that there were no nurse-led clinics for prisoners with long-term conditions and no effective recall system to maintain ongoing care. They noted that such prisoners were managed through the GP. Inspectors noted that this affected GP waiting times which, at six weeks, were too long.

Independent Monitoring Board

28. 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 latest annual report for the year to August 2018, the IMB reported that, overall, staffing levels had improved but that they were concerned by the lack of experience resulting from so many new officers. The IMB was very concerned about the general fabric of buildings, with examples of floors lifting through damp, unhygienic showers and basic furniture in short supply. They reported that psychoactive substances (PS) were easily available and substance misuse had escalated throughout the year. They found that healthcare staffing levels had improved. With an ageing prison population, they found that there had been an increase in wheelchair users. The noted that cell doors were not wide enough for wheelchairs so they often cluttered the landings.

Previous deaths at HMP Channings Wood

29. There have been eight deaths at Channings Wood since February 2017. Two of the previous deaths were from natural causes, two were self-inflicted and three were drug-related. There are no significant similarities with the previous cases.

Assessment, Care in Custody and Teamwork (ACCT)

30. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Findings

The diagnosis of Mr Best's terminal illness and informing him of his condition

31. On 12 July 2016, Mr David Best was sentenced to three years and six months in prison for sexual assault and was sent to HMP Exeter.

32. On 12 July, at his initial health screen, a nurse noted that Mr Best had a history of anxiety and depression and had been under the care of the mental health team in the community. A prison GP re-prescribed him mirtazapine for depression.

33. On 5 August 2016, Mr Best was transferred to HMP Dartmoor.

HMP Dartmoor

34. On 2 May 2017, Mr Best saw a nurse because he had blood in his underwear. Tests of Mr Best's urine showed that he had a urinary tract infection (UTI) and a prison GP prescribed him antibiotics.

35. On 22 May, Mr Best saw a nurse because he was exhausted and saw more blood in his urine. Mr Best gave another urine sample which showed that he had an infection. A prison GP prescribed him more antibiotics.

36. Mr Best first told healthcare staff at Dartmoor on 2 May 2017 that he had blood in his urine. The clinical reviewer said that visible blood in urine was uncommon, especially at Mr Best's age, but could result from the inflammation of the bladder lining as a result of infection.

37. He next saw healthcare staff about blood in his urine on 22 May, two weeks after finishing his course of antibiotics. Another blood test showed that he had an infection and he was prescribed another course of antibiotics.

38. The National Institute for Clinical Excellence (NICE) guidelines for the management of suspected urological cancer state that a referral should be made under the suspected cancer pathway for bladder cancer for a patient aged 45 years and over who has unexplained blood in their urine either without a UTI or which persists or recurs after a UTI has been successfully treated.

39. The clinical reviewer said that while on both occasions the blood in Mr Best's urine was linked to a proven UTI, it did recur. He said that it was 'arguable' that consideration should then have been given to referring Mr Best under the suspected bladder cancer pathway after his second presentation.

40. On 10 July 2017, Mr Best was transferred to HMP Bristol and the following day, he was released on licence. On 13 July, he was recalled to Bristol after he breached his licence terms. On 2 August, he was transferred to HMP Channings Wood.

HMP Channings Wood

41. On 19 September, a prison GP reviewed Mr Best. He noted that Mr Best had pain and an increase in passing urine. He did not examine Mr Best but referred him to a hospital urology department. There is no record of a referral letter in the medical records.

42. On 25 September, Mr Best had blood tests to check his kidney function. A prison GP reviewed the results and recorded that they were normal.

43. On 26 September, Mr Best saw a nurse because he again had blood in his urine. He gave another sample which showed that he did not have a UTI. A prison GP noted that the test was normal and took no further action.

44. On 24 November, Mr Best saw a nurse at the treatment hatch and told him that he had a lump in his testicles. The nurse examined him and found a lump in his groin. Mr Best said that it was very painful and that he was passing blood in his urine. A nurse tested Mr Best's urine sample which indicated a possible infection. On 27 November, Mr Best gave another urine sample. On 29 November, a prison GP prescribed him antibiotics because the test result showed that he had an infection.

45. On 13 December, a prison GP reviewed Mr Best who told her that he still passed urine frequently and that his groin was still tender and swollen. The prison GP prescribed more antibiotics and planned for him to be reviewed by a male prison GP. On 18 December, Mr Best saw a prison GP, who after examining him, said that he had a hernia in his left groin. He prescribed more antibiotics for a UTI and referred him to the outpatient's department at a hospital.

46. On 27 December, Mr Best told a nurse that he had pain when passing urine. She asked him to give a urine sample but there is no record to confirm whether he provided this.

47. On 10 January 2018, a prison GP reviewed Mr Best who told her that he had constipation, difficulty passing urine, a lump in his groin and back pain. She gave him a laxative and pain relief for his back pain and arranged for a urine sample. On 12 January, she reviewed the test results which were borderline and indicated that Mr Best should provide another sample.

48. On 16 January, Mr Best saw a nurse and told him that he had blood in his urine. He asked for another urine sample to rule out a sexually transmitted disease (STD). A prison GP reviewed the results and noted that he did not have an STD. She took no further action.

49. On 9 February, Mr Best went to the treatment hatch and told a nurse that he had lots of blood in his urine. A prison GP again reviewed the test results which were borderline and suggested that he should be tested again. On 17 February, Mr Best went to the clinic, where he told a nurse that he still had blood in his urine. The nurse telephoned a community GP (an out-of-hours service) and the community GP diagnosed a UTI and prescribed antibiotics. On 20 February, a prison GP noted that Mr Best's urine sample was normal and filed the result.

50. On 9 March, Mr Best told a nurse that he had swollen legs and ankles. The nurse took no action. On 11 March, a nurse went to see Mr Best because he said that he had rectal bleeding, swollen feet and legs. She asked for a stool sample and an urgent GP review. On 14 March, a prison GP reviewed Mr Best who told her that he was struggling with his urine symptoms. He showed her a wet patch on his trousers which she noted as being consistent with him tipping his water bottle over himself. She again thought that he may have a UTI and gave him more antibiotics. There is no record that she asked for a urine sample.

51. On 18 March, Mr Best saw a nurse at the treatment hatch. He was very upset and tearful and told the nurse that his urinary problem was not getting better. He said that he felt like 'an old man who has no control'. The nurse did a urine test and asked for a GP review. No blood was seen in the urine sample and it was sent off for further analysis.

52. On 27 March, a prison GP saw Mr Best who told her that he was wetting the bed at night, had swollen ankles and shortness of breath. She examined his chest and leg swellings. She prescribed antibiotics and asked for another urine test, the results of which were normal, and blood tests to be taken. These tests did not happen until 12 April.

53. On 3 April, a prison GP reviewed Mr Best and noted that he seemed unable to answer simple questions and therefore did not know if his health had improved. He said that he had itchy blotches on his legs. She planned to re-book blood tests. She gave him an antihistamine for the blotches and solifenacin for an overactive bladder.

54. On 7 April, a nurse saw Mr Best in his cell because he said that his scrotum was now much bigger and the cause of his incontinence. When the nurse examined him, he dribbled urine. He spoke to the on-call GP, who advised him to monitor his condition over the weekend. On 9 April, a prison GP reviewed Mr Best who thought that the swelling of the scrotum was due to a hernia. He spoke to a doctor in the acute medical unit at a hospital. The doctor agreed to see him and Mr Best went to hospital, where he stayed until 12 April. There is no record of the hospital discharge summary in Mr Best's medical records.

55. On 20 April, a prison GP reviewed Mr Best, noted that he might have a severe kidney injury (a sudden episode of kidney failure) and sent him to hospital. On 26 April, a nurse manager spoke to hospital staff who told her that Mr Best had a large tumour in his bladder. On 1 May, Mr Best returned to Channings Wood. A consultant urologist, noted in Mr Best's discharge letter that he had a bladder tumour which had been partially removed. The consultant said that Mr Best would be offered palliative chemotherapy because the cancer had spread and his general condition would not cope with more aggressive treatment.

56. On 2 August 2017, Mr Best was transferred to Channings Wood and his healthcare was frequently reviewed by a prison GP. On 26 September, Mr Best again told healthcare staff that he had blood in his urine, a sample of which showed that he did not have an infection. The prison GP took no further action but should have referred him urgently under the suspected bladder cancer pathway which did not happen.

57. During the next six months, Mr Best saw the healthcare team about blood in his urine on seven occasions. On 24 November, he was treated with antibiotics for a confirmed UTI. A prison GP filed the results and took no action. On 13 December, she prescribed a further course of antibiotics but there is no record that his urine was tested which would have been more appropriate.

58. On 12 January 2018, Mr Best again had blood in his urine, a test of which showed a mixed growth which the clinical reviewer said was not regarded as an indication of infection. A prison GP filed the result. This was the second occasion where blood was present in Mr Best's urine without a proven infection. Mr Best went back to the healthcare team on 16 January, with blood in his urine. The prison GP filed a normal urine result. On 9 February, Mr Best said that he had blood in his urine, which again showed a mixed growth. The prison GP filed the result with no further action. On 17 February, Mr Best has blood in his urine and a test showed no infection. The prison GP took no further action.

59. On 14 March, when Mr Best saw the healthcare team about a raised temperature and pain passing urine, a prison GP prescribed antibiotic for a UTI. There is no record of an immediate urine test.

60. It was not until Mr Best's health worsened over the next month that blood tests were arranged. The results showed that his kidney function was impaired and that Mr Best had bladder cancer.

61. The clinical reviewer said that it is difficult to understand why a prison GP did not refer Mr Best under the two-week suspected cancer pathway when he repeatedly presented with blood in his urine. He said that this aspect of care was not equivalent to that which he could have expected to receive in the community. We cannot know if an earlier referral would have affected Mr Best's prognosis but by the time cancer was diagnosed, it had already spread to the extent that treatment was not appropriate.

62. The clinical reviewer said that he had informed NHS England and NHS Improvement South West of a prison GP's actions, and they are investigating the concerns raised. (NHS England has responsibility for investigating concerns about individual primary care performers and contractors.)

63. We make the following recommendation:

The Head of Healthcare at Channings Wood should ensure that a copy of this report is shared with a prison GP and that they discuss the Ombudsman's findings to address the issues raised.

64. On 19 September 2017, a prison GP reviewed Mr Best and noted that he had pain and an increase in passing urine. He referred him to the hospital urology department but there is no record that an appointment was made. There is no record in the medical records that a referral letter was sent to the hospital, as it should have been. The clinical reviewer said that there did not appear to be a robust system in place to ensure that such plans were completed. We make the following recommendation:

The Head of Healthcare at Channings Wood should ensure that a robust process is in place to monitor and audit referrals made by healthcare staff to ensure that they are promptly and appropriately actioned.

Mr Best's clinical care at Exeter

65. On 11 July 2018, Mr Best was transferred to Exeter, and a nurse completed Mr Best's initial health screen. He noted that he had bladder cancer and that he had had one session of chemotherapy. Mr Best said that his next appointment for chemotherapy was on 16 July at hospital and that he now had a catheter fitted. He was moved to the social care wing which holds 11 prisoners and has a palliative care room.

66. A healthcare administrator, spoke to the oncology team at the hospital who arranged for Mr Best to have his chemotherapy sessions moved to another hospital. Between 31 July and 26 September, Mr Best attended hospital as an outpatient for chemotherapy.

67. On 13 July, a prison GP reviewed Mr Best and noted that he had bladder cancer which had spread to the lymph nodes in the pelvis, that he did not have a prognosis or an assessment that the cancer was terminal. She noted that Mr Best lived on the social care wing so that the social care team could review him daily. She asked that care plans be completed for bladder and bowel, skin care and nutrition and reviewed his medication.

68. On 14 July, Mr Best told an officer that he was short of breath and was feeling hot. A nurse saw him and tested his urine which identified a possible UTI. Mr Best's observations worsened and a paramedic, sent him to hospital. Hospital staff said that Mr Best had urinary sepsis and gave him intravenous antibiotics. On 19 July, Mr Best returned to Exeter with antibiotics.

69. On 4 August, Mr Best saw a nurse because his catheter was blocked. The nurse removed the catheter and he said that he was happy without it.

70. On 7 August, a prison GP saw Mr Best because he had a swollen scrotum. She said that he had a hernia and planned to wait until his chemotherapy was finished before sending him for surgery.

71. On 16 August, Mr Best was sentenced to a further two years and eight months in prison for a breach of a sexual harm prevention order and sexual assault.

72. On 29 August, when Mr Best returned from hospital after chemotherapy, hospital staff said that he had a UTI. A prison GP, noted that hospital staff had given him intravenous antibiotics and recorded that he had a hernia which needed surgery after he finished chemotherapy.

73. On 20 September, the day after a hospital chemotherapy session, Mr Best had another appointment for a blood transfusion because hospital staff said that he had anaemia. Mr Best told officers that he was not going to hospital because he was tired. A senior health care assistant, persuaded him to do so and he received a blood transfusion and antibiotics.

74. On 3 October, Mr Best went to hospital for a CT scan of his chest, abdomen and pelvis. A consultant radiologist, said that there was a small reduction in the size of the tumour, that the kidneys were dilated because of backflow from the bladder, that the cancer had spread to lymph nodes in the chest and that Mr Best had enlarged glands.

75. On 19 October, a prison GP saw Mr Best on the wing. He told her that the hospital was going to stop his treatment because the cancer was growing. Mr Best agreed not to have treatment and said that he was feeling well.

76. On 25 October, a consultant oncologist noted in a letter to the prison's healthcare department that they had stopped treatment because Mr Best was not responding to chemotherapy. On 29 October, a prison GP reviewed Mr Best in his cell and gave him a copy of the letter to show his mother. He said that he understood the prognosis, that he was not in any pain and was sleeping well. Mr Best signed an order to say that he did not want to be resuscitated if his heart or breathing stopped.

77. On 6 November, a prison GP noted that she had discussed Mr Best at a multi-agency team meeting and that his prognosis was now about six to nine months, that he was unable to have the hernia operation because of the risk of his skin not healing, that his care plans had been updated and his medication had been reviewed. She noted that Mr Best had told his mother his prognosis and that she could visit him in prison.

78. On 7 December, a prison GP reviewed Mr Best. She noted that he was in denial about his cancer. He wanted the hernia operation but she told him why this was not possible, prescribed him food supplements and planned to have a multidisciplinary team meeting.

79. On 30 December, a nurse saw Mr Best who was distressed because he was wetting his bed which was keeping him awake at night. He said that the incontinence pads were not working. The nurse showed him how to use a convene (a sheath that connects by tube to a urine collecting bag). The convenes did not work and Mr Best continued to wet the bed. On 2 January 2019, a nurse made an incontinence care plan. On 8 January, a nurse telephoned the community bladder and bowel service to ask them to assess Mr Best.

80. On 16 January, two hospice care nurses, saw Mr Best who said that he was still concerned about his incontinence. A nurse said that they would chase up the bladder and bowel service. Mr Best said that he did not have any pain.

81. On 17 January, a mental health nurse reviewed Mr Best's mental health and spoke to him about his end-of-life care. A nurse reviewed his cancer support and continence care plans. On 23 January, a nurse created a personal care plan.

82. On 24 January, Mr Best told a nurse that he was struggling to swallow solid food. She said that she would refer him to speech and language therapists who help with swallowing problems.

83. On 1 February, on the advice of a community bladder and bowel nurse, a nurse tried to give Mr Best a catheter but could not do so because there was blood on the end of Mr Best's penis. She referred this to a prison GP.

84. On 7 February, a nurse saw Mr Best because he had vomited during the night. He told her that he had been able to take his food supplement, had eaten and was feeling better. The nurse planned to monitor Mr Best and ask for a prison GP to review him if he continued to vomit.

85. On 8 February, having spoken to the urology team at the hospital, a prison GP gave Mr Best a new catheter. Healthcare staff frequently checked the catheter which was working correctly.

86. On 13 February, a prison GP reviewed Mr Best because he said that he had a cough, was producing sputum and was short of breath. She prescribed him antibiotics for an infection and said that he should have oxygen if he needed it. The next day, a prison GP arranged for Mr Best to have a chest x-ray and blood tests which showed that he had impaired kidney function. The prison GP said that this was not treatable because of his general condition.

87. From 16 February, Mr Best was too weak to get up and stayed in bed. His parents visited him. On 18 February, a prison GP prescribed anticipatory medication for pain relief and the following day, held a multi-agency team meeting to discuss Mr Best's care.

88. On 22 February, a prison GP reviewed the result of Mr Best's chest x-ray which showed that he had an infection. At 2.15pm, Mr Best's family and a priest visited him. At 8.15pm, an officer checked on Mr Best who was gasping for air so Two nurses went to see him. Mr Best was lying peacefully on the bed with his eyes closed and he had stopped breathing. At 9.45pm, the on-call prison GP pronounced that Mr Best had died.

89. The clinical reviewer is satisfied that the care that Mr Best received at Exeter was equivalent to that which he could have expected to receive in the community. He received regular reviews for his learning disability and mental health.

90. Mr Best's mental capacity to make decisions was assessed and he was involved in his care at all stages after diagnosis. Healthcare staff made appropriate care plans and referred Mr Best to the community bladder and bowel service because of his urinary incontinence. A prison GP organised and held multi-agency meetings to discuss Mr Best's care and a prison GP appropriately prescribed anticipatory medication.

Mr Best's location

91. We are satisfied that when Mr Best was appropriately located in the social care wing at Exeter, where he had access to 24-hour healthcare in the palliative care room.

Restraints, security and escorts

92. When prisoners have to travel outside of the prison, a risk assessment determines the nature and level of security arrangements, including 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. Any restraints used should be necessary and decisions should be based on the security risk taking into account factors such as the prisoner's health and mobility.

93. Between 31 July and 10 October, Mr Best went to hospital nine times for chemotherapy treatment and tests. Healthcare and prison staff completed an escort risk assessment before each visit. Medical staff did not object to the use of restraints. Prison staff noted that Mr Best was a Category C prisoner, was a medium risk to the public, a medium risk of escape, a risk to hospital staff, and had been subject to ACCT procedures until 16 May 2018. Prison staff also noted that Mr Best posed a high risk to females because he had repeatedly displayed inappropriate behaviour, which included touching, both in the community and while in prison. Mr Best had previously inappropriately touched a female member of the healthcare staff which was recorded in the medical records. Prison staff also noted that Mr Best was violent and had threatened staff.

94. Senior prison managers said that Mr Best must be double-cuffed (when the prisoner's hands are handcuffed in front of him and one wrist is attached to a prison officer by an additional set of handcuffs) when being taken to hospital and restrained by an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer) when receiving treatment.

95. Escorting officers noted that on some visits to hospital, Mr Best's behaviour was poor. His attitude towards hospital staff was inappropriate and escort officers had to challenge him about this.

96. We are satisfied that escort risk assessments, including the medical section, were always fully completed and that staff weighed up their responsibility to treat prisoners humanely and to consider his ill health with his significant risk. Because of Mr Best's history of poor behaviour and the nature of his offence, which included inappropriate touching of women, and his continued poor behaviour even in hospital, it was reasonable that senior prison managers decided that he should be double-cuffed when going to hospital and restrained with an escort chain during chemotherapy.

Liaison with Mr Best's family

97. On 18 February, the Head of Safer Custody, appointed an officer as the family liaison officer (FLO) and a senior officer as the deputy family liaison officer. The FLO introduced herself to Mr Best's mother by telephone.

98. At 10.20am on 22 February, the deputy FLO telephoned Mr Best's mother and told her that Mr Best was very ill and said that the family should come to see him. At 11.45am, Mr Best's brother telephoned the deputy FLO and said that he was coming to the prison with his family. At 1.55pm, Mr Best's family saw Mr Best in the healthcare unit and were with him when he died.

99. On 27 February, the FLO telephoned Mr Best's brother and offered her condolences. Mr Best's funeral took place on 19 March. Exeter arranged and met the costs of the funeral in line with national instructions.

Compassionate release

100. Release on compassionate grounds is a means by which prisoners who are seriously ill, usually with a life expectancy of less than three months can be permanently released from custody before their sentence has expired. A clear medical opinion of life expectancy is required. The criteria for early release for determinate sentenced prisoners are set out in Prison Service Order (PSO) 6000. Among the criteria is that the risk of re-offending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section of the Her Majesty's Prisons and Probation Service (HMPPS).

101. An offender manager, saw Mr Best when he first arrived at Exeter. Mr Best told him that he was terminally ill and they talked about an application for compassionate release. Mr Best did not want to apply for release at that time. He said that throughout his time at Exeter, he asked Mr Best about compassionate release but he did not want to apply because he did not believe that he was terminally ill.

102. On 6 November 2018, after a multidisciplinary team meeting, a prison GP noted that Mr Best had a prognosis of between six and nine months and that prison staff needed to consider compassionate release.

103. Prison staff in the Offender Management Unit initiated a compassionate release application but it is undated and we therefore do not know when this happened. It is not known if the application form was sent to the healthcare department, and the document, including the healthcare section, was not completed.

104. We accept that when Mr Best first went to Exeter, he told his offender supervisor that he did not believe that he was terminally ill. When Mr Best's health deteriorated, prison staff started the application and completed basic information in the document. However, the healthcare section of the form was not completed. There is no evidence to confirm whether or not the healthcare team received it or why the application was not progressed. There does not appear to be a robust system in place to check on and ensure the progress of a compassionate release application. While we cannot say whether or not Mr Best would have been released early if his application had been completed, we make the following recommendation:

The Governor should ensure that when a prisoner is diagnosed with a terminal illness, a clear system is in place to complete compassionate release paperwork in a timely manner.

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