

**Investigation into the death
of a man on 28 December 2006
whilst in the custody of HMP Channings Wood**

Report by the Prisons and Probation Ombudsman for England and Wales

October 2007

This is an investigation into the circumstances surrounding the death of a man on 28 December 2006. The man was a prisoner at HMP Channings Wood, and had been diagnosed with pancreatic cancer on 8 December. He died as a result of his illness. He was 65 years old.

I extend my condolences to the man's family and to all those touched by his death.

The investigation was undertaken by one of my colleagues. Both my colleague and I would like to extend our thanks to the Governor of HMP Channings Wood and her staff for their cooperation during the investigation. Thanks also go to the prison's liaison officer for gathering all relevant documentation and ensuring it was made available in a timely way.

The Devon Primary Care Trust (PCT) carried out a clinical review into the healthcare the man received at Channings Wood. I extend my thanks to the PCT's review panel members for completing the review so speedily, and for the recommendations drawn from their findings.

The man had first displayed symptoms of his illness in August 2006 when he presented to medical staff with back pain. The pain was monitored and he was ordered to rest in cell on numerous occasions and to refrain from participating in activities. His symptoms worsened and, following several hospital referrals for tests, he was diagnosed with pancreatic cancer in early December. He was cared for at Channings Wood until his illness deteriorated and 24-hour healthcare was needed. He spent his last few days in the healthcare centre at HMP Exeter before transferring to hospital, and then to a hospice on the day he died.

Once his illness had been diagnosed, the man was cared for in the same way as if he had been in the community. He received good care and support from both healthcare and discipline staff. Every effort was made to carry out his requests, particularly in relation to his family. I commend the work of staff to ensure his family were as involved as far as possible in his palliative care. I also highlight other areas of good practice.

I make no recommendations. Indeed, I have been very impressed by the actions of Channings Wood that were revealed by my investigation. However, the clinical review panel has identified a number of areas which would serve to enhance clinical services for prisoners. I urge the prison health partnership to consider these as part of their ongoing service development.

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Prisons and Probation Ombudsman

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SUMMARY

The man was convicted of a serious offence on 17 December 2004. He was sentenced to seven years in prison. This was his first custodial sentence. He was sent to HMP Gloucester direct from court and moved to HMP Dartmoor a few months later. He remained at Dartmoor until 26 September 2005 when he was transferred to HMP Channings Wood.

He settled well at Channings Wood and had been there for just under one year when he began to experience back pain in the autumn of 2006. The man's symptoms worsened over a number of weeks and, after a series of exploratory procedures at the prison and outside hospitals, he was diagnosed with terminal cancer of the pancreas in early December.

He remained at Channings Wood until 22 December 2006 when he transferred to a 24 hour healthcare facility at neighbouring HMP Exeter. On 27 December, he was admitted to the Royal Devon and Exeter Hospital after he was found collapsed in his cell. He deteriorated rapidly and a bed was made available at a hospice the following day.

The man was admitted into hospice care on the afternoon of 28 December and his family remained at his bedside. He died peacefully at 8.45pm the same evening.

This report centres on the need for good partnership working and regular information sharing and communication when caring for someone with a terminal illness in a prison environment. Prisons are not designed for an ageing population and those with terminal conditions. Despite this, a prison has the same duty of care as a community facility to deliver NHS standard healthcare services to patients. Channings Wood demonstrated this standard throughout. The man was examined, referred, and managed on his wing until this was no longer possible. Along with his family, he was involved in his own care plan until he transferred to the hospice in his final hours.

My investigation has revealed many examples of good practice and I have made reference to these in this report. I would welcome these examples being shared by other prisons. The clinical reviewer also comments positively on the care the man received, but does point to six areas where services could be improved.

THE INVESTIGATION PROCESS

1. The investigation was opened on 10 January 2007. My investigator began by requesting all relevant prison records relating to the man. These included his medical and core records covering the time he spent in prison.
2. Notices to staff and prisoners were supplied and displayed around the prison. These invited anybody with information to talk to my investigator. In this instance, nobody came forward. My investigator examined the records and recorded significant events before visiting Channings Wood herself. Using the evidence gathered from his records, she identified a number of key areas of good practice. On visiting the prison in April 2007, my investigator interviewed the Head of Operations.
3. Devon Primary Care Trust (PCT) was commissioned to undertake a review of the clinical care the man received while in custody. A panel review took place, and it is included in full as an annex to this report.
4. The Coroner was informed of the Ombudsman's investigation. However, the post mortem report was not available at the time of the investigation. The Coroner will receive a copy of this report when it is completed to assist him with his enquiries.
5. One of my Family Liaison Officers contacted the man's family to discuss the purpose of the investigation, and to offer them the opportunity to raise any concerns or questions about his time in prison. The man's family raised no concerns about the prison healthcare he received and commended Channings Wood for the way his death was handled. However, his family did express concern over the quality of care and conditions at the Royal Devon and Exeter Hospital, prior to his transfer to a hospice. My Family Liaison Officer advised the man's family that issues surrounding hospital care were beyond the scope of my investigation, but did provide them with information on how to contact the Health Service Ombudsman. The family will receive a copy of my report.

HMP CHANNINGS WOOD

6. HMP Channings Wood is a category C training prison for convicted adult men. Built on the site of a Ministry of Defence base, work commenced in 1973 and the prison was officially opened the following year. Further construction work was undertaken during the 1980s, which resulted in additional accommodation units. This brought the operational capacity to 667.
7. There are a total of seven residential wings and prisoners are allocated places according to their category, status or needs. There is a wing for drug treatment, induction, enhanced status prisoners, and vulnerable prisoners both high and low risk, in addition to general wings.
8. The most recent inspection by Her Majesty's Chief Inspector of Prisons (HMCIP) was carried out in November 2004. The inspection was an unannounced follow up to a full inspection that took place in November 2002. The follow up inspection found that Channings Wood continued to provide a positive environment for its population. Of the 97 recommendations made in 2002, 68 had been achieved or partially achieved, including a revised shift pattern for staff to reduce the redeployment of officers to all parts of the prison, and thereby secure good staff-prisoner relationships.
9. Against the healthy prison tests of safety, respect, purposeful activity and resettlement applied by HMCIP, Channings Wood was described as performing reasonably well. Inspectors found a "calm and safe place" with "relaxed and friendly" staff-prisoner relations, but stressed that more work needed to be carried out to increase purposeful activity and improve the resettlement of prisoners prior to their release.
10. Maintaining links to family and friends of prisoners forms part of this resettlement strategy. Channings Wood was criticised in 2002 for not providing a visitors centre. (Such a centre is now in place. I personally conducted the official opening in the spring of 2007.) When prisoner's families and friends did visit prisoners, Inspectors were told that they were treated well.
11. HMCIP found the relationship with the local Primary Care Trust was well established at both managerial and practitioner levels. Good health promotion services were being maintained and the 'well man' clinic had teamed up with gym staff to run a joint health promotion initiative. Inspectors reported positively on the standard of primary and clinical care and found good nurse-led clinics for asthma and diabetes. However, the follow up inspection did find that a recommendation to review staffing levels and the skills mix to further develop nurse-led clinics and chronic disease management had only been partially achieved.
12. Channings Wood forms part of the Devon 'cluster' of prisons and shares its healthcare resources with HMP Dartmoor and HMP Exeter. The links between Channings Wood and Exeter's in-patient facility are good and prisoners in need of short term 24-hour care are managed well.

Elderly prison population

13. Prisons are not principally designed for the elderly, and it is difficult for an individual establishment to accommodate an aged population. A thematic review by HMCIP in 2003, found that, although older prisoners make up a small percentage of the overall prison population, the number of elderly prisoners had trebled between 1992 and 2002 and was continuing to grow. The study also said that there was no overall strategy throughout the prison estate for assessing and delivering a regime that addressed the needs of older prisoners.
14. The thematic review found that some elderly prisoners will inevitably spend the rest of their lives in prison. Early release from prison on medical grounds for severely or terminally ill prisoners is subject to restrictive criteria and the thematic review stressed that the prison environment must be geared towards meeting the specific needs of its ageing population.
15. With the exception of a small number of establishments, prisons do not provide a separate regime for elderly prisoners. Channings Wood has seen an increase in its older prisoner population over the last four years. In 2002, approximately 10 per cent of all prisoners were over 50 years old. In 2004, this had increased to 13 per cent. The increase in the number of elderly prisoners has led to the need for regime and healthcare services to reflect this change.
16. HMCIP summed up healthcare provision at Channings Wood: "Despite low staffing levels, there was evidence that staff were professional and caring and provided clinical care to meet the needs of their patients."

KEY FINDINGS

17. The man was sentenced on 17 December 2004, and went to HMP Gloucester from court. He was healthcare screened as part of Gloucester's reception process and told the nurse he was 'borderline' diabetic. He was transferred to HMP Dartmoor on 10 January 2005. He then transferred to Channings Wood on 29 September. He was seen by a nurse and a brief medical history was taken. The man told the nurse he had problems with his heart, but was otherwise stable. His hypertension, high cholesterol and impaired glucose tolerance were also recorded and his medication was listed as ezetimibe and bendrofluazide. The man settled well onto his wing and spent the next few months participating in education.
18. He did not come to the attention of healthcare staff again until almost a year later. On 29 August 2006, he reported having been in pain for about three days. Wing staff noticed that he had been vomiting, and a nurse was called to see him in his cell. The nurse completed a 'Rest in Cell' form which said that the man was to refrain from taking part in the prison regime for one day. He was prescribed buscopan for back pain.
19. On 27 September, he was referred to the healthcare centre's cardiac clinic for a secondary healthscreen. A week later, the man was ordered to 'rest in cell' again following further complaints of back pain. He was due to attend education, but on seeing a Healthcare Officer (HCO), the man was told to refrain from participating for another day. He was seen by one of the prison's doctors, three weeks later on 20 October. The doctor wrote in his medical records that his pain was located in the lower lumbar region and was 'niggling'. The man was described as able to sit, stand and walk with no difficulty, but his medication (naproxen) would be stopped.
20. His back pain persisted and he was ordered to rest in cell on another two occasions. The results of blood tests taken on 20 October did not provide the doctor with any other diagnosis. On 30 October, the doctor referred him for an ultrasound scan at Torbay Hospital and a spinal x-ray at Newton Abbot Hospital.
21. The man was health assessed as an elderly prisoner on 1 November 2006. This assessment was carried out by an HCO and gave a comprehensive account of his health, mobility and lifestyle. The HCO completed an Elder Care booklet. Included in the booklet were details of the man's diagnosis of hypertension in the community and his being in possession of medication for the condition. He also suffered from obesity, but did not have a history of alcohol, drugs or dietary problems. Due to his high blood sugar, the man was assessed as 'borderline' diabetic. The HCO made an appointment for him at the obesity clinic. He was also advised to choose a healthy diet and to attend the over 65s gym.
22. On 8 November, the man presented as unwell in his cell. Other prisoners on the wing had been concerned that he was not eating properly and a nurse was called. On arrival, the nurse found him lying on his bed. He was asked if

he was in any pain and told the nurse that it had not increased since the last time. His observations were taken. He remained anxious, fearing that he could have cancer. The nurse reassured him that his symptoms could be linked to a number of conditions. A note was made in the man's medical record that a spinal x-ray appointment had been made for 21 November at Newton Abbot Hospital.

23. The following day, the healthcare centre received a letter from Torbay Hospital confirming his gastroendoscopy appointment for 23 November. He was also seen at 8.15am in his cell and presented with the same physical symptoms and anxiety.
24. Two days later, on 11 November, the man collapsed in his cell. An urgent call to Hotel 2 (the nurse on emergency call) went out at 8.15am. A HCO responded but found him breathing normally. The man explained that, prior to his collapse, he had experienced severe abdominal and back pain. Again his observations were taken and a full report of his collapse was entered on a casualty form in accordance with local procedure. The HCO made a note which said that, in view of the man's recent medical problems, the pain he had for approximately four weeks and the abnormal blood results and weight loss, an ambulance had been called to transfer him to Torbay Hospital.
25. Half an hour later, the same HCO radioed the communications room to chase up the ambulance request and found it had been diverted to a road traffic accident. A rapid response vehicle arrived at 9.00am in place of the ambulance. The paramedic confirmed that the man needed a transfer to hospital. He was given analgesia to relieve the pain while he waited for an ambulance to take him. At 9.30am, the ambulance arrived and he was transferred to the Accident and Emergency Department at Torbay Hospital. A summary of his notes, referrals and test results accompanied him.
26. The man returned from hospital later the same day. Healthcare staff noticed that he had been sent back without a discharge letter but was in possession of medication. They recorded this appropriately.
27. He underwent an urgent ultrasound scan on 13 November and a full report was completed by the hospital practitioner. The report said that multiple hyper-echoic defined areas had been found in his liver, but that the pancreas could not be seen properly due to an obstruction. The hospital practitioner said that a referral was required for further investigation following these findings.
28. On 15 November, a Coronary Heart Disease checklist was carried out and information obtained from the man and his medical record was separately recorded by the nurse. The nurse noted that he complied well with the screening and only stopped attending the gym in October due to his back pain.
29. Following the man's spinal x-ray on 21 November, he underwent an endoscopy at Torbay Gastroenterology Unit two days later. He tolerated the

procedure well and was diagnosed with gastritis and an 'unusual ulcerated area' following the procedure. A letter from the Unit to one of the doctor's at Channings Wood confirmed that a biopsy would be carried out and that the man would be referred to the gastroenterologist to explore the findings further. He returned to Channings Wood and went back to his cell in the main part of the prison.

30. During the last week of November, the man continued to present with abdominal and back pain. Healthcare staff were called to his wing again and he was advised to take his medication (co-codamol) and to see the prison doctor.
31. On 7 December, a clinical report following the man's outpatient appointment at Torbay Hospital was received by the healthcare unit. The report explained that the initial examination had uncovered 'a very large mass on the head, neck and body of [the] pancreas, typical for [a] tumour'. The report went on to explain that this was indicative of an advanced tumour and that a biopsy should be possible. He was told about his diagnosis on 8 December by a prison doctor.
32. Immediately after the man's diagnosis was received, the healthcare governor at Channings Wood, was informed that an application to support his early release on compassionate grounds had been activated. This was in accordance with Prison Service Order (PSO) 6000. Both the prison's doctor and the hospital consultant, the prison's probation officer, and the governing Governor were all told they would have to produce a written report in support of the early release application. The duty governor told the officers on the man's wing about the early release application. A Senior Officer (SO), also from his wing, then told the officers to pass the information on through wing history sheets and observation books. The chaplain was also told about the application and suggested that the chapel might be a suitable place to use for any family visits.
33. On 13 December, the healthcare unit sent an abridged version of the man's initial diagnosis and assessment to prison staff working at the gate. The assessment told gate staff to expect a visit from Macmillan nurses, a liver specialist and the man's family the following day. The main purpose of the assessment was to bring gate staff up to speed with his symptoms, medication and physical needs in the event that they would need to contact the doctor out of working hours.
34. Later that day, a full healthcare review took place. The review was led by a HCO with the man's full co-operation. At the meeting, his daily living needs were explored, agreed and then recorded in his medical record. The entry was extensive and covered every aspect of his care from mobility to hygiene, diet, psychological needs and pain management. At the time of the review, the man remained on his wing, could use the showers independently and had some mobility. It was agreed that a wheelchair would be provided to ease his access to the chapel and social rooms for visits, and that some of the standard furniture in his cell would be replaced with a more comfortable

armchair, an extra mattress and a pillow. In terms of regime activity, the man was unfit for work. But in order to prevent isolation, and to encourage activity on his wing (LB5), wing staff were instructed to leave his cell door open during core hours and to shut it only during patrol states. This was effectively an open door policy.

35. The man needed assistance in coming to terms with his illness. To address his psychological needs, it was agreed at the review that the wing manager, a Principal Officer, would instruct officers to permit two other prisoners from wing LB7 to visit the man for peer support. Arrangements were also put in place for his family to make full use of the permitted four visits per month, and for him to have maximum access to the Samaritans, Listeners on the wings and the chaplaincy service. Palliative care nurses had arranged to visit him the following day to explain what further support he could receive, if he felt he wanted it, and that his pain management would be reviewed on a daily basis.
36. The next day was a difficult one for him as he told his family about his illness. The chaplaincy service facilitated the visit and accommodated the man, and his family in the prison chapel. The Head of Healthcare had previously offered to speak with his family if that was what they wanted. They did, and the Head of Healthcare provided answers to a number of questions the family had which centred on the care and treatment he would receive post-diagnosis.
37. In a memo to senior prison staff and one of the prison doctors, the Head of Healthcare explained that the man's family had asked about his prognosis, pain management and care plan. In reply, she had told the family that the oncologist was due to form an opinion regarding his prognosis the following week, but that the man might live for a few more months. She also said that he was currently receiving the same pain control methods that he would receive in the community. However, the Head of Healthcare had stressed that good pain management was dependent on him being honest about the levels of pain he experienced.
38. The man saw an Oncology Nurse Specialist (ONS), and the Hepatology nurse on the same day. He discussed his medication and palliative care with the nurses and was happy with the outcome. The Head of Healthcare passed the nurses' contact details on to the man's family at the nurse's request, and told them that the nurse was happy to answer any further questions they had.
39. His family were also told that Channings Wood had begun the process of applying for his release on compassionate grounds. The Head of Healthcare explained that she was waiting for a letter from Torbay Hospital detailing his prognosis to support the application. A nurse would be escorting him to the hospital the following week, and would try to obtain the letter then in order to speed the application process up. The healthcare manager made it clear to his family that she could not pre-empt the decision that the Home Secretary would make.

40. She also discussed the issue of resuscitation with the man's family. In turn, they told her that he had made the decision not be resuscitated if he should collapse. A HCO had witnessed this decision and the healthcare manager noted in the memo that this would be reviewed in line with the man's diagnosis in 28 days time.
41. His family had asked a number of prison-related questions that were better directed at a governor than the healthcare manager. With this in mind, the healthcare manager relayed their queries to the Head of Operations. The man's son expressed a wish to attend the hospital appointment the following week. The governor agreed it would be possible, given the exceptional circumstances, as long as security measures were properly in place. His family also understood that he could deteriorate quickly and wanted to be contacted day or night if he needed to go to hospital. In addition, his family had asked the following questions. (The questions and answers are as they appeared in the memo):

Can family photos be brought into the prison?

Yes, if checked by members of staff that the content is ok

How often can they [the family] visit and how is this arranged?

Normally two visits per month but feasibly can have one visit per week. Chaplain has confirmed visits for Monday and Wednesday next week are already approved.

Can they [the family] bring him anything?

Not usually, but in this instance if they tell the prison what they have in mind, it will be considered.

Can they [the family] help the compassionate release process?

No.

42. On 15 December, the healthcare centre discussed the issue of hospice care with a doctor from the hospice. The doctor said that the man would be accepted at the hospice, given his condition, but that he did not want any patient to remain in restraints. The governing governor did not feel that the transfer could be facilitated, citing the man's high risk status and, at that stage, his predicted prognosis of months rather than weeks, as the reasons.
43. During the following week, the man continued to present to wing and healthcare staff with symptoms of nausea. He was monitored and regular entries were made in his medical and wing records. He told healthcare staff that, since telling his family about his prognosis, he felt a weight had been lifted. His wife and son visited again on 18 December.

44. The following day, the healthcare manager wrote an extensive memo to both the Head of Operations, and the Head of Security. In it, she explained that the man's son would meet the escorting officer at the hospital for his forthcoming appointment.
45. The healthcare manager sent the memo in advance of the man's oncology appointment which had been made for 21 December. Both governors were informed that alongside his son, a member of the healthcare team and a senior officer, would accompany him to the hospital. The man's son was advised that he would be in restraints for the appointment, as set out in Channings Wood's local policy. The memo also recorded that his family had asked whether additional members of the family could visit. The healthcare manager requested details of each family member in order for the request to be considered.
46. The man attended the oncology clinic at Torbay Hospital as scheduled. At the clinic, he was given the results of his endoscopy procedure from 23 November. His biopsies confirmed carcinoma and he went for a CT scan on his chest and stomach. The results of the scan showed a large tumour in the pancreas that had invaded his blood vessels, stomach and duodenum. The consultant oncologist, explained the results to him. The man's illness was not operable and the main concern was to provide palliative care to manage his appetite, weight loss, nausea, and pain, especially his back pain. Treatment options were also explained and the man said he would discuss these with his family. The consultant stressed that there were two options, palliative chemotherapy or 'supportive care'. Because the man did not present as well enough for chemotherapy, the doctor advised him to choose symptom control care.
47. In a letter from the consultant to the prison doctor, dated 21 December, the man's results and details of the consultation and treatment recommended were clearly set out. The letter also confirmed that he would be referred to the hospice team. His prognosis was poor and estimated to be between three to four months. He was not told of his prognosis at his own request, however his son was made aware. The man returned to Channings Wood the same day. The healthcare manager provided further details of his appointment with the consultant in both a memo and in the man's medical records.
48. On the afternoon of 21 December, the healthcare manager was approached by wing staff on LB5 who were concerned about the man's planned move to another living block, LB7. She was told that he rarely left his cell and appeared unsteady when walking. Staff added that LB7 also presented toilet and phone access problems for him and questioned whether this was the right location. At 4.00pm, the man made his way to the treatment hatch on LB5 in a wheelchair, pushed by another prisoner. The healthcare manager then observed that he got up and 'walked hunched' to the treatment room. The man was tearful and told her that he was finding it hard 'to get his head around the news' of his illness. They discussed his condition together and she said that she was concerned he was in such a low mood and worried about giving him his medication in-possession. The man reassured her that

he would 'never do anything silly' because he had a wife and family. They agreed to talk later and he was escorted back to his cell.

49. The man saw her later that evening and they spoke for approximately half an hour. He explained that he had told the consultant that he was in more pain than healthcare staff at Channings Wood knew. On hearing this, the healthcare manager explained to him the importance of working with the healthcare team to properly manage his symptoms, and stressed that he must be honest about his pain levels. He said he wanted to stay at Channings Wood, rather than go to a 24-hour healthcare facility at another prison, or move to a prison closer to his family. He also expressed an interest in moving to LB7. The healthcare manager told him that the prison had a duty of care to ensure his health and safety and to support his needs when considering relocation. Thus an assessment of his capabilities would be needed in order to satisfy all concerned that he could access the toilet and phone on LB7. The healthcare manager made an entry in his medical records for a case conference between the man, a prison doctor and an SO. His care plan was also written up. This confirmed that his compassionate release paperwork would be forwarded to the Governor with an accompanying letter from the consultant.
50. The next morning, the healthcare went to see the man in his cell. They walked up the stairs together and he was told to take one step at a time. He ignored her advice and attempted to walk straight up the staircase. Once at the top, he felt faint and began to fall. The healthcare manager caught him, but he started to vomit and was convulsing. He was put in the recovery position. When he regained consciousness, he went back to his cell.
51. His case conference was held the same day. A governor, an SO, the healthcare manager and a member of the chaplaincy all attended, and the morning's event was discussed. They agreed that 24-hour nursing care was needed and the man's son was told his father would be transferring to a prison with better facilities. The healthcare manager liaised with the Governor to discuss a move to the hospice. The hospice doctor, said that a bed would be available, but the Head of Security at Channings Wood still did not feel the transfer could be facilitated from a security point of view. The prognosis from the consultant was three to four months. The man declined the offer of a transfer to HMP Gloucester, the prison closest to his home.
52. At approximately 6.15pm on 22 December, the man was transferred to the healthcare unit at HMP Exeter. On arrival he was allocated two named nurses to oversee his care. All relevant information from Channings Wood was passed to the staff. A healthcare assessment was carried out by a nurse and placed in his medical record. The assessment clearly stated the name of the man's oncologist and his next of kin details.
53. On 23 December, he complained about his move to Exeter, saying he missed Channings Wood. He stayed in his cell all day and presented as ambivalent in mood. He said he was comfortable, but looked in discomfort and experienced further back pain and nausea. A pressure sore incidence form

was completed and recorded some discolouration to his skin, but no actual pressure sores. A grade 1 pressure score indicator was marked on the form and he was given a Flotech cushion and a pressure relieving mattress to aid his comfort.

54. His care plan mirrored the plan from Channings Wood. A nutrition assessment score of 18, which indicated that he was 'very high risk', was also recorded. This meant that he had difficulty chewing and swallowing and efforts would be made to increase his intake of food and fluids safely.
55. The following day, he was given an emergency PIN for the phone so that he could contact his family. The healthcare manager contacted a nurse at Exeter and told her that a hospice bed had been booked in the event that he needed to be transferred. The healthcare manager explained that all the contact details and escort staff information needed for the transfer were in the man's medical record.
56. At 10.25am on 25 December, he was seen by a doctor at Exeter. The doctor noted that the man had underestimated his pain levels, and that consequently these were not being controlled. The doctor confirmed that he was aware of his prognosis and his wish not to be resuscitated.
57. The man deteriorated further on 26 December. He was seen by another doctor, following a report by a nurse that he had been vomiting fluid. He was prescribed laxatives. He had been observed by the nurse earlier that morning as not aware of his surroundings when he was taken to the phone. He continued to vomit and was seen by a doctor again at 4.55pm. The doctor decided to transfer him to the Royal Devon and Exeter Hospital. His family were to be advised that it could be life threatening.
58. At some point on 27 December, the man returned from the emergency medical ward at the Royal Devon and Exeter Hospital. Prior to his admission, healthcare staff entered his cell and found him collapsed on the floor, vomiting excessively. On closer inspection, he had sustained an abrasion above his right eyebrow. A nurse applied a cold compress to the wound and completed an F213 injury form to record the incident. The man's son was informed. However, the hospital transfer was not recorded in his medical record.
59. While he was in hospital, the healthcare manager contacted Exeter to confirm that the hospice bed had been booked for 28 December. A full risk assessment was completed, detailing the level of escort, restraints to be used and additional security instructions relating to which duty governor to contact if his risk were to alter. For the hospital, the man was escorted by two officers and a single cuff and escort chain was applied. This part of the risk assessment, completed by a nurse at Channings Wood, clearly stated that if escort officers wished to deviate from instructions the duty governor must be contacted to grant permission. At the bottom of the assessment, a footnote was added. It said:

“Due to the sensitivity of his illness, it is important to remain in close contact with the duty governor. It would be unacceptable for this man to die in handcuffs and reasonable action will be supported should an arrest take place.”

60. The risk assessment was a nine part document, designed to cover every possible risk element. It was completed by a member of the probation service, healthcare and security, and was authorised by a governor representing the senior management team at Channings Wood. Following a discussion with the governing Governor, the risk assessment stipulated that restraints were to be used until the man’s relocation to the hospice. A governor gave his approval for their removal in the event of an emergency or treatment. The healthcare manager raised no medical objection to the use of restraints but reiterated on the risk assessment that the hospice lead clinician, had stated previously that he would not accept the man if he was cuffed on arrival. He was permitted to use the Patientline service in the hospital, under staff supervision. This meant that he could contact his family who in turn were given permission to visit once he had transferred to the hospice. The permission extended to his grandchildren for one visit (this was authorised by a governor).
61. On the afternoon of 28 December, the man moved by ambulance from the hospital to the hospice. He was accompanied by a principal officer (PO). A governor told my investigator that he felt it appropriate for Channings Wood to deploy its own staff to undertake bedwatch duty as this was a fairer use of resources, and that the PO had agreed to go. The man’s Prisoner Escort Risk (PER) form correctly stated that restraints must be removed on arrival and they were.
62. At 4.00pm, the hospice doctor examined him and asked for his family to be contacted due to his poor condition. The duty governor was also informed. The doctor then told the PO and an officer, also on escort duty, that the man might be dying. His family were contacted at 4.40pm and a pastoral visit was arranged at his request. At 4.55pm, a governor arrived at the hospice to update his risk assessment to reflect the doctor’s own assessment that he had deteriorated again. The governor ordered no further use of restraints and they were returned to Exeter. The man’s bedwatch log was completed at regular intervals in accordance with local instructions. Following a visit by the chaplain, his family arrived at his bedside.
63. At 8.30pm that evening, his condition rapidly deteriorated. His wife and two of his sons left the hospice, leaving his other two sons with him. The chaplain also stayed at the hospice. At 8.45pm, the man died with his sons at his bedside.

Events following the man's death

64. The PO contacted the control room at Channings Wood and then waited for the coroner to arrive at the hospice. At 9.15pm, the hospice doctor officially pronounced the man's death and the PO relayed this back to the prison.
65. An SO was the orderly officer (codenamed Oscar 1) that evening and in overall charge of the prison. On hearing of his death, the SO deployed a member of the control room staff, to begin a death in custody log of events. The Officer Support Grade (OSG) immediately contacted the duty governor, and between them the SO and the OSG contacted all the relevant authorities and agencies as stipulated in Channings Wood's local contingency plans. They experienced no difficulties in following the correct procedures.
66. Shortly after being informed, the duty governor contacted the man's family and offered to meet with them and the chaplaincy team. The governor then contacted the relevant external agencies, informed prison staff and arranged a hot debrief for staff to attend.
67. The man's funeral took place with his family in attendance. Channings Wood met part of the cost of the funeral in accordance with the relevant Prison Service national instructions.

ISSUES

68. The man arrived at Channings Woods about a year before he became ill. On arrival at Channings Wood, he received a thorough healthcare screening. This was followed up with an older prisoner healthcare needs analysis. From this second screening, he was referred to the appropriate nurse-led clinics and was encouraged to attend the gym and improve his diet and fitness levels as part of an elderly health promotion package.
69. Once he came to the attention of the healthcare team in the autumn of 2006, the healthcare manager took responsibility for his overall care. I am in no doubt that this care was at least of the standard he would have received had he not been in custody. It is a credit to Channings Wood's healthcare team, and the working relationship within the Devon cluster of prisons, that custody did not present a barrier to the delivery of a compassionate and supportive approach to the man's illness. I also judge that the healthcare manager acted over and above her formal responsibilities to ensure his care mirrored the care he would have received in the community.
70. Had he not been diagnosed with a terminal illness, he would have been monitored and cared for under the National Framework for Older Prisoners. Following an elder prisoner healthcare assessment, he was referred to nurse-led clinics in a timely way, and was encouraged to adopt a lifestyle that took into account his age and capabilities. From this assessment, the planned activity enabled him to participate in a more suitable and purposeful prison regime.

Delay to hospice admission and the use of restraints

71. The man was transferred to the hospice on the afternoon of 28 December and died later that evening. This was approximately two weeks after Channings Wood first learnt there was an opportunity to admit him to hospice care. It is clear from the records that the lead clinician at the hospice, had agreed to make a bed available on 15 and later on 21 December. However, these placements were made available on condition that the man would not be subject to any restraints as a patient.
72. His offence was of a serious nature and he remained a high risk prisoner, despite his illness. A prison has a duty of care both to the prisoner and to the public when considering a transfer to an outside hospital or other care facility, and I do not underestimate the difficulty in striking the appropriate balance between compassionate care and public protection. The man's risk assessment was thorough and completed according to Channings Wood's local instructions. When the first opportunity to transfer him to hospice care became available, the consultant oncologist estimated that he had approximately three or four months' life expectancy. This prognosis, coupled with the risk he posed, led the senior management team to take the decision that the removal of restraints could not be facilitated at that time. I believe this was a reasonable judgement in the circumstances.

73. He remained at Channings Wood, in his own cell, until he could not manage his illness independently. I believe the healthcare team did everything they could to keep him comfortable in his preferred environment for as long as possible, and only transferred him to 24-hour nursing care at HMP Exeter when he could not be cared for on the wing any more. When he deteriorated further and a hospice bed became available on 28 December, the duty governor acted speedily to authorise the removal of restraints so that the man could receive palliative care and a dignified end. I do not criticise the decision taken to delay his transfer to the hospice, and congratulate staff at Channings Wood for making his remaining weeks as comfortable as possible in a custodial setting.

Good practice

74. As early as 8 December, the senior management team at Channings Wood began the process of applying for the man's release on compassionate grounds. The decision to set this in motion was made at a time when the prison first learnt of the terminal nature of his illness but did not have a confirmed prognosis. The Prison Service Order (PSO 6000) which provides prisons with guidelines on how to apply for the early release of a prisoner was followed closely. Information required to support the application was gathered as quickly as possible from the consultant at Torbay Hospital, the governors and healthcare manager at Channings Wood, and the Probation Service. This process took approximately three weeks and, once completed, the governing Governor, emailed the Home Office personally to clarify whom to send the application to in order for a decision to be made. The man sadly died before a decision by the Home Secretary could be made. This unfortunate outcome says nothing of the efforts made by Channings Wood to release him, but may say something of the convoluted application process particularly over the Christmas period. I commend the senior management team and staff who contributed to his application so speedily.
75. The man played an integral part in his own palliative care, and so did his family. The staff at Channings Wood maintained family links throughout his illness, and involved his wife and sons in decisions over his care and well being as much as possible. His family was encouraged to make full use of the permitted four visits per month, and the chaplaincy team offered the use of the chapel for the difficult first visit when the man told his family he was terminally ill. The healthcare manager, met with the family and passed on their concerns to a governor who, in turn, provided accurate and reassuring answers without delay. Specific arrangements were made for the man's son to attend a hospital appointment, following his diagnosis, where treatment options were discussed. Additionally, extended members of his family were permitted to visit him shortly before his death.
76. Channings Wood maintained regular contact with his family and facilitated their requests where possible. I have no doubt that the links helped both the man and his family to come to terms with his illness. I commend the efforts made by all the staff concerned.

77. Throughout his illness, information was regularly gathered and shared with appropriate members of staff, his family and parties outside the prison. My investigator found many examples of this, most notably: the duplication of information relating to his diagnosis and care plan across all prison records and to his wing officer(s), an abridged version of his assessment to gate staff, memos to the senior management team and a complete transfer package for healthcare staff at HMP Exeter to follow when he was placed in their care. Again, I congratulate all staff, but particularly the healthcare manager, for keeping all parties up to date and ensuring he received a good standard of care.
78. The man was content on his wing and wanted to remain in the living blocks at Channings Wood for as long as possible. To ensure he remained comfortable, an open door policy was implemented following a needs assessment carried out by a Healthcare Officer. This meant that throughout the day officers were better able to meet his needs. The open door policy also stopped him feeling isolated. In addition, a Principal Officer instructed wing staff to allow two prisoners to visit the man in his cell for peer support. Once he deteriorated, he was moved to Exeter where he received 24-hour nursing care. I congratulate the HCO and PO for recognising how the regime could be adapted to meet the man's needs.
79. In sum, prison staff ensured that there was ample opportunity for his family to visit the prison, to attend a hospital appointment and eventually, the hospice, in what were exceptional circumstances. Family contact and ongoing communication was of a high standard and his next of kin were invited to participate as much as possible in managing his terminal illness. He was compassionately managed and transferred to an outside hospice in a timely way. That said, although there would have been no effect on the ultimate outcome, the clinical review has highlighted a number of areas where practice could be improved.

Clinical Review

80. The clinical review panel made the following comments:

“The man died at a hospice, following a rapid deterioration due to pancreatic cancer with widespread metastatic disease. It was difficult to provide a realistic diagnosis, until he presented with more overt symptoms warranting investigation during the autumn of 2006.”

“Pancreatic cancer is often described as having a relatively insidious onset with little warning, until the condition is well established and treatment options are limited. In this case, he was considered for a full range of interventions that were largely determined by his failing health and his own wishes. His prognosis was poor and deterioration rapid.”

“His end of life care was expeditiously and generally well planned with a difficulty encountered in formulating an appropriate plan informed by a security risk assessment prior to consideration for transfer to a hospice before

Christmas, compounded by his rapidly changing presentation. Regrettably but unavoidably, he was initially transferred to Type III healthcare at HMP Exeter prior to arriving at the hospice.”

81. The clinical review panel has identified a number of areas which the prison health partnership should consider as part of their on-going service development.