Investigation into the circumstances surrounding the death of a man at HMP Preston in July 2010

Report by the Prisons and Probation Ombudsman for England and Wales

June 2011

This is the report of an investigation into the death of a man, a prisoner of HMP Preston. He died in the prison's healthcare centre in July 2010. He was 60 years old.

One of my family liaison officers contacted the man's ex-wife to explain my role. I would like to reiterate what he said by way of condolences to his family, and apologise for any additional distress caused by the delay issuing this report.

The investigation was undertaken by one of my senior investigators. Both he and I would like to thank the Governor of Preston and his staff for their participation in the investigation.

The man had been in prison a number of years, and his health was failing. He had problems with his liver, and in December 2009 was transferred to HMP Preston so that he could receive round the clock care as an in-patient in their healthcare centre. I am told that he was not always the easiest patient to manage and, on a number of occasions, he discharged himself from hospital against medical advice.

A clinical reviewer was asked by the local Primary Care Trust (PCT) to undertake a review of the man's clinical care. I appreciate her assistance throughout the investigation and her final report. As is often the case when investigating a natural cause death, I have relied heavily on her report and conclusions. She found that his care was equivalent to that which he could have expected in the community. I make five recommendations which, given that he spent his time in Preston in the healthcare centre, are largely directed to the Head of Healthcare. My recommendations cover record-keeping, mental health assessments, communication with outside agencies, and information regarding resuscitation. I also comment on recording important discussions, arranging prisoner escorts, family liaison, and cell call bells.

I agree that the man received good care whilst he was at Preston. The arrangements were varied as his wishes changed particularly whether or not he wished to be resuscitated. Careful thought was given to whether he should be considered for compassionate release. He did not have a home to go to and he preferred to stay in prison. This was agreed and detailed arrangements were made to make sure that he was not left alone as he reached the end of his life.

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

Jane Webb
Acting Prisons and Probation Ombudsman **June 2011**

CONTENTS

SUMMARY

1. The man had been at HMP Preston since 8 December 2009, although he technically remained a prisoner of HMP Buckley Hall. Whilst at Buckley Hall he had been taken ill and admitted to hospital. He was found to have problems with his liver which would require him to be in a prison with 24 hour healthcare. As Preston contains the in-patient unit for prisons in that region and he was taken there when he was discharged from hospital. He was admitted to healthcare and, with the exception of visits to and stays in outside hospital, remained there for the rest of his life.

2. The man's care in Preston was good. He was constantly monitored and, whenever necessary, referred to outside hospital. Sadly, he did not always comply with his treatment, and he discharged himself from hospital against medical advice on six out of 12 occasions. He had cirrhosis of the liver and hepatitis C and it was explained to him that, without a liver transplant, his prognosis was poor. But he did not want the treatment that would be necessary for a liver transplant, despite knowing the consequences of refusing.

3. Even with the man's apparent mixed feelings towards his own care, I judge that staff did their best to make him comfortable. Being on the healthcare centre, he was regularly assessed, and his nursing needs were met. The Governors of Preston and Buckley Hall discussed the possibility of applying for compassionate release for him. However, he had nowhere to be released to and, as his health was declining, they decided that he would be better to remain in the prison's care. He agreed with this decision as he did not have an address to go to.

4. Although he had been out of touch with his family for some years, staff helped him to contact his ex-wife who subsequently visited him.

5. The man had changed his mind more than once about whether he wanted staff to try to resuscitate him, should the situation arise. But after his final stay in hospital, on his return to prison he agreed that a Do Not Resuscitate (DNR) notice should be put in place.

6. In the last two weeks of his life, the man's health deteriorated rapidly. As he became more ill, the prison did their best to make him comfortable. He was placed in a cell with another prisoner so that he had company. Extra staff were detailed to work in the healthcare centre so that his cell door could remain unlocked and allow staff to have immediate access when necessary. In early July he died in his room. In keeping with his wishes, staff did not attempt resuscitation.

7. I make five recommendations regarding record-keeping, mental health assessments, communication, and resuscitation notices. I also comment on recording important information, arranging hospital escorts, family liaison, and prisoners being able to summon assistance to their cells.

THE INVESTIGATION PROCESS

8. My investigator formally opened the investigation at HMP Preston on 6 July 2010. He spoke to the Governor and was given full access to all relevant records relating to the man, including his prison and medical files. He spoke to staff who had cared for him and prisoners who knew him, including the deputy governor and the then Governor of HMP Buckley Hall. He made himself available to the Prison Officers Association, the Independent Monitoring Board and the chaplaincy if they wished to speak to him but they did not do so.

9. Notices were posted to staff and prisoners about my investigation, inviting contributions if necessary. None were received. The investigator had access to statements made by relevant staff after the man died.

10. The local Primary Care NHS Trust asked the clinical reviewer to carry out a review of the man's clinical care. I am grateful to her for undertaking this review. My investigator discussed aspects of his treatment both with healthcare staff at Preston and with the reviewer.

11. The investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and request a copy of the post mortem report. Upon completion, my report will be sent to the Coroner to assist in his enquiries into the man's death.

12. One of my Family Liaison Officers (FLOs) contacted the man's ex-wife. He told her of my investigation and invited her family to ask any questions or raise any issues for consideration. She did not have any specific issues which she wanted my investigation to address. She requested a copy of the draft report when it is issued. She subsequently confirmed that she had no comments on the draft.

HMP PRESTON

13. HMP Preston is a category B local prison (containing prisoners for whom the very highest conditions of security are not necessary, but for whom escape must be made very difficult). It accepts adult males from the courts serving Lancashire and Cumbria. Mainly Victorian, its wings were built between 1840 and 1895 on a site which had been occupied since 1790. The prison closed in 1931, reopened for military use in 1939 and as a civilian prison in 1948. It became a local prison in 1990, and now serves the courts by holding male offenders over the age of 20 who have been remanded in custody, are awaiting trial, or awaiting allocation to another prison after being sentenced.

14. Preston contains the in-patient facility for the north-west region, with health services provided by NHS Central Lancashire Provider Services. The in-patient facility holds prisoners who are too ill for normal location but do not require admission to an outside hospital. Admission is arranged by referral from the original establishment, followed by an assessment from the team at Preston. There are separate landings for patients with mental and physical needs, with a total of 30 beds. On the physical needs landing, six staff are on duty by day, and two at night. This includes healthcare officers. There is a full-time doctor between the hours of 9.00am to 5.00pm Monday to Friday. Between 5.00pm and 8.00pm there is a doctor in the prison's reception area. At night, on-call cover was, at the time of this investigation, available through a contract with Care UK.

Previous deaths at HMP Preston

15. The man was the eleventh prisoner to die in Preston since my office took over responsibility for investigating deaths in custody in 2004. Four of these deaths were due to natural causes. I have previously made recommendations regarding record-keeping in the healthcare department, and I make a similar recommendation in this report.

Do Not Resuscitate Notices (DNRs)

16. A Do Not Resuscitate Notice (DNR) on a patient's file means that resuscitation should not be attempted and is designed to prevent any unnecessary suffering. The United Kingdom medical profession has guidelines for circumstances in which a DNR may be issued:

    a. if a patient's condition is such that resuscitation is unlikely to succeed
    b. if a mentally competent patient has consistently stated or recorded the fact that he or she does not want to be resuscitated
    c. if there is advanced notice or a living will which says the patient does not want to be resuscitated
    d. if successful resuscitation would not be in the patient's best interest because it would lead to a poor quality of life.

Her Majesty's Chief Inspector of Prisons

17. The last report on Preston published by Her Majesty's Chief Inspector of Prisons was of an announced inspection in August 2009. The report noted that the service provider had recently completely overhauled the healthcare department after a period of lack of investment. The department was showing signs of recovery, although this had yet to reach to prisoners.

Independent Monitoring Board (IMB)

18. Each prison in England and Wales has an Independent Monitoring Board made up of volunteers from the community, responsible for monitoring day-to-day life in the prison and to ensure that proper standards of care and decency are maintained. The last report published by the IMB for Preston was the annual report for the year to 31 March 2010. Although the Board noted that it had been a particularly difficult year for Preston's healthcare services, there is nothing in the report that concerns this investigation.

KEY EVENTS

19. The man was convicted of murder in 1993 and had been in prison since that time. In the early part of his sentence he did not settle well, and his record shows that he had some problems with the prison system. In 1997 he transferred to HMP Grendon, and undertook some offence-related work. From this point on, records show a change in his attitude to his sentence.

20. Having spent time in a number of prisons, the man moved from HMP Highpoint to HMP Buckley Hall in November 2008. On arrival he was noted to suffer with osteoarthritis (a disease affecting the joints), and that he had in 2003 been diagnosed with asthma, although he remained a smoker. He was offered help to stop smoking.

21. The man had fairly regular contact with healthcare staff. He suffered pain in his joints as a result of age and rheumatism (inflammation of the joints), and in August 2009 he asked if he could be given a walking stick.

22. On 7 December, the man was taken to the healthcare centre, complaining of pain in his stomach. He said that he had been constipated for some days. He was taken to the accident and emergency unit at hospital and given blood tests and x-rays. An abdominal or bladder mass was detected. Whilst hospital staff were still investigating what was wrong with him, he refused to wait for the results. Against the advice of doctors in the hospital and prison healthcare staff, he discharged himself from hospital. He returned to prison that evening.

23. Having been persuaded to do so, the man went back to hospital on 9 December. However, he once again discharged himself against medical advice.

24. On 14 December the man was taken back to hospital, suffering from significant pain around his stomach. He underwent tests, and his medical record show that on 16 December it was suspected that he was suffering from cirrhosis of the liver (this is a condition in which the liver slowly deteriorates due to scar tissue replacing healthy liver tissue, partially blocking the flow of blood through the liver and preventing it's full function), with abdominal ascites (an accumulation of fluid in the stomach).

25. Initially he was to be treated in hospital via an abdominal tap (to drain away the fluid), but healthcare staff in Buckley Hall and the hospital doctor agreed that from here on, the man would best be held in a prison with 24 hour healthcare. (Although Buckley Hall has 24 hour nursing cover, there are no in-patient facilities.) Healthcare staff at Buckley Hall contacted Preston, which contains the in-patient facilities for the Prison Service's north west region. After discussion between the two healthcare departments Preston agreed to accept him.

26. When the man was discharged from hospital, the arrangements were put in place and he transferred to Preston on 18 December. On arrival he was

allocated to the healthcare centre (where he was to remain throughout his time in Preston). He was assessed by healthcare staff, and a care plan put in place.

27. Prison Doctor A was concerned that the man had not had any follow-up from the hospital. The doctor contacted the doctor there on 7 January 2010 and, after some initial difficulty, arranged a hospital appointment for him for 12 February.

28. However on 7 February the man's ascites worsened and he had to be taken to the Accident and Emergency (A&E) Department of the hospital. He was admitted, but discharged himself on 15 February, against medical advice.

29. He saw the prison doctor again the following day. The hospital had agreed to arrange an out-patient appointment for him to have an oesophogastroduodenoscopy (OGD – a test to view the oesophagus, intestine and stomach). The hospital had identified an infection in his liver, though it was not clear whether this was hepatitis C (an infectious disease affecting the liver, which can cause scarring). He himself felt well, and was content to await contact from the hospital. He saw the doctor on 18 February, and said that he felt tired, and had been sick that morning. However, his stomach felt better, and the doctor noted that the extent of his ascites was low.

30. The man next saw the doctor on 25 February. He reported feeling very low over the previous few days, although he had no thoughts of self-harm. He had not heard when his parole hearing was due. The suspicion that he was suffering from cirrhosis of the liver had been confirmed, and investigations were ongoing, but he had not heard from the hospital. The prison had also not received the discharge summary, and there was some confusion as to whether his OGD would be performed before his scheduled hospital appointment on 26 April. He was under the care of a consultant at the hospital so the prison doctor contacted his secretary. She said that she would ensure the discharge summary was forwarded to the prison. He said he would telephone again the following week to discuss progress.

31. Consequently, the consultant wrote to the prison doctor on 1 March. He said that the man had tested positive for hepatitis C, and been treated for peritonitis (inflammation of the membrane that lines part of the abdominal cavity). He had responded positively to antibiotics, fluid restriction and diuretics (medicines that remove water from the body by increasing the amount of urine the kidneys produce). Arrangements had been made for him to have an endoscopy as an out-patient prior to his April appointment. (An endoscopy is a procedure using a long, thin tube with a light and a camera to examine the inside of the body.)

32. The prison doctor assessed the man on 2 March. He said that he felt nauseous, and had been sick twice in the previous two days. He had a productive cough (that produces phlegm), and his ascites was larger than previously.

33. The doctor telephoned the hospital on 2 March and again on 4 March, but received no reply. He telephoned again on 9 March, and this time managed to

speak to the consultant's secretary. She supplied a discharge summary from his previous stay in hospital, and confirmed the date for the OGD as 1 April. The doctor subsequently went to pass this on to him, but found him quite unwell. Having discussed it with him, and stressing the importance of not discharging himself again, the doctor referred him to hospital. He was admitted that afternoon.

34. The man was admitted to the Gastroenterology Department. It was confirmed that he was suffering with liver failure, cirrhosis, hepatitis C and ascites. Under the care of a hospital doctor, he received treatment and his ascites was drained. He was discharged on 12 March, although the papers do not show if this was his own doing. The hospital told him that they could do little for him, and that he needed a liver transplant. He agreed to participate in discussions, and was placed on the waiting list. He was told that the process could take between two and three years.

35. Over the following week, the man complained of feeling unwell. On 1 April, he was due to attend hospital for his endoscopy, but was unable to attend because of problems arranging an escort. (Prisoners leaving the prison to go to outside appointments need to be assessed as to the risk they present, and escorted by prison staff.) As he technically remained a prisoner of Buckley Hall, it fell to them to arrange a hospital escort. They had not, however, been informed of the appointment so an escort was not arranged. The appointment was rescheduled for 28 April.

36. Prison Doctor B observed on 11 April that the man's abdomen was swollen, and he looked emaciated. The doctor noted on the medical file that, if he got any worse, he should be sent to hospital. He was readmitted to hospital the following day and remained there until 17 April, when he was discharged. He was readmitted the following day, but discharged himself the same day.

37. On 14 April, the man's dossier was referred to the Parole Board. This was required by the timeline for their scheduled consideration of his case.

38. By 19 April, the man required constant care. He was sometimes confused, and had difficulty moving around. Prison Doctor C came to see him and he was moved to a different part of the healthcare centre. The doctor had discussed the issue of resuscitation with him and it was agreed that should the situation arise, staff would not attempt to resuscitate him. A DNR notice was put in place. He was put on to the Integrated Care Pathway for the Dying Patient, a palliative care pathway. (Palliative care is provided when patients will not recover from their illness, but are receiving treatment to reduce the severity of their symptoms.) He was referred to a local hospice. Although a bed was not available one of the hospice's specialist nurses came to assess him. He provided a syringe driver (a small pump used to gradually administer small amounts of medication to patients over a period of time) to provide him with ongoing pain relief.

39. However, Prison Doctor A stopped the palliative care approach the following day. He did not think that the prison healthcare team had enough information

available to agree to such an approach at this stage, and there had been no opinion from the consultant. He referred the man to hospital that afternoon, and asked for a specialist opinion on his ongoing care and for management plans for his illness. The man, however, discharged himself and was returned to prison late that evening. When he arrived back, he did not have his syringe driver and the hospital had provided very little information. Staff contacted the hospital but they were unable to trace the syringe driver. The doctor cancelled the DNR order on him until further information was available about his ongoing welfare.

40. The man complained of pain during the early hours of 21 April. Staff contacted Prison Doctor A by telephone, and gave him some tramadol (strong painkillers). This did not stop the pain and, after once again contacting the doctor, staff provided him with morphine (opiate pain relief) via another syringe driver.

41. Later that morning Prison Doctor D saw the man. His pain seemed to be under control, and he seemed alert. He was aware that the prognosis for his illness was not good. The doctor spoke to the consultant, who confirmed that he was content to continue to see him as an out-patient. The doctor asked for information to be sent through about his condition, prognosis, and how he should be managed. Prison healthcare staff needed to know how actively they should provide treatment. His medication was altered, and he was taken off the syringe driver.

42. Medical records later that day indicate that the man felt better. Alert, and able to get to the toilet without assistance, he nevertheless still complained of slight pain in his stomach. A copy of the cancellation of his DNR notice was placed in his medical record, and a further copy placed in the handover diary so that staff coming on for night duty were aware of the fact.

43. On 24 April, the man was noted to have oedema (fluid retention) in both legs. He appeared to be alert and aware, and did not complain of pain, but refused to keep his legs raised as recommended. As the morning wore on, he became more confused and agitated. He had trouble swallowing his medication, and both legs swelled further, causing him pain in his feet. He was encouraged to keep his feet raised, and nursing staff discussed with the doctor the possibility of changing his medication to liquid form.

44. That day, the prison received a letter from the consultant. He wrote that without a liver transplant, the man's prognosis was poor and the doctor would only estimate a 50 percent chance of him living until the end of the year.

45. On 26 April, the man's ascites was causing him problems and he was taken back to hospital. He was becoming increasingly confused, and staff discontinued his morphine. He refused medication and said that he did not want his failing health to be actively treated. He was told that to be considered for a transplant, he would need to stay in hospital and be treated for malnutrition with nasal-gastric feeding (feeding and administering drugs via a tube inserted in the patient's nose). He said that he did not want this and, against medical advice, tried to discharge himself on 30 April. He was,

however, persuaded to stay in hospital until the following day. His discharge letter noted that his condition was not conducive to a liver transplant and, if he discharged himself from hospital, all they could do was help control his symptoms. The letter said that he appeared to be aware of the implications of his behaviour.

46. On his return to prison, the man seemed to settle. He was aware and well orientated, and able to move around with the aid of his walking stick. He complied with his treatment, and seemed to generally have a more positive attitude.

47. However, on 5 May, he complained of pain in his toes. He saw Prison Doctors E who found him relatively well. He was willing to comply with treatment. His foot pain continued over the coming days, and on 7 May he also complained of increased abdominal pain. The same day, a letter was received from the hospice. They had reassessed his case and, as his medical team were pursuing treatment, they had discharged him from their files.

48. The man developed shingles, and his oedema worsened. His stomach was also sore, and had become more swollen. Healthcare staff were concerned, and on 12 May he was admitted to hospital. However, he discharged himself again on 15 May. He was due to have his ascites drained, but told hospital staff that he was aware that he would die soon, and did not want further treatment. He said he would prefer to return to prison. A note on the medical file indicates that he understood what he was doing and the possible consequences.

49. Having previously spoken about the subject with medical staff at the prison, the man again discussed resuscitation with hospital staff. He said that, should the situation arise, he did not want to be resuscitated. A DNR notice was put in place whilst he was in hospital. But this agreement in the hospital would not apply in prison and, on his return to prison, the subject would need to be addressed.

50. The Governors of Preston and Buckley Hall discussed the man's ongoing care. This included consideration of making an application for compassionate release. No written records of these discussions were made as they took place over the telephone. Both Governors told my investigator in person what they discussed.

51. Once they had spoken, the Governor of Buckley Hall visited the man in hospital. He explained the compassionate release process. The man said that he had nowhere to be released to. He agreed with the Governor that with his illness this was likely to be a problem for his ongoing care. He agreed that a compassionate release application should not go forward. He told the Governor that, even though they had been out of contact for some years, he would like to contact his ex-wife.

52. On his return to prison, Prison Doctor C discussed the man's care with him on 18 May. He was aware of where he was, and said that he did not want to go

into hospital. He told the doctor that, should the occasion arise, he did not want to be resuscitated. He agreed to a DNR notice being put in place, although he told the doctor that he wanted to discuss this with his ex-wife. Later that day, he repeated to Nurse A that he did not want to go to hospital for any further treatment. The following day he confirmed to Prison Doctor E that he did not want to be resuscitated, although the doctor could not find confirmation of this on the medical record.

53. Following the man's wish to see his ex-wife, the Governor had liaised with the deputy governor at Preston, about arranging this. This resulted in another governor at Preston contacting her on 19 May. On 20 May, he confirmed to staff that he had changed his mind about resuscitation. He said that, until he had had the chance to speak to his ex-wife, he wanted to be resuscitated.

54. Following her contact with the Governor, the man's ex-wife agreed to visit him. She came to the prison and saw him on the morning of 21 May.

55. Just before 6.00am on 26 May, on hearing a noise from the cell, a nurse found him laying on the floor of his cell, his legs having given way beneath him. He had hit his head, but did not seem to have suffered any injury. However, that afternoon he received a visit from the chaplain, and asked to be given the last rites.

56. That same day, he also received a visit from a team from the hospice. He was frightened of dying alone, and a care package was put in place for him which included having someone with him. On 30 May, he was moved into a shared cell.

57. The man's health continued to deteriorate. On the late afternoon of 30 May he was having trouble breathing, and said that he had had chest pains during the night. His skin was bleeding where his shingles had caused sores. He was admitted to hospital, but discharged himself the same day before staff could conduct tests.

58. A doctor had a long discussion with the man on 1 June. He was not in pain, but was suffering from insomnia and anxiety, which sometimes led to panic attacks. He told the doctor that he wanted to be taken to hospital or resuscitated if necessary, and would like to go to a hospice.

59. His health continued to fail. He fell on 7 June whilst getting out of bed, although he did not appear to cause himself any injury. His breathing was very laboured, and staff were concerned that he might have fluid on his lungs. He would not respond to staff, and he was taken to hospital that afternoon. Hospital staff wanted to contact his next of kin, but the Governor said that following her visit to the prison, his ex-wife had expressed a wish to have no further contact with him. He remained there until 11 June when he once again discharged himself.

60. After his return to prison, the man's health began to deteriorate more rapidly. This was expected with the conditions with which he was suffering.

61. A note on the records by Nurse B on 12 June says that his resuscitation status needed to be reviewed. There is, however, no indication why.

62. The man occupied a four bed cell in the healthcare centre, and only two beds were in use. This ensured that he had the company of a cellmate, but in a spacious area. A hospital bed was provided rather than the usual beds in use in the healthcare centre. He was offered an air mattress to improve his comfort, but declined. He continued to be seen by one of the prison doctors every day.

63. He became extremely unwell over the coming days. He was sick, and was retaining fluid. He was placed on restricted fluids in his diet to try and ease his ascites, but on 16 June he told staff that he no longer wanted to be on restricted fluids. The records show that he was advised to persevere with the restriction, but do not make it clear whether he was taken off it at this stage. He needed incontinence pads at all times. Medical records show that on 17 June, he said he was willing to receive hospital treatment, but on 19 June refused food and took fluids, even though he was advised against doing so. He had trouble breathing, but being given oxygen would require him to stop smoking which he was not willing to do. Instead, his doctor provided a nebuliser (a device used to administer medication in the form of a mist inhaled into the lungs).

64. Having seen his ex-wife, the man had reconsidered his position on resuscitation. On 21 June, he told Nurse A that he had changed his mind, and no longer wished to be resuscitated if the situation arose. The doctor put an entry to that effect on his medical record, and a note was made on the front of his case file. Additionally, the change was confirmed at a healthcare team staff meeting, and the nurse arranged for all the healthcare staff to be individually e-mailed the information.

65. The man was still suffering pain and so the doctor spoke to a palliative care consultant on 22 June. His pain relief medication was increased, with other medication suggested for use if required. He was now unable to move without assistance, and a pressure-relieving mattress was ordered. He only ate small amounts of food, though was still able to take sufficient fluids. On 25 June, he told staff that he no longer wished to be on fluid restriction measures, and that he was aware of the consequences of this. He signed a disclaimer to that effect. During the early hours of 29 June he was unsettled, but refused any help from medical staff. The following day he seemed to be in better spirits, and had a better night. On 1 July, he also had a settled day, although he was very sleepy.

66. In the early morning of Friday 2 July, the man complained of pain in his stomach, but said he would wait until day staff came on duty for pain relief. He was unable to retain anything which he ate or drank, and could not swallow his morning medication. Nurse A had been involved in his care through his time in Preston, and on that morning she could see that his body was beginning to peripherally shut down. The level of oxygen in his blood was dropping, his hands had gone blue in colour, and his blood pressure had dropped. He was sick, and brought up blood. She sought advice from nurses at the hospice. They recommended that, as he was unable to swallow his medication, pain

relief should be administered to him through a syringe driver. She therefore obtained one to help make him more comfortable.

67. The man had previously indicated that he was frightened of dying on his own, and had given this as one of the reasons why he was reluctant to go into hospital. Nurse A therefore made arrangements for one of the healthcare centre's support workers to sit with him. She was to remain with him through the day. Additionally, his cellmate had promised him that he would not leave him to die alone. He agreed to remain in the cell to provide company and moral support for him.

68. Through the day he remained very ill. He received a visit from the chaplain. Cell doors on the healthcare centre are locked and unlocked at certain times throughout the day, in accordance with general prison policy. However, the duty doctor agreed that healthcare staff would need constant access to his cell.

69. Shortly before lunchtime, a nurse contacted the prison's duty governor for that day and told her that the man was extremely ill. The duty governor discussed this with the Deputy Head of Security and the Prison Officers' Association. They agreed that the cell door could be left unlocked if a prison officer was posted outside the cell at the times it would ordinarily be locked. This also allowed the healthcare support worker or another member of the healthcare team to stay at his bedside with him through the day.

70. At this point, the duty governor and Nurse A spoke at length to the man's cellmate. They pointed out how ill he was, but his cellmate said that they had become friends whilst in the cell together and he had promised not to leave him to die alone. He was adamant that he wanted to stay in the room, and signed a note confirming that it was his choice to do so. He was told that he could change his mind and ask to move at any time.

71. Staff did what they could to make the man comfortable. When the day shift ended and day staff left, the prison went into patrol state (when the staff numbers are lower than during the day). Two nurses were on duty in the healthcare centre. A prison officer was stationed outside the cell. At approximately 9.20pm the officer noticed that he did not appear to be breathing. He went into the cell, but still could not detect any signs of breathing. Nursing staff were attending a healthcare incident elsewhere in the prison, so the officer put an urgent call over the radio network for the nurses to attend.

72. The nurses immediately returned to the man's cell and checked him for signs of life. He had stopped breathing, and they could not find a pulse. In line with his wishes, resuscitation was not attempted.

73. The nurses informed the Senior Officer, Night Orderly Officer that evening and in charge of running the prison. They also contacted the duty governor and the Head of Healthcare. They requested an out-of-hours doctor attend the prison. The duty governor was on her way home when she received the telephone call, and she returned to the prison. She summoned additional resources, in the form of a communications officer and two senior officers. Two members of the

staff care team were in the prison at the time, so the extra staff coming in to provide cover allowed them to make themselves available. One of the care team members based herself in the healthcare centre so that she was immediately available if required. An Officer Support Grade was also on duty that evening and he spoke to some staff who might need support. (He did this again the following day.) The Head of the care team was briefed and was available to come into the prison if required. The duty governor for the following day was also briefed as to what had happened.

74. Initially, staff had some difficulty arranging for the on-call doctor to attend the prison. However, she finally attended at approximately 11.00pm. The man's death was certified at 11.25pm.

Informing the family

75. Preston notified staff at Buckley Hall of the man's death that evening. The Governor arranged for someone to contact his ex-wife by telephone to inform her.

Debrief

76. It is usual following the death of a prisoner to hold a debriefing session with staff involved in his or her care. It ensures that staff have an opportunity to discuss any issues arising, and for support to be made available.

77. At 1.45am on 3 July a debrief was held for staff involved in the man's care in his final hours. This included both healthcare and discipline staff. The only area of difficulty raised was that it had taken one and a half to two hours to arrange for an on-call doctor to attend the prison to certify death, and this had been a difficult time for staff. The staff care team were in attendance, and staff were reminded that support was available should they feel that they needed it.

Support for prisoners

78. Support was made available for the man's cellmate, and he was moved into a cell with a friend. The following morning, support was made available for all prisoners in the healthcare centre. Members of the chaplaincy and the mental health crisis team came to visit them, and they were reminded of the availability of the Samaritans and of Listeners (prisoners trained by the Samaritans to offer confidential support to other prisoners). There were no prisoners on the wing who were on support measures for those thought to be at risk of harming themselves, but one man had only been taken off such support the previous day. He was moved to the Care Suite, with a Listener. All those in the prison who were subject to support measures (25 prisoners) had their cases and support levels reviewed.

Post mortem

79. A post mortem was carried out at the hospital on 6 July 2010. According to the doctor's report, the man's death was due to:

1a end stage liver failure with bronchopneumonia
1b alcoholism and hepatitis C

80. The liver failure was due to cirrhosis. The report noted that death was due to natural causes.

Funeral

81. Buckley Hall arranged and paid for the man's funeral. One of the healthcare managers who knew him represented Preston. His ex-wife was invited to attend.

Issues

Clinical care

82. The clinical reviewer notes that the man was under regular and constant review by medical and nursing staff at Preston. He was referred wherever necessary to the local hospital for specialist input, even though he frequently discharged himself against medical advice and refused to comply with treatment. Staff worked hard to create a compassionate environment for him in prison, and addressed his needs in a dignified and professional manner. I am pleased at the level of care and support that was made available to him and commend the staff in the healthcare centre for their professionalism and compassion.

83. She points out that, while clinical observations were clearly carried out at regular intervals, there are improvements that could be made in record-keeping. Both electronic and manuscript records were kept, which made things difficult to follow. Care plans and hand written continuation notes did not make it clear whether care took place in the prison or hospital. A number of signatures were illegible, and the position of the member of staff making entries on the record was not clear.

84. The clinical reviewer also notes that, while care plans identified problems and needs, records do not make clear that the plan was systematically followed. Some comments, such as “looks unwell”, do not allow a proper medical consideration of the man’s health at that time. Some observations were not followed up properly and, although review dates are given on the care plan, notes did not always show that they had taken place. The Head of Healthcare should consider the clinical reviewer’s comments and remind staff of the importance of maintaining clear and identifiable records.

    The Head of Healthcare should remind staff of the importance of maintaining clear and transparent records, with all names being clearly legible.

The man’s refusal of treatment

85. I have considered whether, as the man continually discharged himself from hospital against medical advice and/or declined to comply with his treatment, he should have been referred for a mental health assessment. (Any individual, who is deemed to be mentally capable, is entitled to refuse treatment and should be assessed by a qualified practitioner.) On 18 May, when noting the files that he did not want to be resuscitated, Prison Doctor C wrote that he was “fully aware”, meaning that he had all his mental faculties. However, when he sought to discharge himself from hospital on 10 June, the consultant thought that the level of disorientation meant that he was not of sound mind to do so. The discharge letter when he left hospital on 1 May said that he appeared to be aware of the implications of his behaviour. When he discharged himself from hospital on 15 May, he told hospital staff that he was aware that he would die soon and did not want any more treatment. The discharge note said “I felt his cognition was intact and he understood the consequences of his actions”.

When he rejected the fluid restrictions on 25 June, he told staff that he was aware of the consequences, and signed a disclaimer confirming this.

86. It seems likely to me that the man was aware of the implications of his decisions not to comply with his treatment. Although his files show that he was disorientated at times, these do not seem to have been overriding considerations when he took his decisions to discharge himself from hospital or refuse to comply with his treatment. Nevertheless, prisoners who refuse medical treatment should be properly assessed by a psychiatrist to ensure that, in the legal sense, they have the mental capacity to decide whether to accept treatment. I therefore make the following recommendation:

When a prisoner refuses medical treatment, the Head of Healthcare should consider whether they have the mental capacity to make this decision and document this accordingly.

Communication with outside agencies

87. There were occasional problems with communication between the prison and outside health agencies. When the man was discharged from hospital back to prison, discharge letters were not routinely sent. This caused difficulties for those in the prison caring for him. On one occasion this led to a level of confusion over his care whereby Prison Doctor C put him on an end of life care pathway, only for Prison Doctor A to take him off it the following day. Being unable to contact the hospital specialist to confirm his care management, Prison Doctor A admitted him to hospital to seek clarification.

88. The clinical reviewer makes a recommendation about communications with outside agencies, and I agree with her. Accepting that the problem appears to have been with the hospital communicating with the prison, it may be that a protocol needs to be established between the prison and local hospitals to try and ensure that these problems do not occur. I ask the Head of Healthcare to consider how best to address these difficulties.

The Head of Healthcare should consider how to ensure that information about prisoners' treatment is relayed effectively between outside agencies and prison healthcare.

89. When the man died, staff had some difficulty arranging for the on-call doctor to attend the prison. There was a long delay between the request being made and the doctor arriving, which was a very difficult time for staff. I know that the Head of Healthcare is aware of this issue, which was beyond the prison's control, and I do not imply any criticism of the prison by making a recommendation here. But in order that the chances of similar problems occurring in future are minimised, I recommend that the issue is raised with the relevant agency.

The Head of Healthcare should raise the issue of the delay in the on-call doctor reaching the prison with the relevant authorities, to reduce the risk of the problem recurring.

Consideration of compassionate release

90. I am pleased that the Governors of both Preston and Buckley Hall gave consideration to applying for compassionate release. In light of their discussions, the Governor of Buckley Hall went to see the man in hospital to discuss this in person. The decision, which he agreed with, that his best interests would be served by remaining in prison, does indeed seem to be the compassionate choice. I would have preferred, though, my investigator to have seen documentary evidence of the consideration. I do not make a recommendation, but would ask the Governor to ensure that records are kept of important discussions such as their consideration of whether he could be compassionately released.

Do not resuscitate (DNR) notices

91. The man, quite understandably, seems to have had difficulty coming to terms with the decision whether he wanted to be resuscitated should the situation arise. He made a decision then changed his mind on a number of occasions.

92. This is a sensitive issue which can be difficult for staff. Prison Service policy on resuscitation of prisoners is contained in the Prison Service Order (PSO) 2700. This PSO states:

> "**Resuscitation**: Policy remains that staff should continue to attempt resuscitation – as appropriate to the injury – until told to stop by a healthcare professional, e.g. a member of the Ambulance Service or a doctor, or rigor mortis has clearly set in …"

93. PSO 2700, however, relates primarily to suicide prevention and self-harm management when a prisoner is found unexpectedly in a medical emergency. It may be that further guidance is required for situations such as this. In the man's case, staff at Preston seemed to treat his requests not to be resuscitated appropriately, in line with medical guidelines, and with respect for his wishes. Nevertheless, the clinical reviewer points out that the records do not make it clear how decisions on DNR notices were to be documented and communicated to staff, and recommends that procedures are clarified. I agree.

The Head of Healthcare should review procedures relating to the documentation and communication of Do Not Resuscitate notices

Informing the man's next of kin

94. The man had been out of touch with his family for a number of years. Even though, with the help of prison staff, he contacted his ex-wife not long before he died and received a visit from her, they were not in ongoing contact. Once they were notified of his death, staff at Buckley Hall contacted his ex-wife by telephone to inform her of what had happened.

95. Guidance on breaking the news of a death in custody to next of kin is contained in Prison Service Order (PSO) 2710 and its annex. The guidance is that breaking the news face to face is preferable. But bearing in mind the lateness of the hour, and considering the circumstances between the man and his ex-wife, informing her in this way does not seem unreasonable. I note that she was contacted again the following day and asked if she needed anything further of the prison, and said that she was grateful to be informed, but did not want any further dealings with the matter.

There was some initial confusion between the two prisons over who would officially act as family liaison officer. Because the man technically remained a Buckley Hall prisoner, it was not clear whether Buckley Hall or Preston should act as liaison. Further to the issues addressed in the previous paragraph, it did not have a serious effect in this case, so I do not make a recommendation. But as Preston contains the in-patient unit for the region, the situation may happen again, and I draw the issue to the Governor's attention so that the problem does not arise in the future. The Governor could consider establishing a protocol for the provision of family liaison services for prisoners in healthcare who are technically in the custody of another prison.

Hospital escorts

96. On 1 April, the man missed a hospital appointment because, as he technically remained a prisoner of HMP Buckley Hall, they should have provided an escort. This appears to be a one-off incident so I do not make a recommendation, but the Governor and the Head of Healthcare will wish to ensure that there are systems in place to make the necessary escort arrangements well in advance.

Emergency cell bells

97. My investigator noted that there was only one emergency cell button in the cell which the man and his cellmate shared. This was positioned by the door of the cell which would usually be occupied by four prisoners. He was not mobile and could not reach the button. Had his cellmate required assistance or been incapacitated, neither prisoner would have been able to summon help. In this investigation this did not arise as a problem, so I do not make a formal recommendation. But the Head of Healthcare may wish to ensure that, in the event of an emergency, all prisoners are able to summon assistance.

CONCLUSION

98. The man was an elderly man with significant health problems. As soon as they were clearly identified he was transferred without delay to Preston, where he could receive 24 hour care in the healthcare centre.

99. He would frequently not comply with his treatment. Of 12 occasions when he was admitted to hospital, he discharged himself against medical advice on half of them. Nevertheless, I believe that staff did their best to provide treatment, and they cared for him in a professional and compassionate way. Having been out of touch with his ex-wife for a number of years, he was able to contact her with the assistance of staff, and they met for a final time. As the end of his life drew near, the prison made special arrangements to make him more comfortable.

100. The clinical reviewer notes that the man received care commensurate with, and possibly in excess of, that which someone with his health problems could have expected to have received outside prison. He was constantly reviewed, reassessed, referred to outside agencies where appropriate, and his health investigated. He received appropriate treatment and pain management. He did not wish to accept the conditions required for a liver transplant, and she comments that without his cooperation it is difficult to see how much more could have been done for him.

101. I make five recommendations. They cover maintaining clear records, mental health assessments for prisoners who refuse treatment, communication with outside agencies, and Do Not Resuscitate notices. I also comment on arrangements for documenting important discussions, arranging prisoner escorts, family liaison, and cell call bells.

RECOMMENDATIONS

1. The Head of Healthcare should remind staff of the importance of maintaining clear and transparent records, with all names being clearly legible.

2. When a prisoner refuses medical treatment, the Head of Healthcare should consider whether they have the mental capacity to make this decision and document this accordingly.

3. The Head of Healthcare should consider how to ensure that information about prisoners' treatment is relayed effectively between outside agencies and prison healthcare.

4. The Head of Healthcare should raise the issue of the delay in the on-call doctor reaching the prison with the relevant authorities, to reduce the risk of the problem recurring.

5. The Head of Healthcare should review procedures relating to the documentation and communication of Do Not Resuscitate notices.