Investigation into the circumstances surrounding the death of a man at HMP & YOI Exeter in February 2008

Report by the Prisons and Probation Ombudsman for England and Wales

October 2008

This is the report into the death of a man. He died at a Hospice on 28 February 2008, having been transferred from HMP Exeter five hours earlier. The man was 63 years old.

A post mortem was held at the request of the Exeter Coroner and it revealed that the man's death was due to natural causes. He had been diagnosed with a carcinoma of the lung with cerebral metastases. Unexpectedly, the man's condition deteriorated rapidly as the result of a secondary cancerous tumour in his bowel. The cause of death was recorded as a perforated sigmoid colon.

I extend my sincere condolences to the man's partner, family and friends.

My thanks go to the Governor at Exeter and his staff for their help and assistance to my investigator. I am particularly grateful to a Principal Officer (PO) for his support.

Devon Primary Care Trust (PCT) appointed a clinician to conduct a clinical review of the care afforded to the man whilst he was in Exeter. I am grateful to the clinician for her review.

I make five recommendations to Devon Primary Care Trust in relation to medical records, palliative care and prescribing. I also make three recommendations to the Governor in relation to the physical environment of healthcare, hospital escorts and Prison Service Order 2710. I note two areas of good practice in relation to the staff and prisoners of a wing, and the support offered by nursing staff.

In this final version of report the man's family have responded to the draft report. I deal with those points in the report under family issues. Devon Primary Care Trust and the Governor of Exeter have accepted all the recommendations from the draft report.

Jane Webb
Deputy Prisons and Probation Ombudsman **October 2008**

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SUMMARY

The man died on 28 February 2008 at a hospice. He had returned to prison in August 2007, for breach of a prevention order. On his reception into custody he was noted to have type two diabetes.

In September, the man was seen by the prison doctor as he was complaining of shortness of breath and pain in his right arm. Blood tests, a chest x-ray and an electrocardiograph (ECG) to monitor his heart, were ordered by the doctor. In October, the ECG indicated some heart damage. The man was referred to a chest specialist at a hospital as the chest x-ray indicated a tumour on his lung.

Due to a lack of escort staff the appointment for mid October was cancelled and re-arranged for early November. On 13 November, the chest specialist wrote to the doctor and confirmed the diagnosis of a tumour on the man's lung. A biopsy carried out at the hospital on 22 November, indicated a non-small cell cancer.

The man saw the chest specialist on 3 December when his cancer and prognosis was discussed. He then had a course of radiotherapy. The man remained in normal location on a wing until mid January, when his health deteriorated and nursing care was necessary. The man moved into the healthcare unit and a nursing plan was initiated. Hospice staff advised healthcare staff caring for the man about palliative nursing. Case reviews, with hospice staff were held in the healthcare unit. The man was also seen weekly by a palliative care nurse from the hospice.

Towards the end of January, the man returned to a wing for a short period as he was unhappy in the healthcare unit and felt isolated. A week later, the man returned to the healthcare unit as the location on the wing became unsuitable for his increasing nursing needs. A secondary cancer had also been found in his brain, this was causing the man to lose his sight and become confused.

The man spent four weeks in healthcare. His cell in healthcare was inappropriate to care for a terminally ill man and specialist nursing equipment was not available. My investigator concludes that staff nursed the man professionally, within the constraints of less than desirable conditions.

On 26 February, the man's health rapidly declined. He was in pain and agitated. A case review was held and his pain control medication was reviewed. Two days later, the man deteriorated further. A hospice nurse visited him in the morning and arranged for him to be admitted to a hospice. A release on temporary licence (ROTL) was completed by the Governor and the man was transferred to the hospice at 1.00pm.

The man was accompanied by the chaplain and the man's partner was informed of this transfer and went to the hospice to be with him. The man died five hours later at 6.00pm.

THE INVESTIGATION PROCESS

1. One of my investigators visited Exeter on 20 March 2008. Notices and the Ombudsman terms of reference had been sent to the prison in advance of her visit. One prisoner responded to those notices and saw my investigator during her visit.

2. My investigator met the Governor, the chaplain, a member of the Independent Monitoring Board (IMB), and the liaison officer. Later, my investigator met with the head of healthcare, two nurses and the prison doctor.

3. During the afternoon my investigator, visited the healthcare centre and saw the man's cell. Later she visited a wing and spoke to a wing officer and two of the man's friends.

4. One of my own family liaison officers, made contact with the man's partner informing her of our investigation. She raised several points in relation to the man's care whilst at Exeter. Her concerns were about the man's personal hygiene whilst in healthcare and the care afforded to him, as well as concerns about the delivery of palliative care within a prison setting and the sudden deterioration in his medical condition. These issues are considered further within the report.

5. On 6 and 7 May, my investigator returned to Exeter to interview prison staff and the head of healthcare.

HMP & YOI EXETER

6. The prison is located within the City of Exeter and was built around 1850. It currently has four accommodation units with a healthcare facility in support. The Certified Normal Accommodation is 314 and the Operational Capacity 533. The prison holds both adult male remand and convicted prisoners committed to custody from Cornwall, Devon and south west Somerset.

7. HM Chief Inspector of Prisons, Ms Anne Owers, conducted an unannounced inspection of Exeter in October 2007. In Ms Owers's report an overview of healthcare services said:

> "Health services had maintained much of the progress previously reported. There was only a short waiting list for the dentist. Pharmacy arrangements were basically satisfactory, although there were still problems with arrangements for in-possession medications. Mental health work was good and developing. The inpatient regime remained poor, and secondary health screening for new arrivals was voluntary, which was inappropriate."

8. The Independent Monitoring Board's Annual Report for 2007 said of the prison;

> " There are some very dedicated, professional staff working in Exeter Prison. Relationships between staff and prisoners are very good. Prisoners generally feel safe in custody. However, we would like to see a more purposeful and constructive use of prisoners' time through the extension of education, skills and leisure opportunities. The challenges of operating within predominantly Victorian buildings designed for another age are immense. The pressure of very high prisoner numbers adds to the difficulties and requires continuous attention to the maintenance of clean and safe living and working environments. As monitors, we expect to see creative management solutions to these problems in the coming year."

9. Since April 2004, when I became responsible for investigating all deaths in prison, there have been four previous apparently self inflicted deaths and one of natural causes at Exeter. The previous natural cause death did not have any similarities to the man's death.

KEY FINDINGS

10. On 20 August 2007, the man was received into Exeter. A first reception health screen noted that he was receiving metformin, a medication for type two diabetes. The man had stopped smoking in 2003 and there were no mental health concerns. He told the nurse he had given up alcohol.

11. The man was seen again in healthcare on 4 September. He had pain in his right arm from the shoulder to his fingers and was prescribed medication, as a mild pain killer was not helping. Naprosyn, a non-steroidal anti-inflammatory drug was prescribed.

12. Nine days later, the man was again seen in healthcare. He was complaining of shortness of breath and a dry cough. His blood pressure rate was 140/85 and pulse rate 60 beats per minute, and his chest was clear on examination. The naprosyn was stopped and paracetamol was prescribed. The doctor ordered a full set of blood tests, which were taken on 18 September. I have not been able to identify through the medical notes the result of the blood tests.

13. On 27 September, the man was still suffering form shortness of breath. He was seen by the doctor who recorded that he had a good colour, no ankle swelling but his blood pressure was elevated at 171/100. The doctor requested an electrocardiograph (ECG) to monitor his heart rate and a chest x-ray and arranged to review the man's condition in a further ten days.

14. The man attended healthcare for the ECG on 4 October. The doctor noted that the results of the ECG indicated inferior myocardial symptoms (indication of changes to the heart function). Five days later, the man was prescribed aspirin and simvastatin (to lower his cholesterol). The doctor examined the chest x-ray on 11 October and told the man that he was being referred to a chest physician.

15. On 30 October, the doctor recorded that he man had not yet been seen by a chest physician at a hospital. An appointment for mid October had been cancelled, as there were insufficient staff on duty to assign officers to escort him to the hospital. The doctor noted that the man must attend his next appointment in early November.

16. In early November, the man attended the hospital for tests. There is no correspondence from the hospital in the man's prison medical notes. The clinical review indicated that at this point a serious illness was suspected.

17. On 6 November, the man went to healthcare where he saw two nurses. It is recorded in the medical notes that the man seemed positive, but wanted to have further tests done as soon as possible before he told his friends and family about his illness. The nurses explained to the man the likely progress of his medical condition and thought that he appeared grateful for their support.

18. Two days later the man was seen by the doctor. They discussed a diagnosis and it was noted he was waiting for a bronchoscopy (a test where a camera is inserted via the mouth to look at the lungs). The following day, the man saw a nurse and they discussed his present medical condition. The man had still not told his friends and family and was waiting until he attended the hospital for an indication of the long term prognosis.

19. On 13 November, the man's medical notes indicate that his bronchoscopy had been cancelled following a multidisciplinary meeting at the hospital. A new plan for a computerised tomography (CT) scan, a special type of X-ray machine, was arranged for 15 November.

20. The nurse dedicated to D wing saw the man in his cell on 28 November. They discussed his present medical situation. The nurse noted that the man was calm and thought he might not be fully aware of his current situation. The nurse agreed to accompany the man for an appointment at hospital to see a specialist consultant in early December.

21. On 3 December, the man was seen at a hospital by a registrar. He was accompanied by a prison nurse. The registrar informed him that he had lung cancer, with a prognosis of six to nine months left to live. He told the man he would be treated with radiotherapy for five consecutive days and it was important that this treatment was not interrupted. The man would also be assessed for chemotherapy. The nurse assured the registrar that the man's pain could be managed within the prison setting.

22. The man saw the prison doctor the following day, who prescribed tramadol, to treat moderate to severe pain. The man said he wished to continue working as he was comfortable during the day but felt pain at night. On 8 December, the man had a long discussion with a nurse. He said he had spoken to his partner about his illness and was happy that the Governor had allowed him to have extra visits. He felt supported by healthcare, but said he did not wish to die in prison. Staff told the man that everything would be done regarding his health, respect and dignity. On 18 December, he began his course of radiotherapy.

23. Four days later, the man told a nurse he was experiencing pain at times, and feeling tired as a result of his ongoing treatment. The nurse noted that he was seemingly in good spirits on the outside, but was concerned that he might be depressed. Nine days later the doctor, after a consultation with a doctor from the hospital, stopped the man's tramadol. He was prescribed oramorph, an oral solution that contains the active ingredient morphine sulphate, an opioid painkiller, for pain control.

24. On 6 January 2008, the man told a nurse that he was experiencing pain, and was now taking paracetamol regularly as well as oramorph. He was sleeping well, but felt that his eye sight was deteriorating. He had given up work as it was too much for him. Four days later, a specialist palliative care nurse from a hospice visited the man. Later that day, when he went to collect his

oramorph, he told the nurse that he felt unwell and the nurse helped him to his cell and referred him to the doctor.

25. On 12 January, the man was moved from the third landing to the ground floor to assist his mobility. Later that day a member of the healthcare staff received a telephone call from his partner. She was concerned that during a visit that afternoon the man was having problems with his sight and mobility. Healthcare staff told the man's partner that he was being seen twice a day by nursing staff and had been reviewed by the doctor the day before. The man's partner was concerned about his ability to cope and the type of care he was receiving. The staff member advised her to call the healthcare manager and liaise with her.

26. Two days later, a nurse was called to see the man in his cell. He was complaining of pain and rapidly deteriorating eye sight. On 15 January, The man told the doctor he felt he was in 'cloud cuckoo land', unable to concentrate, unable to find words, and with a loss of peripheral vision. The doctor examined him and found his vision to be impaired. He noted that there could be cerebral secondary cancer. The doctor offered the man a place in the healthcare centre, which he accepted.

27. On 20 January, the man rang his cell bell in the healthcare centre as he was coughing up blood and was distressed. The healthcare staff rang the doctor who advised that if he started to vomit blood then the emergency doctor service should be called. The doctor also told staff that if the man became further distressed he could be given diazepam. Staff helped wash The man and advised him to call staff if he vomited blood. Later, the man's condition deteriorated, he became breathless, was still coughing up blood and sweating. The emergency doctor service was contacted and it was decided to admit the man to outside hospital. He was taken to hospital but returned two hours later after being examined and stabilised on opiates.

28. The following day, a nurse from the hospice visited the prison for a case review. Arrangements were made for the man to receive extra visits from his partner and from his friends on a wing. A palliative care policy was to be added to the man's medical notes with contact numbers for advice and support for staff. In addition, a risk assessment was to be undertaken by the health and safety manager in response to specialist nursing care equipment being brought in for the man, and a hospice nurse would visit him every week.

29. The man asked to return to the wing as he felt isolated in healthcare and had little association outside of his cell. He transferred back to the wing on 24 January, following an opthalmic appointment for his deteriorating vision. Wing staff and friends of the man were aware of his failing health but thought they could support him at that time.

30. On 29 January, the hospice nurse noted that the man was confused and agitated at times. The nurse suggested a change in his medication with the inclusion of diazepam (a sedative and anxiety-relieving drug). The next day, he was prescribed stemetil (a drug that elevates vomiting). It was also

recorded that the man remained confused and officers were concerned about his ability to remain on the wing. Later that evening, he fell onto the floor from his bed. He was assisted back to his bed with no apparent injuries.

31. On 31 January, when the man saw the doctor on the wing he was unable to tell the doctor anything or give answers to questions. The doctor noted that the man required full time nursing care and he was returned to the healthcare centre.

32. The nursing plan recorded all daily interventions with the man, noting his medication and deteriorating medical condition, which included constipation and bleeding from his rectum. The man remained confused and disoriented. He received regular visits from his partner and friends from the wing. His pain management included morphine sulphate and oramorph.

33. The man attended hospital for tests including a CT scan on 12 February. On 22 February, he was seen in the oncology department at a hospital. A large brain mass was visible on the scan, which was affecting his sight and mobility. The doctor noted that there was a marked deterioration in the man's condition and a prognosis was made that he had six weeks left to live. The clinical reviewer found that the man elected not to pursue any further radiotherapy, and no future out patient appointments were made.

34. It was recorded on 26 February that the man was unsettled, and disoriented. He was finding it difficult to move around his cell and co-ordinate his balance to sit on the toilet. At 5.15am, he was found on the floor of his cell. Two officers from the main prison came to healthcare to assist nursing staff help him to bed. This was repeated one hour later, when he was found again on the cell floor. There were no obvious injuries from these falls, but for safety reasons his mattress was placed on the floor.

35. Later that day a multi-disciplinary case review was held to discuss the man's care. The review was attended by a hospice doctor, a palliative care nurse, the prison doctor, the head of healthcare, the chaplain, and the Deputy Governor. They decided he should not be resuscitated, although there is no record that this was discussed with him. It would have been inappropriate, at this time, to discuss this issue with the man, as he was suffering from confusion and distress due to the cerebral metastases in his brain. An entry in the man's notes said, "The palliative care nurse to undertake home visit to see the man's partner and discuss situation with her."

36. Plans were made to transfer him to a hospice a week later. A compassionate release application was to be considered. An assessment of the man's immediate nursing needs was discussed and a specialist bed was ordered from an outside source.

37. The next day, the man was moved back onto his bed as he was unwilling to have his mattress on the floor. His pain level had increased and he became distressed. The doctor agreed to increased analgesia and diazepam. A bed with sides was ordered and was due to arrive the following day, with a hoist to

assist lift the man. At this stage he was only taking fluids and was unable to eat meals. During the evening, the emergency doctor service was contacted because he was in pain and distressed. Extra medication was administered. The man had also become incontinent.

38. On 28 February at 4.10am, the man became unsettled and cried out in pain. Further medication was administered and two officers from the main prison came to healthcare to assist nursing staff lift him so they could attend to his hygiene needs. The man vomited at 8.15am, and appeared distressed.

39. At 9.50am, the man was reviewed by the doctor. The doctor recorded that he was not responding to verbal statements, his breathing was irregular and he was unable to take oral medication, therefore he was given a morphine injection. At 11.30am, a hospice nurse visited the man and, with the doctor, agreed that he should be admitted to the hospice. A release on temporary licence was completed by the prison.

40. At 1.00pm, the man was taken to the hospice. The chaplain accompanied him in the ambulance. The man's partner was contacted and informed of his admittance to the hospice. On arrival at the hospice, the chaplain introduced herself to the hospice staff and the man's partner. The chaplain then left the hospice. The man died with his partner by his bedside at 5.55pm.

41. The man's partner was unsure of the financial arrangements for the man's funeral. Hospice staff informed her that financial assistance could be gained through the local authority. When the chaplain made contact with the man's partner to discuss funeral arrangements, she was told that some financial assistance had been made through the local authority. The chaplain made representation to the Governor and the prison offered expenses to make up the remainder of the financial shortfall for the man's funeral.

42. On 10 March, the chaplain officiated at the man's funeral, and a memorial service was held in the prison's chapel. Support was offered to prisoners and staff.

ISSUES

Clinical Care

43. A review of the man’s medical care was commissioned with Devon Primary Care Trust (PCT) and carried out by a clinician. Also a panel of clinicians met to appraise the review and endorsed the recommendations on behalf of the PCT.

44. They reviewed the man’s medical records and a report by the prison’s doctor. References were also made to his core record, and the hospice records. My investigator also requested that the clinician look at the physical environment of the man's cell on the healthcare unit.

<u>Continuity of care and medical records</u>

45. The clinical reviewer together with the review panel concluded;

> “All previous medical records should be sought to ensure continuity of care and that community doctor records or a doctor summary should be obtained to ensure continuity of care. The performance targets require 100% of patients to receive secondary health screening. There was no documentation that indicated The man had received a secondary health screen.”

They further added:

> “All entries in medical notes should be signed by the person attending the patient and their names printed in case of any queries arising from the consultation or treatment prescribed. All entries in medical notes should be signed by the person attending the patient and their name printed, the record must be dated and timed … Care must be taken with medication entries in the medical records and referral letters, to prevent inconsistencies and medication errors arising.”

I endorse the following recommendation

Medical records should be sought from previous custodial sentences and community doctor to ensure continuity of care. All entries in the inmate medical records should be completed, legibly signed with date and time and presented in chronological order including all health screening documents.

<u>Escorts</u>

46. The man should have attended an out patient appointment in early November 2007. This appointment was cancelled through a lack of escort staff. The appointment was rearranged and was not considered to have an effect on the man’s treatment. However, the doctor made an appeal to the prison that

subsequent appointments should not be cancelled. Appointments for medical procedures should not be cancelled because of the absence of an escort.

47. It is important that prisoners attending out patient appointments should not have appointments cancelled, especially when there is an indication of a potential serious illness.

Healthcare staff should be consulted before a prisoner's out patient appointment is cancelled to determine the nature of that appointment and its importance.

48. There was evidence of good practice by healthcare staff in sending a nurse to accompany the man for his out patient appointment on 3 December 2007. Furthermore, when the man was transferred to the hospice he was accompanied by the chaplain. At this stage, he had been released on temporary licence, and so there was no necessity for him to be escorted by officers.

Palliative Care

49. The clinical review concluded that diazepam should only be prescribed as recommended for seizures and recommended medication should be prescribed for agitation. The reviewer said,

> "Best practice would suggest that diamorphine and stemetil should not have be given to the man at an earlier stage of his deteriorating condition as this would have been more appropriate as analgesia than diazepam at the later stage of his illness. Diazepam is not a treatment of choice in palliative care as per the joint formulary for symptoms of agitation of confusion , first line treatment is midazolam, haloperidol and levomepromazine. A joint formulary should be followed for palliative care prescribing."

50. Furthermore, the review found that a syringe driver, of analgesia should have been prescribed earlier in the man's treatment. It might have prevented some agitation and made the pain easier to control. If a syringe driver could not be provided in the prison then the man should have been transferred to the hospice earlier in his care.

I endorse the following recommendations:

Training needs for staff in palliative care should be identified and arranged. Palliative care patients should have a comprehensive management plan in advance, reflecting the actual and anticipated needs of the patient.

Care must be taken with medication entries in the medical records and referral letters, to prevent inconsistencies and medication errors arising. A joint formula should be followed for palliative care and prescribing in line with instructions from hospice staff. The Gold Standard Framework (community palliative care plan) should be adopted within Devon prisons.

As the man's condition deteriorated, he was placed in the healthcare unit so that his nursing care could be better managed. Palliative care information and advice was sought through the hospice and the man was seen by a palliative nurse whilst in the healthcare unit and on the wing. Specialist equipment was required to support the man's nursing care plan. Some of this equipment was not delivered in time to help the nursing staff care for him. Palliative care nursing in a busy local prison like Exeter is difficult to manage and the equipment is not readily available in this setting. On two occasions, healthcare nurses had to rely on wing staff to help lift the man as a hoist was not available.

51. The man's partner raised the important issue of the way in which palliative care is addressed in prisons. She appreciated that the prison did their best to look after the man and herself, but she felt they were disadvantaged by lack of money and trained staff. The man's partner hoped that this report could look at this issue so that lessons could be learned for the future.

<u>The man's location</u>

The wing

52. The man should have been transferred to the healthcare unit on 30 January after he fell on the wing. There were 16 beds in use that night in the healthcare unit. It may have been appropriate to transfer a prisoner from a single cell to the ward to free up a single cell for the man. If he had refused to leave the wing, then it should have been documented in his medical records.

53. The man told friends that he preferred to remain on the wing as when he was in healthcare he had no access to showers. In practice, there was a shower in the man's cell, but by this time he was confused. The man said that on the wing he could rely on friends to help him with his personal hygiene. The man's partner did appreciate that due to his confused state, he may have refused showers. However, she felt that more could have been done to coax and persuade him to shower.

54. The man returned to the wing from healthcare for seven days at the end of January. A wing officer saw him in healthcare at the end of January. The man told the officer he was unhappy in healthcare, felt isolated and preferred to be with his friends. With the support of this officer and staff on the wing, the man returned there. He was supported by his friends, who knew him well and assisted him with day to day living. The wing officers ensured that the man was cared for properly. However, after seven days, it became impossible for him to remain on the wing, as his health was deteriorating. For

health and safety reasons, the man returned to the healthcare unit where he could be nursed more adequately. In terms of the man's dignity, it would not have been appropriate for his friends of his to act as nurse carers for him.

I note the support of the wing staff and prisoners for the help and support they offered the man.

55. The clinical reviewer concluded that patient manual handling training should be mandatory for all healthcare staff. Also the equipment available to help staff and patients within the prison should be reviewed

Patient manual handling training must be mandatory for all healthcare staff. Access to equipment within the prison healthcare setting should be urgently reviewed.

Healthcare centre

56. The unsanitary state of the man's cell has been raised by members of the prison staff and visitors. A care plan dated 2 February 2008 said that staff should assist the man with activities of daily living. This is something that particularly concerned the man's partner.

57. The man was visited by two friends from the wing whilst he was in healthcare. One of his friends told my investigator that the condition of the cell was unacceptable. It was unclean and the toilet bowl had dried faeces on the rim and inside the bowl. The friend described the smell as unbearable. Both friends tried to clean the toilet on one of those visits. The man's mobility was impeded by his condition and it was noted that his vision was deteriorating.

58. On the day the man was admitted to the hospice, the chaplain told my investigator that she found the toilet area to be unclean with a bad smell.

59. My investigator saw the man's cell in healthcare whilst visiting the prison on 20 March. The cell was in need of decoration and in my view was unsuitable for a prisoner with a terminal illness. The cell was equipped for double occupancy, but whilst the man was located there, he occupied it alone. A double cell was required accommodate a suitable bed but nevertheless, there was little space then left to move around in. The toilet and shower area showed signs of wear and the fabrication of those facilities looked stained.

60. At interview a Senior Officer (SO) told my investigator that the man's cell was cleaned daily by the wing orderly, with the exception of the last two days before the man died. The SO did not allow the wing orderly into the cell for those days, to preserve the man's dignity as he was so ill. By this stage the man was being nursed in bed and so nursing staff took care of his hygiene needs. The SO also told my investigator that the toilet and floor were made of a fabric that stained easily. Bleach is not allowed as a cleaning fluid in healthcare and stains are impossible to remove. This does not negate the necessity for thorough cleaning.

61. The SO also said that the internal décor is difficult to keep up to standard as the paint is removed from the walls when they are cleaned. I endorse the recommendation made by the clinical reviewer regarding the physical environment in the healthcare unit.

Healthcare staff must ensure that all cells are clean and sanitary and patients must be cared for in an environment which is clinically clean and fit for purpose.

The physical environment on healthcare should be reviewed and has been highlighted as requiring significant investment for improvement.

62. There was evidence of good practice, which should be commended within the clinical review. Firstly, I welcome the early engagement with hospice care and the named nurse support from the hospice. There was good pain control from the emergency doctor service, consistent with the joint formulary in palliative care prescribing.

63. Healthcare staff offered support to the man and this was evidenced by staff taking time to help him come to terms with his diagnosis and accompanying him to outpatient appointments. A comprehensive nursing care plan was identified for the man on his admission to the healthcare unit.

64. A full nursing plan was implemented when the man was admitted to healthcare. The plan indicated when the man's personal hygiene needs were met by either nursing staff or the man himself. There is no evidence in the nursing care plan that he was left in soiled clothing. He was a large man, requiring two to four people to move him in his bed. Two nursing staff told my investigator that when the man had two falls out of bed the day before he died, they had to rely on wing staff to help them return him to bed. Afterwards, the nursing staff would have alerted extra staff to help move him and ensured he was changed and made more comfortable.

Family liaison

65. The man's partner would have liked to have been notified earlier about his worsening condition. However, his sudden deterioration was unforeseen.

66. The post mortem examination found that the man died of perforated sigmoid colon (tumour in the bowel). This secondary form of cancer had not been detected by hospital staff. Two days before his admittance to the hospice, a case review was held and plans were underway to arrange his transfer in a week's time.

67. I understand the man's partner's shock at the sudden deterioration. However, the now known cause of his death indicated that hospice staff and healthcare staff were unaware of the tumour that caused the rapid decline in his health.

68. I endorse the recommendations in the clinical review, which addressed the palliative care available in the prison. I hope that those recommendations

answer the man's partner's concerns about the provision of palliative care in prison.

Funeral Expenses

69. The man's partner was advised by hospice staff to apply for local authority funding for his funeral. She was not aware of the prison's obligation to assist with funeral expenses under Prison Service Order 2710. This is a sensitive subject to discuss with family, and especially in the man's case as he had been released on temporary licence. Nevertheless, it would have been appropriate for his partner to have been told of this arrangement, in a sensitive manner, when he was admitted to the hospice.

The Governor is reminded of the prison's obligation to offer funeral expenses in accordance with Prison Service Order 2710.

Family issues raised from draft report

75. The man's partner responded to the draft report. She still felt that her partner had not received appropriate palliative care in Exeter, whilst waiting to be transferred to the hospice. She was still concerned about the sudden deterioration in her partner's condition.

76. In response to those concerns the draft report does make recommendations about future palliative care measures that require addressing in Exeter. The PCT have responded to those recommendations.

77. The man's death was due to a tumour rupturing in his bowel causing peritonitis. This tumour had not been identified by the hospital. The man's cancer was well advanced and secondary tumours had spread across his body, healthcare staff and hospice staff were not aware of this undiagnosed tumour. The day before the man was admitted to the hospice, a multi-agency meeting had been held at Exeter and arrangements were underway to provide a bed for him there in seven days time.

78. Both the man's partner and his brother told my family liaison officer that on a visit to see the man a person from healthcare services told them that when the man came towards the end of his life he would be in a nice room where they could visit and be with him. I assume this was referring to the hospice. I was unable to speak directly to this person, but spoke to the head of healthcare who told me that this person was referring to the physical environment provided by the hospice.

79. I understand the man's family's concerns over his care at Exeter and my family liaison officer has spoken to the family about the process of the man's inquest, where questions regarding the man's diagnosis and hospital care could be raise, which are outside the remit of my office.

RECOMMENDATIONS

For the Chief Executive of Devon Primary Care Trust

1. Medical records should be sought from previous custodial sentences and community doctor to ensure continuity of care. All entries in the inmate medical records should be completed, legibly signed with date and time and presented in chronological order including all health screening documents.

   Accepted – "Records are being sought from the last period in custody when disclosed. We are undertaking a pilot of obtaining records from the community. Records for all cases where a prisoner declares on going health problems and where treatment for a condition is required are sought from either a GP or Hospital consultant to ensure continuity of care and prompt follow up.

   Audits of IMR's are being undertaken and a review of the in patient care plans are also being undertaken."

2. Training needs for staff in palliative care should be identified and arranged. Palliative care patients should have a comprehensive management plan in advance, reflecting the actual and anticipated needs of the patient.

   Accepted – "We have an End of Life policy in place and work closely with our colleagues in the local hospice. Two staff have undertaken further training with the Hospice care team. Staff will be detailed to attend further training events."

3. Care must be taken with medication entries in the medical records and referral letters, to prevent inconsistencies and medication errors arising. A joint formula should be followed for palliative care and prescribing in line with instructions from hospice staff. The Gold Standard Framework (community palliative care plan) should be adopted within Devon prisons.

   Accepted –"The joint formulary is followed and instruction/guidance for prescribing is always sought.

   The Gold Standard Framework is written into the end of life policy and is directed by advice from our hospice care colleagues."

4. Patient manual handling training must be mandatory for all healthcare staff. Access to equipment within the prison healthcare setting should be urgently reviewed.

   Accepted – "A review of the use of the joint equipment store is being undertaken by the commissioner. The needs of individuals are as directed by the hospice care staff. Manual handling training is being sought for all staff."

5. Healthcare staff must ensure that all cells are clean and sanitary and patients must be cared for in an environment which is clinically clean and fit for purpose.

   Accepted – “All the cells in HCU have been painted by the works staff.
   There is sometimes a conflict with keeping the cells in excellent order and the availability of painters to undertake after a problematic prisoner.
   Staff on the unit supervise orderlies in cleaning cells, where a patient is unable to undertake this due to health problems. Staff will also clean cells where it is not ethically acceptable for another prisoner to undertake this. HMP Exeter is pursuing the commissioning of separately employed cleaning staff in line with the recent Infection Control audit which will, in time, enhance and professionalise this situation.

   Due to the resin made toilets, stains are impossible to remove without bleach products, which are unavailable, but these are cleaned daily. Appropriate cleaning will be included within a commissioned service specification.”

For the Governor of HMP Exeter

1. Healthcare staff should be consulted before a prisoner’s out patient appointment is cancelled to determine the nature of that appointment and its importance.

   Accepted – “Detail managers have been instructed to comply with this. Any conflict is then referred to the Duty Governor.”

2. The physical environment on healthcare should be reviewed which has been highlighted as requiring significant investment for improvement.

   Accepted – “This is being done as a result of the previously mentioned Infection Control audit.”

3. The Governor is reminded of the prison’s obligation to offer funeral expenses in accordance with Prison Service Order 2710

   Accepted – This is noted

Good Practice

1. I note the support of wing staff and prisoners on the wing for the help and support they offered the man.

2. I further note the good practice of nursing staff indicated in the clinical review.