Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Malcolm Ball, a prisoner at HMP Stafford, on 30 January 2023

A report by the Prisons and Probation Ombudsman

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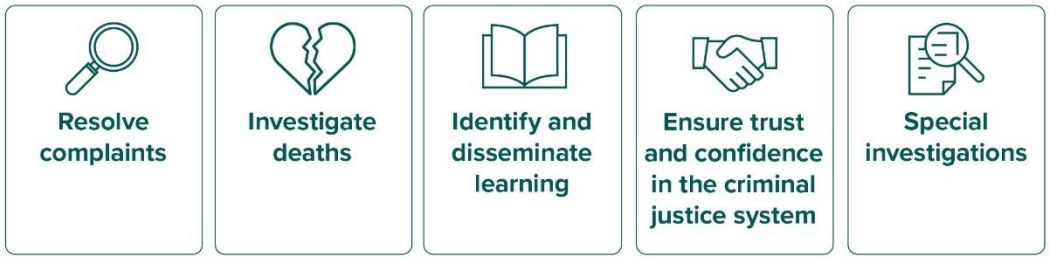
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

On 30 January 2023, at HMP Stafford, Mr Malcom Ball died of dehydration, secondary to ischaemic heart disease and chronic constipation, following a prolonged period of food and fluid refusal. He was 73 years old. I offer my condolences to Mr Ball's family and friends.

Mr Ball chose to stop eating a little over a month before his death. The clinical reviewer concluded that the care received by Mr Ball at Stafford was of the standard reasonably expected, and therefore equivalent to what he would have received in the wider community. She noted in her report that the care Mr Ball received was compassionate, and that his wishes were well documented, widely known, and respected.

We are satisfied that healthcare and prison staff did everything they could for Mr Ball in challenging circumstances. We make no recommendations. However, we have brought some matters to the Governor and Head of Healthcare's attention where policy guidance was not strictly followed, or processes could potentially be improved.

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

Adrian Usher
Prisons and Probation Ombudsman **November 2023**

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Summary

Events

1. On 16 August 2017, Mr Malcolm Ball was sentenced to seven years and six months in prison after being convicted of child sex offences.

2. Mr Ball experienced multiple physical health problems but had no recorded history of mental ill health diagnoses.

3. On 21 December 2022, the lead GP at Stafford reviewed Mr Ball's recent gastroscopy results and documented that it had been identified that Mr Ball had a condition known as 'Barrett's Oesophagus' (damage to the lower oesophagus), as well as a hernia, and probable coeliac disease.

4. On 26 December, Mr Ball cut his arms and hands with a razor blade. As a result, staff began monitoring him under suicide and self-harm prevention procedures (known as ACCT). Around this time, Mr Ball stopped eating food and taking his medication.

5. On 19 January, staff transferred Mr Ball to the prison's Specialist Care Unit (SCU) to manage food and fluid refusal. SCU staff observed Mr Ball continuously and completed daily clinical observations in line with local policy guidance. Healthcare staff also discussed Mr Ball at regular multidisciplinary team meetings, ACCT reviews, daily healthcare meetings, and other forums.

6. The lead GP offered treatment to Mr Ball for the symptoms which he said made him want to die, but he declined this and said that he wanted to be 'left alone to die in peace'. Mr Ball understood that food and fluid refusal would bring about his death, and healthcare staff frequently checked his mental capacity.

7. At 3.07pm on 30 January, Mr Ball stopped breathing. The lead GP attended the cell and, at 3.35pm, confirmed that Mr Ball had died.

Findings

8. The clinical reviewer concluded that the care received by Mr Ball at Stafford was of the standard reasonably expected, and therefore equivalent to what he would have received in the wider community. We are satisfied that staff did everything they could for Mr Ball in challenging circumstances.

The Investigation Process

9. We were notified of Mr Ball's death on 30 January 2023.

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

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

12. The investigator interviewed one member of staff at Stafford on 17 April 2023, and obtained relevant information from the Deputy Head of Healthcare and Head of Healthcare via email.

13. NHS England commissioned a clinical reviewer to review Mr Ball's clinical care at the prison. She conducted the interview jointly with the investigator.

14. We informed HM Coroner for Staffordshire South of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

15. The Ombudsman's family liaison officer contacted Mr Ball's next of kin to explain the investigation and to ask if he had any matters he wanted us to consider. The next of kin requested a copy of this report, and asked why the family were not informed when Mr Ball's health and care became critical. We have addressed this issue in our report.

16. We shared the initial report with HM Prison and Probation Service. They identified two factual inaccuracies, which we have amended in this final report.

17. We also shared the initial report with Mr Ball's next of kin. They did not respond.

Background Information

HMP Stafford

18. HMP Stafford is a Category C training prison for prisoners convicted of sexual offences. It holds around 750 men. Practice Plus Group (PPG) provides healthcare services.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Stafford was in January 2020. Inspectors reported that waiting times for most healthcare clinics were short and there was a clear application system, with nursing staff triaging potentially urgent issues. Patients with long-term conditions were managed well by a practice nurse and the GP. Reviews of these conditions were reliably scheduled, and care plans were in place. Additional health checks relating to a long-term condition were carried out as required.

Independent Monitoring Board

20. 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 30 April 2023, the IMB reported that Stafford was a very safe prison in which prisoners' health and wellbeing needs were met. They reported that the number of incidents of self-harm had fallen from the previous reporting year and that prisoners' concerns about healthcare had fallen significantly.

Previous deaths at HMP Stafford

21. Mr Ball was the 23rd prisoner to die at Stafford since January 2020. Of the previous deaths, one was self-inflicted, and the rest were from natural causes. There are no significant similarities in our findings from our previous investigations.

Assessment, Care in Custody and Teamwork

16. 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. Checks should be carried out at irregular intervals to prevent the prisoner anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held.

17. As part of the process, a support plan (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the support plan have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet,

which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, Management of prisons at risk of harm to self, to others and from others (Safer Custody).

Key Events

22. On 16 August 2017, Mr Malcolm Ball was sentenced to seven years and six months in prison after being convicted of child sex offences.

23. Mr Ball was released from prison on licence on 17 May 2021, but recalled to HMP Hewell on 2 June. On 6 October 2021, he was transferred to HMP Stafford where he remained until his death, aged 73.

24. Mr Ball experienced multiple health problems, including ischaemic heart disease, a history of alcohol dependency, osteoarthritis, a hernia, hypertension (high blood pressure), and pre-diabetes.

25. Mr Ball had no recorded history of mental health issues, suicidal ideation, or self-harm.

26. Between February and December 2022, Mr Ball received both prison-based and external hospital treatment for an array of gastrointestinal, cardiological and dermatological issues.

December 2022

27. On 21 December, the lead GP at Stafford reviewed Mr Ball's recent gastroscopy results, which were received by Stafford on 19 December. The report stated that Mr Ball had 'Barrett's oesophagus' (damage to the lining of the swallowing tube that connects the mouth to the stomach), a large hiatus hernia (which is common in older patients and does not normally require treatment), and probable 'coeliac disease' (a condition where the immune system attacks and damages the gut when gluten is consumed).

28. The Deputy Head of Healthcare told us that the gastroscopy report did not indicate Mr Ball had probable coeliac disease, and that the report of another patient appeared to have been inadvertently scanned and attached to Mr Ball's medical records by hospital staff. Healthcare staff did not identify this at the time.

29. The lead GP tasked the nurses to review Mr Ball to discuss the diagnoses, to address the coeliac food issues, and to discuss increasing his prescription of esomeprazole (a medication that reduces stomach acid).

30. On 24 December, a nurse assessed Mr Ball as he reported feeling unwell and experiencing discomfort after eating. The nurse examined Mr Ball and did not identify any concerns. She identified that Mr Ball had a NEWS2 score of one (indicating low clinical acute risk). The nurse documented that she had emailed the kitchens to request a coeliac diet for him. (NEWS2 is a system used in healthcare settings to identify the degree of illness of a patient and whether critical care intervention is required.)

31. At 10.05pm on 26 December, prison staff called a medical emergency 'code red' indicating blood loss needing emergency treatment, after Mr Ball cut his arms and hands with a razor blade. As a result, staff began monitoring him under suicide and self-harm monitoring procedures (ACCT).

32. Mr Ball told a nurse that he had self-harmed due to 'constant noise' on the wing. Staff moved him to a safer cell (a cell designed with fewer clear ligature points to reduce the risk of suicide and self-harm) and referred him to the Inclusion Service (an integrated mental health and substance issue service).

33. On 27 December, staff held an ACCT case review and described Mr Ball as 'acting out of character'. He said he had no current thoughts of self-harm. All staff present agreed that the ACCT observations would remain at the same level (three per hour).

34. During the ACCT review, Mr Ball said that he was in pain due to his bowel issues and could 'no longer cope'. He told staff that he was embarrassed as his bowel problem made him soil himself and he said that eating caused him pain. Staff also noted during the review that Mr Ball had not recently collected his prescribed medication from the pharmacy. (At the time, Mr Ball was issued with a supply of medication to keep in his cell and take as prescribed.) They documented that Mr Ball had started to refuse food and fluids, and that the change in his presentation was likely triggered by his bowel complaints. No one started a food and fluid refusal log at this stage.

35. Later that day, a nurse completed a physical health assessment for Mr Ball and found that his clinical observations were within the normal range. The same afternoon, prison staff found a large amount of unused prescription medication in Mr Ball's cell and handed it over to the healthcare team.

36. That evening, Mr Ball did not collect his medication despite encouragement from healthcare staff. As a result, healthcare staff decided they would administer his medication to him every day for the foreseeable future.

37. On 28 December, Mr Ball had a further ACCT review where staff recorded that his bowels were causing him pain and he appeared dehydrated.

38. The next day, another ACCT review took place. Mr Ball did not wish to engage due to his abdominal pain and told staff he did not want to have the coeliac diet offered to him or take his medication. Staff moved Mr Ball back from the safer cell to a shared cell in his normal location but kept the ACCT procedures open.

January 2023

1 – 10 January

39. On 1 January, a nurse assessed Mr Ball and recorded that his clinical observations were within the normal range. Mr Ball reported feeling frustrated that his medication had been taken out of his possession and he continued to refuse to take it. The nurse advised Mr Ball of the support available to him, including Listeners (prisoners trained by the Samaritans to support their peers) and the chaplaincy.

40. The next day, a nurse assessed Mr Ball again. He told the nurse that the last thing he had eaten was a gluten-free mince pie on Christmas Day, which upset his bowels. Mr Ball said he wanted to cancel his forthcoming GP appointment (scheduled for 3 January) because he did not want to waste healthcare time.

41. On 3 January, a GP reviewed Mr Ball and recorded that he was not eating or taking his medication. The GP described Mr Ball as seeming 'depressed'. Mr Ball told the GP that he was not eating because he did not want to have diarrhoea and other symptoms. Mr Ball declined a review of his medication and was not receptive when the GP explained the reasoning behind a gluten free diet and how it would help manage his symptoms.

42. On 4 January, a mental health nurse completed a mental health assessment of Mr Ball. He told her that he was in a lot of abdominal pain and was waiting to die. Mr Ball said he did not have any mental health problems apart from wanting to die because he was in pain. He said he had no thoughts of harming himself and did not want to engage with healthcare staff. She instructed officers to start the food refusal protocol as per Prison Service Instruction (PSI) 64/2011 policy guidance on 'managing prisoner safety in custody'.

43. Later that day, healthcare staff discussed Mr Ball at their daily meeting and put him on daily observations to try and build a therapeutic relationship with him. From then on, healthcare staff encouraged Mr Ball every day to take his medication and eat. Staff also discussed Mr Ball at an Inclusion Service meeting, following his earlier referral, and placed him on the caseload of a senior mental health nurse.

44. On 5 January, staff radioed a 'code blue', indicating a medical emergency, after Mr Ball complained of pain in his abdomen. Healthcare staff described him as appearing dehydrated and presenting with a NEWS2 of eight (indicating high clinical risk). Mr Ball attended hospital in an ambulance where he received intravenous (IV) fluids and returned to Stafford at 10.30pm.

45. On 6 and 7 January, healthcare and prison staff continued to monitor Mr Ball's health and completed welfare checks on him, however he generally refused to engage with them.

46. On 8 January, at around 9.45am, the senior mental health nurse explained to Mr Ball that his body would shut down if he continued to refuse food and fluids, and by doing this he was effectively bringing about his death. She requested an urgent medical review.

47. At around 11.50am, a nurse took Mr Ball's clinical observations and found that he presented with a NEWS2 of seven (indicating a high clinical risk), with an onset of new confusion. Staff radioed a code blue, which triggered a call for an ambulance, but Mr Ball refused to go to hospital for treatment.

48. At this point, the prison appointed a family liaison officer (FLO) to speak to Mr Ball's family about the current situation. However, Mr Ball was adamant that he did not want his family to be contacted. At 2.00pm, an urgent ACCT review meeting took place where staff confirmed that Mr Ball had last eaten on 26 December and had last taken his medication on 28 December. Staff continued to record Mr Ball's daily diet and fluid intake on his ACCT document.

49. Following a long discussion with the senior mental health nurse, Mr Ball agreed to attend hospital for treatment. He arrived back at the prison the next morning and consumed two bowls of soup. Mr Ball also took his prescribed esomeprazole medication but declined his other medication.

50. At an ACCT review meeting later that day, Mr Ball told staff he only wanted to consume a liquid diet, such as soup, milk, and custard. All staff present (including the Deputy Head of Healthcare and Inclusion Service Manager) agreed that Mr Ball currently had the mental capacity to make decisions and referred him to a psychiatrist for further assessment. They told the psychiatry team that Mr Ball had started to eat small amounts again, so the psychiatric assessment was not deemed urgent.

11- 20 January

51. Staff continued to monitor Mr Ball's food intake and undertake regular ACCT case reviews, welfare checks, and clinical observations. On 11 January, the lead GP spoke with the senior mental health nurse and confirmed his view that Mr Ball had mental capacity.

52. On 12 January, Mr Ball refused to attend an outpatient cardiology clinic appointment and the request for a psychiatrist appointment was formally stood down because he was eating small amounts of food again.

53. On 13 January, staff completed a mental health care plan for Mr Ball.

54. On 15 January, wing staff reported to a nurse that Mr Ball had not eaten for two days. A nurse saw Mr Ball, who said that he had not experienced any more rectal bleeding and declined to have his clinical observations taken. The nurse documented that Mr Ball seemed low in mood, and that he had not taken his medication all weekend and was refusing food again.

55. On 16 January, Mr Ball told staff at an ACCT review that he still did not want his family to be contacted. He said he was in a lot of pain when trying to open his bowels and had seen 'a lot of blood'. Mr Ball said he had no thoughts to harm himself and his primary concern related to his abdominal pain and bowels. Healthcare staff agreed to give him an enema (inserting liquid or gas into the rectum) at his request for ongoing constipation. Staff present decided to close the ACCT document. They agreed that Mr Ball's issues were medically related and that he would be monitored by healthcare and his food intake would be recorded on a separate food log.

56. Later that day, a nurse documented that Mr Ball refused the enema and continued to decline to provide a faecal sample as requested by the GP. The nurse said it was explained to him for over 25 minutes what the medical risks were of declining medication and food and fluids, but he continued to refuse. The nurse advised Mr Ball to contact healthcare if he changed his mind about the enema.

57. On 17 January, Mr Ball refused to attend a GP appointment. Healthcare staff discussed Mr Ball's case at a Safety Intervention Meeting (SIM - a multi-disciplinary team meeting) and agreed to refer him to forensic psychology (not part of the healthcare service) to request a formulation (a shared understanding of the problem) regarding his food refusal. They also planned to continue to discuss Mr Ball at the daily healthcare meetings and SIMs.

58. On 18 January, following a medical assessment, staff called an ambulance when Mr Ball presented with a NEWS2 score of five (indicating medium clinical risk). Staff

encouraged Mr Ball to go to hospital and explained again that there could be a risk of death if he did not eat or drink, however he refused to attend. Paramedics deemed Mr Ball to have mental capacity to make this decision. Healthcare staff made a clinical plan to continue with clinical observations and to call an ambulance if Mr Ball's condition deteriorated.

59. On 19 January, Mr Ball was discharged from the senior mental health nurse's caseload following the recent ACCT review closure and agreement that Mr Ball's needs were medically related, rather than mental health related. Following a GP review, Mr Ball was offered a bed on the Specialist Care Unit (SCU, an eight-bed ward for rehabilitation and end-of-life care) which he accepted. Staff re-opened his ACCT document, which was in the post-closure stage, as he declined to answer if his food and fluid refusal related to a wish to die. Staff held an ACCT review meeting, where Mr Ball was described as 'remaining adamant that he would not eat and drink.' The GP documented that Mr Ball appeared to have capacity to decide to refuse food and fluids, and that Mr Ball was not always clear about why he was refusing. The GP concluded that Mr Ball should be regarded as being terminally ill and would be unlikely to survive if he continued to refuse fluids.

60. Later that afternoon, staff held a multi-agency meeting and created a care plan for Mr Ball in the SCU. The senior mental health nurse visited Mr Ball and concluded that a mental health intervention was not needed at the time as Mr Ball's needs related to his physical health. A GP reiterated to him that he would only have a matter of days to live if he continued to not have fluids. The GP recorded that Mr Ball fully understood this.

61. At the multi-agency meeting, staff decided to complete clinical observations every four hours, and healthcare staff would encourage Mr Ball to eat and drink slowly. A re-feeding syndrome care plan was developed in case Mr Ball started eating again, and staff noted that he had not eaten for five days and not consumed fluid for forty-eight hours.

62. Later that day, an Advanced Nurse Practitioner (ANP) completed a Malnutrition Universal Screening Tool (MUST) and found Mr Ball to be at high risk of malnutrition.

21 – 29 January

63. In the morning of 21 January, Mr Ball drank 430ml of water and 200ml of a vanilla supplement drink when talking to a healthcare assistant (HCA). Once the HCA left the room, staff observed Mr Ball on camera filling up a cup from the tap, so a nurse went to see him, and he consumed a further 200mls of water.

64. That afternoon, Mr Ball told staff that he thought it was a mistake that he had started to drink again that morning, and he was reassured and encouraged that he had not made a mistake. Mr Ball said that he planned to stop drinking the next day despite encouragement from staff not to do this.

65. On 22 January, staff carried out clinical observations every four hours. Mr Ball declined to eat, drink, and take his medication despite regular encouragement.

66. In the morning of 23 January, Mr Ball agreed to take some fluids. Shortly afterwards, he vomited which led to staff calling an ambulance. Despite medical advice given by a paramedic, Mr Ball declined a transfer to hospital. Paramedics advised Mr Ball that his body was 'shutting down' which was leading to his death. Paramedics, a GP, and the prison's mental health team assessed him as having the mental capacity to refuse admission to hospital and that he understood that he was dying.

67. The lead GP reviewed Mr Ball later that day same day and recorded that he had 'deteriorated considerably', and that his breathing was rapid and shallow. A ReSPECT form (an advanced decision document stipulating a person's wishes for treatment in the event of an emergency) was completed with Mr Ball and he said that he did not want to go to hospital, did not want any medical treatment, and did not wish to be resuscitated in the event of a cardiac arrest.

68. The lead GP concluded that Mr Ball had the mental capacity to make the relevant decisions regarding medical intervention.

69. That afternoon, during a mental health assessment, Mr Ball said he did not have any plans to end his life, but he knew that by not eating and drinking he would bring about his death. Mr Ball declined any offer to consider medication but said that he would take morphine (pain relief).

70. On the same day, Mr Ball was discussed twice at a Practice Plus Group (PPG) national team meeting which included representation from a solicitor. They discussed that Mr Ball had completed an advanced decision to refuse medical treatment (ADRT), which detailed that he wished to die from refusal of food, did not want to take medication (including pain relief) and did not want any clinical interventions.

71. As a result of this meeting, the lead GP re-assessed Mr Ball's mental capacity and concluded that he had mental capacity in regard to the detail of the ADRT and understood these decisions would lead to his death.

72. Later that afternoon, Mr Ball declined clinical observations and told the nurse that he had 'had enough'. That evening, a nurse and supervising officer (SO) visited Mr Ball in his cell to go through the ADRT document again. The nurse read the document to Mr Ball, and he confirmed that it was an accurate reflection of his wishes, and he signed the form. Nurses and GPs continued to discuss the ADRT document with Mr Ball to check his understanding and capacity.

73. The lead GP offered treatment to Mr Ball for the symptoms he reported that made him want to die, but he declined this and said that he wanted to be 'left alone to die in peace'. The clinical services manager offered pain relief to Mr Ball in the event he became distressed or in pain, but he also declined this.

74. On 24 January, staff held a multi-disciplinary meeting where it was concluded that a psychiatrist opinion was not needed because Mr Ball had been deemed to have mental capacity to refuse food and medical intervention. A comprehensive plan of care was put together to support primary healthcare staff and advise them what to do in the event of possible situations relating to Mr Ball's future clinical deterioration.

75. Between 25 January and 27 January, staff witnessed Mr Ball consuming small amounts of water, which they monitored hourly on a fluid balance chart. He continued to refuse food.

76. On 27 January, the senior forensic psychologist spoke to Mr Ball in his cell. She described Mr Ball as being in and out of sleep during the consultation and reported that he responded with some humour. She explained her role to Mr Ball and invited him to talk about his current situation. Mr Ball asked if his engagement was optional and indicated that he did not wish to engage in an assessment.

77. Later, a nurse approached the psychologist with a message from Mr Ball to pass on an apology for not engaging with her. She revisited Mr Ball and explained he had no reason to be sorry, and it was agreed she would return in a weeks' time to continue.

78. From 28 January, Mr Ball did not consume any fluids. Healthcare staff checked him regularly and recorded that he appeared dehydrated. Mr Ball also declined any clinical observations and medication.

79. On 29 January, at around 9.30am, healthcare staff heard a bang from Mr Ball's cell. They attended immediately and found Mr Ball to have fallen to the floor of his cell with his head and shoulders leaning against the wall.

80. That afternoon, healthcare staff regularly checked Mr Ball and he continued to decline any clinical observations. Staff asked Mr Ball if he was in any pain, which he denied, and he continued to decline any healthcare intervention.

30 January 2023

81. At around 9.00am, nurses noted that Mr Ball's feet were cold, blue, and mottled and described him as being 'vacant and restless'. Mr Ball appeared to be hallucinating and was seen plucking at things in the air. A nurse tried to take Mr Ball's pulse but could not locate a radial pulse (on the wrist) and recorded his respiratory rate at thirty breaths per minute. In response to Mr Ball's presentation, fifteen-minute welfare checks were initiated.

82. At 10.30am, healthcare staff were concerned that Mr Ball's death was imminent, so arranged for members of staff to sit with him continually on a rotational basis. Staff offered Mr Ball a transfer to hospital and pain relief, which he declined.

83. At 11.00am, the clinical services manager contacted the prison security department and requested approval to have Mr Ball's door open, which was approved.

84. At 3.07pm, a nurse observed that Mr Ball had stopped breathing and that she could not feel a pulse. The lead GP attended the cell and confirmed that Mr Ball had died.

Contact with Mr Ball's family

85. On 30 January, the prison FLO attended the home address of Mr Ball's next of kin to break the news of his death in person. He offered the next of kin a visit to the establishment to see the SCU and meet staff members and prisoners involved in Mr Ball's care and to collect his personal property.

86. Stafford contributed to the costs of Mr Ball's funeral in line with Prison Service instructions.

Support for prisoners and staff

87. After Mr Ball's death, the Duty Governor debriefed the staff involved in monitoring and caring for Mr Ball in his final hours to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

88. The Duty Governor asked about the prisoners who were close to Mr Ball, whether as allocated carers or friends. He advised that the prison could facilitate assistance to them via the Listeners, Samaritans & Chaplaincy. He confirmed that notices would be sent out the next morning to both staff and prisoner groups, signposting where they could get assistance if required.

89. The Duty Governor also confirmed that all prisoners who were currently subject to ACCT procedures, whether they knew Mr Ball or not, would receive an ACCT review that day.

Post-mortem report

88. The post-mortem report concluded that the cause of Mr Ball's death was dehydration, secondary to ischaemic heart disease and chronic constipation.

Findings

89. The clinical reviewer concluded that the care Mr Ball received at HMP Stafford was of the standard reasonably expected, and equivalent to that he could expect to have received in the wider community.

90. Food refusal policy is set out in the Department of Health (DoH) guidance for 'the clinical management of people refusing food in immigration removal centres and prisons' (2010).

91. The policy states that establishing a person's primary reason behind their food refusal is important. Mr Ball was not always clear about why he refused food, fluids and medication. He initially told staff that he was experiencing physical symptoms related to his digestive condition, and that he chose not to eat so as not to exacerbate this. At other times he said that he did not eat because he wished to die (without being clear on the reasons for this). He was often not forthcoming when repeatedly asked about this by staff.

92. In interview, the lead GP at Stafford told us, "[Mr Ball] had got to the end of his tether, he didn't want to continue with life, and he wanted to die. He chose to die by food and fluid refusal, and possibly we told him that he would die from that, and that was why he chose that route".

93. The clinical reviewer noted in her report that the care Mr Ball received at Stafford was compassionate, and clearly distressing for staff as they watched Mr Ball deteriorate. She concluded that Mr Ball's wishes were well documented, widely known, and respected. Staff from a variety of healthcare disciplines regularly assessed and commentated on Mr Ball's capacity to refuse food and fluids.

94. The clinical reviewer also noted that the care received by Mr Ball when he was admitted to the Specialist Care Unit (SCU) on 19 January was of high clinical quality in challenging circumstances. SCU staff observed Mr Ball continuously and completed daily clinical observations in line with local policy guidance. Mr Ball was also discussed at weekly Multi-Professional Complex Case Clinic (MPCCC) meetings and at regional Practice Plus Group (PPG) meetings. Prison and healthcare staff also discussed Mr Ball regularly within other settings, such as ACCT case reviews, daily healthcare meetings, and other multi-agency meetings.

95. We are satisfied that healthcare and prison staff did everything they could for Mr Ball in challenging circumstances. We make no recommendations.

Governor and Head of Healthcare to note

96. Although we make no recommendations, we bring the following matters to the Governor and Head of Healthcare's attention where policy guidance was not strictly followed, or processes could be improved.

Food refusal policy

97. Prison Service Instruction (PSI) 64/2011 on managing prisoner safety identifies that prisoners refusing food or fluids should have a food refusal log in place.

98. When Mr Ball was refusing food, staff did not always record on a food refusal log or within Mr Ball's ACCT record what he had consumed.

99. There was also a delay in commencing a food refusal log once Mr Ball began refusing food on or around 27 December 2022. It was requested by a nurse on 4 January 2023.

100. On 24 January, a regional MPCCC meeting concluded that a psychiatrist opinion was not needed because Mr Ball had been deemed to have mental capacity to refuse food and medical intervention. This conclusion was reached by the psychiatrist. The PPG policy for 'the management of food and fluid refusal' (version 3, 2021) states that patients who are continuing to refuse food and fluids should have a second opinion assessment by a psychiatrist.

External referrals

101. The PPG policy for 'the management of food and fluid refusal' (version 3, 2021) states that an immediate referral to a dietician should be completed when a person begins food refusal.

102. Staff referred Mr Ball to an external dietitian on 12 January 2023 (over two weeks after he started refusing food) but he was not seen by a dietician before he died. We bring this to the attention of the Head of Healthcare and SCU Clinical Services Manager.

Other learning

103. The clinical reviewer highlighted additional learning points that we bring to the attention of the Head of Healthcare.

Inquest

104. The inquest into Mr Ball's death concluded on 20 April 2026, and found that Mr Ball died following food and fluid refusal with an intent to take his life.

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Independent Investigations

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