

**A report into the circumstances surrounding the death of a
prisoner at HMP Bristol, at Southmead Hospital,
Bristol, in June 2007**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

July 2009

This is the report of an investigation into the circumstances of the death of a man on 24 June 2007. The man, a life sentenced prisoner at HMP Bristol, had suffered from chronic obstructive pulmonary disease (COPD) and related ill health for some years. This led to admission to outside hospital on several occasions. After becoming unwell in his cell, he was admitted to Southmead Hospital, Bristol, for the final time on 23 June 2007. He died the following day. His death was as a result of chronic obstructive pulmonary disease, bronchopneumonia and pericarditis. He was 80 years old. I would like to extend my condolences to the man's friends, family and all those touched by his death.

The man had been located at HMP Leyhill. However, when it became clear that he required 24 hour care, he transferred from Leyhill to the healthcare centre at HMP Bristol. He spent many months in the healthcare centre which, because of its small size and his disabilities, was restrictive but which he bore with good humour. It is evident that during his extended stay in the healthcare centre the man's medical care was responsive, sympathetic and aimed at controlling and relieving the effects of his chronic conditions. All aspects of his care were, with one exception, well documented. This investigation has been unusually wide in scope to cover issues raised by the man's next of kin.

The investigation was led by my colleague. I would like to thank the management and staff at HMP Bristol and HMP Leyhill for their assistance and co-operation during the course of his enquiries. I am also grateful to the clinical reviewer who conducted an independent review of the man's medical care in prison on behalf of the Bristol Primary Care Trust.

I make two recommendations on clinical matters and a further one to the Prison Service regarding facilities for elderly prisoners. I am pleased that all of my recommendations have been accepted. I must apologise for the delay in issuing this report.

The man had been in continuous custody for almost four decades.

Stephen Shaw CBE
Prisons and Probation Ombudsman

July 2009

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SUMMARY

The man, a life sentenced prisoner at HMP Bristol, died on the evening of 24 June 2007 at Southmead Hospital, Bristol. He had been admitted to the hospital the previous day as a medical emergency. The man was 80 years old at the time of his death.

The man had been convicted and imprisoned at HMP Winchester in 1968. By 1981, he had lost contact with all but one member of his family. He transferred to HMP Leyhill in May 2003. In January 2005, the man was refused release on licence. In August of that year he signed a Certificate of Indemnity in favour of a long time friend, which gave him legal guardianship and powers of attorney.

The man had been diagnosed with chronic obstructive pulmonary disease (COPD). He used an electric scooter to get around and was a smoker until the end of his life. In February 2006, while at Leyhill prison, the man was admitted to Southmead Hospital, Bristol with respiratory problems. He remained there for six days until 2 March. Because of an increased need for medical supervision that could not be met at Leyhill, he was discharged from hospital to HMP Bristol where he was admitted to the In-Patient Department of the healthcare centre. Initially, this was as a temporary measure, but because suitable accommodation could not be found in another prison the man remained at Bristol.

Although the man had transferred to Bristol for medical reasons, as it was not a Lifer Centre (a prison designated to hold life sentenced prisoners), he remained under the control of Leyhill for sentence administration purposes. This situation caused some conflict because of his perception that staff at Leyhill had a negative view of him and that this, in turn, had led to the refusal of release on life licence.

After previous unsuccessful reviews by the Parole Board, the man was again refused release on licence in March 2007 and a further review was set for September 2008. His view was that negative reporting by Leyhill staff was at the root of the decision not to release him, and he instructed his solicitors to pursue a Judicial Review of the decision. His solicitors wrote to the Home Secretary on 16 May requesting the case be referred back to the Parole Board. The man also made efforts to secure a transfer from Bristol and away from Leyhill, so that he could benefit from a reassessment of his case by another prison in preparation for his next review.

At Bristol, the man suffered frequent deterioration of his COPD. In several instances, his medical condition could not be managed within the prison and required him to go into hospital. He was admitted to hospital on three occasions during May and June 2007 and was prescribed continuous oxygen therapy. The man also had anaemia. Doctors wished to investigate but he refused the preparatory work needed to carry out the procedure. In spite of counselling by medical staff, he continued to refuse the procedure. On 13 June, the man told the doctor that he did not wish to be kept alive should his condition deteriorate significantly. The man's condition continued to deteriorate over the following week and he was monitored by medical staff at Bristol. During the late morning of 23 June, because of the nature and extent of his deterioration, the doctor sent him by ambulance to Southmead Hospital as a medical emergency. Later that evening, the

man refused further treatment and attempted to discharge himself from the hospital. The Bristol In-Patient Department Manager visited him at the hospital and persuaded him to remain.

The following day (24 June 2007), the man again refused treatment. The Roman Catholic chaplain visited and the man spoke to him about his concern that hospital staff were about to pursue a more aggressive treatment regime which he did not want. The chaplain confirmed with hospital staff that no aggressive treatment was planned and the man settled. He died at about 11.00pm the same evening.

A post mortem examination confirmed that the man died as a result of COPD, bronchopneumonia and pericarditis. A Requiem Mass was performed at Leyhill's chapel and his body was cremated after the service. His ashes were received by his long time friend.

I make three recommendations. Two concern the completion of medical records and end of life planning at Bristol. The other is a recommendation to the Prison Service about the development of facilities to support the ageing prison population.

THE INVESTIGATION PROCESS

1. My investigator visited HMP Bristol on 9 July 2007. He was given a full briefing about the circumstances surrounding the man's death. The liaison governor was subsequently briefed periodically by my investigator during the investigation. My investigator also met representatives of the Prison Officers' Association and the Independent Monitoring Board (IMB).
2. Staff and prisoners at Bristol and Leyhill who had relevant information relating to the man were invited to make themselves known to the investigator. One prisoner at Leyhill took up the invitation. The investigator met with relevant prison staff including members of the medical department.
3. One of my Family Liaison Officers wrote to the man's friend and designated next of kin and guardian, about the investigation. She also spoke to him on 1 August 2007 and has maintained contact since. Unfortunately, the pressure of other cases has led to a delay in producing this report for which I must apologise.
4. Bristol provided copies of the man's prison and medical records. A clinical review of the man's care was undertaken on behalf of the Bristol Primary Care Trust.

HMP BRISTOL

5. HMP Bristol is a category B local prison with an operational capacity of 606. It holds adult and a limited number of young male prisoners, both remanded and sentenced, in cellular accommodation. In 2005-06 Bristol ceased to be a Lifer Centre (a prison designated to hold life sentenced prisoners) and the Lifer Unit was disbanded.
6. Healthcare at Bristol is provided by the Bristol NHS Primary Care Trust. Bristol's healthcare centre (HCC) has a 20 bed In-Patient Department (IPD) with capacity for 18 inpatients and 2 prisoner cleaner/orderlies. The IPD rooms are a mixture of hospital cells, safer custody cells, two gated cells and a cell for the disabled, which is where the man lived prior to his final discharge to Southmead Hospital. There is wheelchair access to the HCC on the ground floor, the IPD, but not in the rest of the prison.
7. During the week, medical cover is provided by doctors from 8.30am until 5.00pm. After this time, Brisdoc provides cover until 8.30am the following morning. At weekends, a doctor attends Bristol from 9.00am until midday to see new receptions and prisoners reporting sick.
8. During the core day (7.30am - 8.30pm), the HCC has two clinical staff who are either nurses or healthcare officers (HCOs) and two prison officers. Outside these hours, there is a trained nurse and one healthcare assistant. At night, keys to access all parts of the prison are only carried by the night orderly officer who is in charge of the prison. Nursing staff carry a sealed pouch containing a key that can be used to access a cell in the event of an emergency. Each cell in the healthcare centre has a cell call bell which should be answered as and when necessary. Healthcare centre cells have large observation and access flaps in the doors so that medication and other (e.g. a cup of water) items may be administered or passed in without the necessity of unlocking the door. A patrol officer sees all prisoners in the centre at frequent but irregular intervals during the night.
9. HM Chief Inspector of Prisons, Dame Anne Owers, conducted a full inspection of HMP Bristol in January 2005 and made a follow up inspection in March 2008. Of relevance to this investigation, her 2005 report recommended that:
 - disabled access to the primary/day care facility should be installed
 - modifications should be made to the in-patient area for better access to the association room and bathroom.
13. At the time of the 2008 inspection, the first of the recommendations listed above had not been achieved, thus Dame Anne repeated it in the follow up. The other recommendation had been partially achieved in that modification to the bathroom for disabled patients had been completed, but movement within the IPD remained restricted.

14. Dame Anne said that since her earlier report Bristol was no longer resourced for life sentenced prisoners, and that all such prisoners should be transferred out of Bristol within six months.

KEY EVENTS LEADING UP TO 24 JUNE 2007

15. The man was first received into HMP Winchester, at the age of 40, from Winchester Assizes on 23 May 1968. He had been sentenced to life imprisonment for manslaughter. He was later given a tariff (minimum period to serve) of 10 years imprisonment. In the course of the following 35 years, the man moved to a number of prisons.
16. The man was known by his friends to be a committed Christian. He joined a Carmelite order and while at HMP Blundeston was recognised as an Itinerate Secular Carmelite Missionary attending a dedication service there in 1986. He had made vows, which he renewed annually on the same day, to reform his life. The man wore the scapula (religious habit) during services at Leyhill. The Roman Catholic chaplain at Leyhill believes that the man's faith made a big difference to his life and that he had reformed. In the same year, the man threatened suicide in a letters to an MP and the Governor of Blundeston because of the uncertainty about the length of time he would spend in prison. Following this threat, he had an interview with the prison medical officer but no action was considered necessary.
17. The man was first sent to open prison conditions at HMP Lindholme in 1996. He returned to closed conditions after he was found unsuitable, having obtained a driving licence in a different identity via his solicitor. In 1998, he again transferred to Leyhill open prison, but his performance on the Sex Offender Treatment Programme (SOTP) Relapse Prevention Programme raised concerns and he was again sent back to closed conditions. On 21 May 2002, at HMP Littlehey the man was placed on F2052SH self-harm monitoring procedures until the following day when the document was closed.
18. In May 2003, on the recommendation of the Parole Board, the man left Littlehey to return to Leyhill for a second time. The Parole Board recommendation indicated that the man was expected to take part in a booster SOTP and also to demonstrate his trustworthiness. His next review was planned for September 2004. By this time, the man was suffering with chronic lung disease and angina and used an electric scooter to aid his mobility around the prison and its grounds. He volunteered to work in the chapel office and played the organ in church services. He also requested a transfer to Norwich prison's elderly and infirm prisoners unit.
19. On 27 October 2003, the man was considered by staff at Leyhill to be at risk of self-harm, having told a staff member that he felt suicidal because of some aspects of an offending behaviour course he was required to attend. He was again placed under the F2052SH self-harm monitoring procedures for two days. During this time, he told medical and other staff that he was feeling low, because of a disagreement with members of the Psychology Department, but not suicidal or at risk of self-harm. After close observation and recommendations from medical and other staff, the monitoring procedure was lifted, with the man's agreement, on 29 October.

20. In December 2004, the man told his personal officer that he was still in contact with his sister who was in poor health. In July, an escorted visit to her was planned but was cancelled in August because she had been admitted to hospital. In April 2005, he was recorded as being unhappy at being refused permission to visit his sister. On 1 June, a similar application was also refused while she was in hospital.
21. The man did not complete the booster SOTP, citing health reasons. However, concerns were raised during those parts in which he had participated about his lack of motivation to address his offending behaviour and resistance to examining areas of risk. A fellow prisoner and long time friend said that the man had complained to him about the content of the SOTP and also about the psychologists at Leyhill. The man did not like the group discussion and the role play within it, and had refused to take part in the SOTP because of those elements.
22. The man was subject to annual Parole Board assessments. On both occasions that he was resident at Leyhill a forensic psychologist, was responsible for producing that assessment. The forensic psychologist did not recommend the man for release from prison on either occasion as his professional opinion was that the man remained a risk to the public.
23. In a report dated 24 January 2005, an independent psychologist advised the Parole Board that the man posed a low risk of committing a further serious offence, principally because of his advanced age. However, he also thought that the man was at high risk of parole failure because of his inability to abide by the rules of supervision. This would potentially lead to a recall to a closed prison and be a retrograde step. The independent psychologist suggested three alternatives:
- Leave the man at Leyhill. (A step the independent psychologist thought was not progressive.)
 - Seek a place at Norwich's elderly prisoners unit.
 - Release the man to a religious community. (The independent psychologist added that this option had been explored without success.)
24. On 25 January 2005, the man attended a Parole Board hearing at which he had legal representation. The chaplain also spoke in support of his release and he believes that parole was not granted because of the forensic psychologist report.
25. The Parole Board notified the man on 1 February 2005 that they were not satisfied that he posed no risk to the public and his release was refused. They disagreed with the independent psychologist that he posed a minimal risk of committing a serious offence. They also told the man that he had not made the progress they had expected of him since he transferred to Leyhill. They considered that he was not motivated to address his offending behaviour whilst in custody. They also felt there was no purpose in placing the man on any further programmes. (The man had offered to undertake a suitable community-based programme.) The Parole Board supported the

view that the man should remain at Leyhill until such time as his health needs could not be met by the healthcare available there. They told the man that before he could be released there should be demonstrable evidence that he could be trusted in the community after a prolonged period of successful resettlement leave. The man's personal officer recorded that he took the decision badly and was feeling very down.

26. On 28 August 2005, the man signed a Certificate of Indemnity in favour of his long time friend, visitor and main external supporter. The certificate, witnessed by a Justice of the Peace from the Bristol bench and the chaplain the RC chaplain at Leyhill, gave the man's friend legal guardianship and powers of attorney.
27. In October 2005, it was recorded that the man was waiting for an interview with staff from HMP Norwich's elderly prisoners unit. There is no evidence in his prison record that this interview took place but information supplied by the man's friend and legal guardian indicates that the man was visited by staff from Norwich but did not meet the criteria for transfer. A note of a meeting with the man on 16 January 2006 records in contradiction that, "Options for a transfer, at [the man's] request have been explored. He has turned down the specialist unit at HMP Norwich, and other establishments have refused to accept him."
28. The man was feeling low on 14 December 2005 as he had been refused Release on Temporary Licence (ROTL). He complained to his personal officer that he had done all the work he could with the Psychology Department and was still thought to be a risk. On 21 December, the man completed a complaint form seeking clarification of the risks identified in the risk assessment.
29. To address the complaint, a meeting of relevant staff (the Lifer Governor, the Lifer Manager, the Senior Psychologist, the Seconded Probation Officer and the man's Personal Officer) took place on 16 January 2006. The panel concluded that the man had not benefited from SOTP and was therefore regarded as an untreated sex offender who continued to demonstrate psychopathic tendencies. His risk level remained high, and he remained at Leyhill only because his age and ill health meant he was manageable. His continued presence at Leyhill did not imply that he would be granted ROTL to leave the establishment.
30. The man met with the members of the panel who gave him a detailed explanation of the outcome. At their invitation, he commented on each of the points raised. During the conversation, the man told the meeting that he had no confidence in the senior psychologist and would rather go back to closed conditions to get his case reviewed by someone else. He said that he wanted to remain at Leyhill but could not give up on the prospect of release. He concluded by saying that he would refer the matter to his solicitors.
31. The man was admitted to Southmead Hospital, Bristol, from 26 February 2006 until 2 March under prison bedwatch escort. As a category D prisoner (this is

a prisoner who can be trusted to serve their sentence in open conditions), he was not subject to mechanical restraints in hospital. His treatment for respiratory problems included oxygen therapy. The man's friend kept in regular telephone contact with the man during this time. The man became concerned about his ability to cope if he returned to Leyhill and spoke about this to prison managers during their visits to him and to the hospital medical staff. On 1 March, a note on the man's history sheet reveals that, in view of his condition, a registered general nurse from Leyhill (the signature is not clear) undertook to arrange a transfer to a prison with 24 hour medical care on his discharge from the hospital. At 2.30pm the following day, he was discharged to HMP Bristol where he was to be held on a temporary basis until more suitable accommodation, commensurate with his medical needs and his security category, was found. The man's friend and legal guardian attended the hospital and waited with the man for his transport.

32. On arrival at Bristol, the man was immediately admitted to the IPD. His admission sheet indicates that his physical health and mobility were both poor, but that his appetite and food and fluid intake were good. The man was seen by a doctor and offered the services of the chaplaincy, Samaritans and a Listener (a prisoner who is trained by the Samaritans to support other prisoners). A note on the admission sheet indicates that the man did not want any details of his family recorded.
33. The man remained committed to his faith and, for a while, maintained telephone contact with the chaplain at Leyhill. During those conversations, he expressed a wish to be cremated on his death and for his remains to be buried outside the chapel at Leyhill. The chaplain sent the man's scapula to him at Bristol.
34. A part time Roman Catholic chaplain at Bristol came to know the man quite well. He considered the man to be a sick and elderly man who had deteriorated during his time at Bristol. The Assistant Roman Catholic chaplain, also saw him in the prison healthcare unit where she sometimes gave him Holy Communion. The man sometimes wore the scapula to Sunday services. The chaplain spoke to the man soon after arrival at Bristol and explained that wearing the robe would draw unwanted attention from others. The man understood and did not wear it during services in the prison but wore it annually when he renewed his vows with the chaplain.
35. At interview with the investigator, the chaplain described the man as a committed Catholic who was an undemanding, humble and repentant man. He said the man felt that he had paid his debt to society, did not want to die in prison, and could not understand why, after all the years, he had not been released. The man had told him that he liked Leyhill but that he had been at odds with the senior psychologist there and, as a result, had remained in prison.
36. The chaplain told my investigator that he had concerns about the man's care in the last months of his life at Bristol. His opinion was that the Leyhill psychologists had maintained a negative and unsympathetic view of the man.

He also believed that Bristol was not equipped for the care of elderly sick prisoners and staff did not have the training and range of skills needed. The view that Bristol is not adequately resourced and trained for the general care of the elderly infirm is shared by the IPD Manager, who cited the facilities for bathing, wheelchair access and visits as examples. Whilst recognising that at Bristol the HCC was the only appropriate location for the man to be supported, the clinical reviewer expresses the view that there is a need to develop more appropriate accommodation as the prison population becomes older.

37. On 9 May 2006, the man's solicitors wrote to the Lifer Review and Recall Section at the Home Office. The solicitors asked, in the light of the man's failing health and the unlikelihood of him ever returning to Leyhill, for the management of his case to be transferred from Leyhill to Bristol. The correspondence was passed to the Prison Service. HMP Bristol responded that, because it was no longer a Lifer Centre, it was unable to accept management of the case. It was also pointed out that staff at Leyhill were attempting to find a place where the man's needs could be best met and, under those circumstances, the responsibility for management of the case remained with Leyhill. In July, the man wrote to a Probation Officer at Leyhill, in preparation for his next Parole Board case review, asking her to research the possibility of release to a nursing home in Norfolk.
38. The man's last Parole Board hearing took place on 5 March 2007. Again, he was legally represented and he made application to be accompanied by a member of the Roman Catholic chaplaincy. The Parole Board did not approve release and a further review was scheduled for September 2008. The man's view was that negative reporting by Leyhill staff and his probation officer were at the root of the decision not to release him. He instructed his solicitors to consider a request for a Judicial Review of the decision. At interview with the investigator, the chaplain commented that the refusal to grant release led to the man losing the will to live and contributed to his decline. He believes that the senior psychologist was in great part responsible for that refusal.
39. On 25 March 2007, the man wrote to a healthcare manager at Bristol indicating that he was exploring the possibility of being transferred to HMP Erlestoke. In a further letter on 18 April, he gave reasons for being transferred to HMP Ashwell. He contended that his outside support team was mainly based there and he could benefit from a reassessment of his case by another and, in his view unbiased, prison in preparation for his next review.
40. An entry on 30 March in an in-patient care sheet indicates that the man had low levels of oxygen in his blood. A nurse wrote in the action section that the man should use the oxygen for a minimum of 15 hours daily as prescribed by the respiratory nurse.
41. On 4 April, the man complained of increasing breathlessness. He was examined by a medical officer at Bristol, who noted that he had continued smoking against his advice and he warned him about smoking while using

oxygen. He also noted that the man was overusing his ventolin nebuliser which he was due to stop using on the following day.

42. The medical officer assessed the man again on 6 April with a view to withdrawing his remaining two nebulisers (salbutamol and ipratropium) because of heart arrhythmia (an abnormal heart rhythm). He planned to stop the nebulisers and mucodyne on 7 April. If the man's breathing remained stable, he also planned to stop his prescription for phylocontin a few days later. The doctor noted in the man's medical record that he would review and re-assess any functional improvement in the man's health. On 8 April, the medical officer recorded that the man had queried why his mucodyne prescription had been stopped and that he had been taking them for more than four weeks without any benefit. The doctor again advised the man to stop smoking.
43. The medical officer noted on 18 April that the man had been mobile using a Zimmer frame before he moved to Bristol. He added that his medical condition did not prevent him from walking and that he should be encouraged to do so. The doctor felt that he could not justify the risks involved in continuing some of the man's medication if he did not walk. In spite of this, he emphasised that physiotherapy would be inappropriate but did not explain the reasons why.
44. On 6 May, another nurse noted that the duty governor had granted permission to allow the man's cell door to be left open over the lunchtime patrol period. During that time, the man's observations were taken on two occasions and at 3.45pm the medical officer undertook a medical review. He noted that the man complained of being more breathless than usual, concluding that he probably had a chest infection. The doctor wrote in the man's record that he should have continuous oxygen, and take his nebulisers as usual. In addition to the man's other medication, he prescribed antibiotics. He also noted that the man's clinical observations should be taken every three hours and he would conduct a further review on the following day.
45. Following an observation by nursing staff that he was lethargic, the man was admitted to the Bristol Royal Infirmary (BRI) on 7 May for congestive obstructive pulmonary disease (COPD). The man's physical observations showed that his oxygen saturation figures (known as sats) were low. His care plan evaluation sheet indicates that he was initially due to be admitted for 24 - 48 hours but he remained there for eight days. On 11 May, the man had a gastroscopy (an examination that looks inside the oesophagus, stomach and duodenum) which appeared normal and no further investigation was proposed.
46. A note dated 15 May in the man's Continuous Clinical Record indicates that the man's friend and legal guardian had been in touch with Bristol to convey the man's concerns about returning there and particularly his access to medical care at night. He was assured that a nurse from the HCC would visit the hospital before the man's discharge to ensure that his needs could be met. The first nurse went to the hospital to assess the man and he was

discharged later that day. The care plan shows that he was given antibiotics for seven days, steroids, nebulisers and oxygen. His other medication was adjusted and his haemoglobin levels were to be monitored. The results of a gastroscopy and mid stream urine (MSU) tests were negative. A colonoscopy was planned and the man had refused a physiotherapy assessment. He also needed assistance with his personal hygiene.

47. On 16 May, the man's solicitors told him that they were unable to challenge the decision to refuse his release. However, they had sent a 'letter before action' to the Home Secretary, in which they asked him to reconsider the date of the next review, setting a deadline of 4 June for a response. They argued that, because of the man's age and his deteriorating ill health, the case review should be set for no later than 20 December 2007. They explained that if this was not granted, they intended to issue Judicial Review proceedings. Two days later on 18 May, the man asked HCC staff if Probation Service supervision of his case had been transferred from Norwich to Bristol. They told him that a letter had been received requesting an up to date report on his activities.
48. Following concerns about his breathing and oxygen sats, the man was admitted to Southmead Hospital at about 11.00pm on 20 May with suspected heart failure. He was treated with oxygen therapy and was encouraged to walk. The outside hospital occurrence sheet records that on 22 May the man discussed smoking with the chest physiotherapist, whose opinion was that oxygen therapy was of little use to a smoker.
49. In a letter dated 25 May, the man was offered an appointment on 11 June at the Bristol Royal Infirmary for an endoscopy examination, with a view to establishing why he was anaemic and whether he was suffering from bowel cancer. On the same day, a doctor from Southmead Hospital contacted HCC staff to tell them that the man would be discharged in the middle of the following week and needed an oxygen concentrator to assist his breathing. The doctor said that the hospital would ask the British Oxygen Company (BOC) to liaise with Bristol to supply the necessary equipment.
50. Because of his respiratory difficulties, the man remained in hospital until 30 May receiving regular oxygen therapy and an assessment for long term oxygen therapy. Following his discharge, he was given an appointment to be reviewed by the hospital in eight weeks. Hospital staff also said that the man had been self caring, using a Zimmer frame and required minimal assistance. After the man's return, the medical officer detailed that the man was on continuous oxygen therapy, that he was to be offered help in stopping smoking, and that he was to be put on a reducing course of prednisolone (a corticosteroid to help control inflammatory and allergic conditions such as asthma) over a period of 12 days. The man's prescription chart shows that he received this planned treatment until 7 June when the prescription was altered. The doctor also detailed treatment for COPD (including nebulisers four times daily), right ventricular failure (failure of the right side of the heart), atrial tachycardia (rapid heartbeats in the upper chamber of the heart) - where

he noted that the nebulisers made this condition worse - and suspected anaemia.

51. The man's Zimmer frame had been left at the hospital, but was returned on that day and he was concerned at the loss of his wheelchair. The man also signed an IPD admission agreement. The document is a standard acceptable behaviour agreement, but there were several hand written insertions:

"Wheelchair on the agreement that I will mobilise to

1. Get food
2. Shower
3. Exercise as accord to care plan"

A further insertion in the document adds, "to use sanitary arrangements".

The man's medical record contains a Bristol HCC weight chart, started on 31 May 2007, on which his weight was recorded at 13½ stones.

52. On 31 May, an oxygen concentrator was installed (by BOC Medical) in the man's cell to provide the man with long term oxygen therapy. The following day, the man's friend and legal guardian wrote to the Head of Healthcare at Bristol to express concerns about the man's care since his return from hospital. He complained that a member of staff was putting the man under pressure to become more active. The staff member had withheld the man's nebuliser overnight, which had put him under stress and was likely to be a danger to his health. The man's friend raised a second issue that the man's wheelchair had been missing on his return from hospital and the replacement had no footrests or seat cushion. He asked for positive action to be taken. An undated note, signed by (the head of healthcare) on the reverse of the letter, confirmed that the man had received his nebuliser and wheelchair and that he (the head of healthcare) did not intend to reply to the letter because the issues outlined had been resolved.
53. A note in the man's Continuous Clinical Record dated 4 June shows that he was coping well with oxygen therapy but had complained that he was not getting his nebulisers before 7.00am. On the following morning, the man walked a few yards, and again in the late afternoon walked from his cell to the kitchen with the aid of his Zimmer frame. His weight on 5 June was recorded as 14st 2lb and the following day as 13st 8lb. On 7 June, the head of healthcare was asked to see the man urgently because he was complaining of shortness of breath. The doctor increased the prednisolone from 10mg to 40 mg daily for five days; thereafter it was reviewed and again reduced. The man's weight was noted at 13st 9lb and remained so for three days. On 8 June, he was allowed a saline nebuliser at night to ease his breathing.
54. The man remained in the HCC where he continued to experience a number of symptoms, principally respiratory. In light of this, on 7 June a note was made in his Continuous Clinical Record to the effect that, should he remain unwell on 10 June, the preparation for the endoscopy on the following day would be cancelled. On 9 June, he was still unwell. A healthcare staff nurse explained

the preparation required but the man declined to have the procedure and signed a disclaimer to that effect. The importance of the procedure was reiterated on 10 June, but the man again declined. Following a further refusal on 11 June, the procedure was cancelled and the hospital was informed that the man did not want the appointment re-booked. The man's weight was recorded as 13st exactly on 10 June and 14st daily thereafter until 15 June when he became unfit to be weighed.

55. In a conversation with the head of healthcare on 12 June, the man said that his solicitor had written to the Home Secretary to ask for his case review to be brought forward. The man asked the doctor to state whether he thought he was "terminally ill" or "very seriously ill". The doctor confirmed the latter description. On the following day, the two men again had a conversation in which the man told the doctor that he did not wish to be kept alive if his health deteriorated significantly. He explained that he had ceded power of attorney to his friend and legal guardian and that this man was now effectively his next of kin. The head of healthcare suggested that the man should make his wishes known formally by consulting his solicitor and preparing a living will.
56. On 17 June, the man voiced his concerns to a doctor that he had no control over his salbutamol. The in-possession prescription record indicates that he was prescribed an additional salbutamol nebuliser on that day which was issued in his possession on 18 June. The prescription chart showed that the man had both in-possession and not in-possession prescriptions for salbutamol. The man took the not in-possession nebuliser as prescribed until the morning of 23 June when he was admitted to outside hospital. The man's weight was recorded as 91kg (14st 3lb) on 18 June, after which no further weight information was recorded on the weight chart.
57. The doctor noted that the man tended to over-use the medication but that he could be given more at the discretion of nursing staff. The In Patient Care Plan indicates that the man enjoyed calm and settled nights around this period, until the night of 20 June when he complained of shortness of breath and was given a nebuliser. The records show that he made a good recovery, although he had refused to get into bed.
58. On 19 June, The head of healthcare and the man discussed the possibility of a colonoscopy to determine the cause of the man's anaemia. Again, he was again not keen to have the procedure and agreed to tell the doctor should he change his mind.
59. The chaplain told my investigator about an incident that occurred about a week before the man's death. The man was in a single cell with a bell to be used to alert staff. The man had told him that he had pressed his emergency cell bell at around 10.30pm to summon help to use the lavatory. A nurse eventually attended at about 2.00am but was unable to help because she had no keys to unlock the door. At 5.00am, assistance arrived but by this time the man was lying on the floor having been unable to get to the lavatory. The man told the chaplain that this was not the first time this sort of incident had happened although it had been the worst. The Care Plan – Evaluation Sheet

shows that, in the main, the man had settled nights, except the nights of 19/20 June when he is reported to have used his nebuliser at 2.50am, and 20/21 June when he complained of being short of breath and was given a nebuliser at 1.35am. The Continuous Clinical Record during this period makes no mention of the incident the man referred to but records that the man had become incontinent on one occasion on 16 May following discharge from hospital on 15 May. On 21 June, his friend spoke to the man by telephone for the final time. The man told him he was distressed at not having access to his nebulisers at night, although the prescription chart shows that he had in fact received nebulisers at night as prescribed.

60. Following the man's death, his friend spoke to my family liaison officer about his concerns that in the final weeks before the man's death his medication had been altered by a locum doctor. The man's friend said the man had not been able to use his nebuliser at night due to a new regime. He had been issued the medication as needed but not given the necessary capsules in advance.
61. The man's Continuous Clinical Record contains entries for a Seretide inhaler, prescribed on 30 May, to be used twice daily which was administered as prescribed by the head of healthcare until 23 June. Salbutamol and ipratropium bromide nebuliser solutions were prescribed by the head of healthcare on the same day, to be taken four times daily including one night time dose of each. These prescriptions were both re-issued on 11 June and the salbutamol again on 22 June. The prescription chart shows that both nebulisers were in use, as prescribed, from 30 May until the morning of 23 June.
62. During the night of 20/21 June, the second nurse was called to examine the man because of his breathing difficulties. While so doing, she found a quantity of frusemide, one of the man's prescribed medications, hidden in his cell. She gave one to the man and destroyed the remainder. A care plan was written later in the day to ensure that the man swallowed his medication in front of the issuing nurse. During the day on 21 June, the man's physical observation notes show that he was distressed as his oxygen sats had dropped. The third nurse reassured him.
63. On 22 June, the third nurse noted the man was tired but had accepted his nebuliser. The man's physical observations were noted as having dropped further at 11.45, but by 2.15pm his sats had risen again to 83%. A note to continue monitoring the man's sats was made in the Continuous Clinical Record.
64. In the early morning of 23 June, a Healthcare Officer (HCO) made a note in the man's Care Plan – Evaluation Sheet that he had found several smoked roll-up cigarettes in the man's toilet area. He also recorded that the man had nicotine stained fingers and had ordered tobacco from the prison canteen. His friend and fellow prisoner visited him in his cell between 10.00 and 11.00am. In his interview with the investigator, this man mistakenly remembered the day as a Sunday rather than a Saturday. He said that the

man had told him that he felt unwell. The man's friend said he could see that the man's breathing was very bad. At about 11.00am, a fourth nurse took the man's physical observations and noted that his blood pressure was low at 80/40. The reading was taken again at 11.10am with the same result. At 11.20am, the head of healthcare examined the man and noted that he was pale and conscious but short of breath. In view of the man's deterioration, the doctor arranged for him to be sent to hospital by ambulance as a medical emergency. Whilst waiting for the ambulance, the man's observations were monitored.

65. The assistant chaplain interrupted the chaplain towards the end of the normal Saturday morning chapel service to tell him that the man was dying. The chaplain finished the service and went with her to the man's cell. The chaplain told my investigator that he felt a distinct resentment to his presence in the cell by an unnamed member of staff. The chaplain anointed the man before he left for the hospital, and the man asked him if he was dying.
66. At 11.50am, the man left the prison to go to Southmead Hospital. The Continuous Clinical Record shows that a referral letter and the man's treatment record card were sent to the hospital with him. At 3.00pm, the prison control room confirmed to the IPD Manager, that the man had been admitted to hospital. She in turn spoke to the duty governor about informing the man's next of kin and was told that the chaplaincy would do so.
67. Later that evening, against the advice of his doctors, the man refused further treatment and attempted to discharge himself from the hospital. The IPD manager visited the hospital at 8.30pm. The man was encouraged to remain and to give the bypap (oxygen therapy) another try overnight, at a reduced pressure to make it more comfortable for him. He agreed.
68. On the following day (24 June 2007) at 2.15pm, the IPD manager telephoned Southmead Hospital to check on the man's progress. She was told that he was again refusing treatment and there were no plans for his discharge. During that evening, the chaplain was asked to go and speak to the man following a further attempt to discharge himself. On his arrival at the hospital with the senior of the two escorting officers told him that the man was "being obnoxious". This comment was made within the man's room, and he might have heard it. The chaplain spoke to the man, who was concerned that the hospital staff were about to pursue a more aggressive treatment regime which he did not want. He was also concerned at the rate of flow that his oxygen equipment was delivering to his mask. The chaplain then consulted the duty doctor who confirmed that no aggressive treatment was contemplated. This calmed the man. The chaplain also spoke to the nurse about the oxygen flow and she reduced it.
69. At interview, the chaplain suggested that the man's frequent admissions to outside hospital had made him unpopular with prison staff. He had spoken to the "head nurse" and asked to be called towards the end of the man's life so that he could administer last rites and so that the man would not die alone. The "head nurse" had queried this request, and the chaplain is of the belief

that nursing staff at Bristol have little knowledge or regard for differing religious beliefs and needs. The chaplain also complained that one of the escorting officers had been insensitive when talking to him in the man's presence. He had reminded the man that the man was very ill, but did not want to make an issue of the matter in a situation that might have made the man's position worse. He said that he later spoke to a member of the IMB about the incident.

70. The man died at around 11.00pm on 24 June and the hospital informed Bristol at about midnight. Although the man had been alone (under escort) when he died, he had been visited by the Roman Catholic chaplains for 30 minutes during the evening. A message was left for the man's friend and legal guardian, who was on holiday, informing of the man's admission to hospital. It is a source of regret that he did not receive the message until his return and was unable to get to the hospital to be with the man.

After the man's death

71. As the man had died in an outside hospital, HMP Bristol did not fully activate the contingency plans for a death in custody. The Acting Healthcare Manager noted on a Bristol North NHS PCT risk assessment form that the man's next of kin (his legal guardian) had been informed of his death on 25 June. The man's personal belongings were put together for collection by his next of kin and were subsequently collected by him. His clinical notes were updated, photocopied and secured.
72. The IPD manager was informed that the man had died at 7.10am on 25 June. She then informed the man's friend and fellow prisoner, of the news and she and other healthcare staff sat with him to support him. The IPD manager informed the duty governor at 10.15am.
73. A post mortem examination was carried out at Southmead Hospital. The opinion, set out in a report dated 4 July 2007, was that the man had died from bronchopneumonia and pericarditis which had arisen against a background of chronic obstructive pulmonary disease. The post mortem report commented that bronchopneumonia and associated conditions are common causes of death in the elderly, and that there was nothing to suggest that the man's medical management had been in any way deficient.
74. A Requiem Mass, conducted by the chaplain from Bristol and the chaplain from Leyhill was held on 16 July at the Leyhill Chapel. The service was attended by staff and prisoners from the respective prisons. The man's friend and legal guardian also attended and made a tribute to him. Following the service at Leyhill a funeral service took place at the local crematorium where the chaplain officiated. After the cremation the man's friend and legal guardian arranged for a short dedication service and the man's ashes to be spread in the Kent churchyard where his father had once been rector.

ISSUES CONSIDERED DURING THE INVESTIGATION

Medical care

75. The man had been in prison custody continuously since 1968. On reception into prison, he was fit and well and remained so for the next 30 years, experiencing only minor ailments. As he became older, the ailments were commensurate with his advancing years. He was a regular smoker until the end of his life.
76. The man had been diagnosed with COPD and heart failure several years before he arrived at Leyhill in 2003. This had led to mobility problems and eventually resulted in the use of an electric scooter to enable him to move freely around Leyhill, which is a large site. The man's health deteriorated to the extent that Leyhill was no longer able to offer him the healthcare supervision he needed and so he transferred to HMP Bristol in March 2006, where he remained for the next 15 months until his death.
77. The clinical review, carried out on behalf of Bristol PCT is based on the man's prison medical record. It includes an assessment of the care provided for the man by staff at Bristol until his death on 24 June 2007 at Southmead Hospital. The man had been moved into the healthcare centre as an in-patient to be given increased support. Over the final months of his life, his condition continued to deteriorate. He required continuous oxygen therapy as well as other medical interventions and had been admitted to outside hospitals on three occasions.
78. The man's friend, and next of kin, has raised a concern about the man's apparent weight loss over the final months of his life. The man's weight had been monitored for a period from the end of May until 18 June during which time his recorded weight generally increased but the record contains fluctuations, in one instance by as much as 14lb in a 24 hour period (I assume this must have been a recording error). No concerns were raised by staff caring for the man about this apparent fluctuation and no specific medication or alteration to his diet to combat weight loss is evident. It is also apparent that there had been inconsistencies in how the man's weight had been recorded and that the records had not been examined. The external examination section of the post mortem report records that the man was "well nourished and well cared for". On the evidence available, it is likely that the man's weight was within acceptable parameters given the general state of his health. I judge it likely, therefore, that his friend's concerns about the man's weight loss over the final months of his life are unfounded. However, inaccurate recording of medical information does not command confidence and is potentially dangerous.

Bristol PCT and the healthcare manager should ensure that healthcare staff adhere to professional standards in the completing of medical records.

79. I believe that the man was well looked after and I have found no evidence to support the concern that he experienced any lack of access to medication at night or any other time. Rather the opposite: medication is recorded as issued as prescribed, following documented indications that the man had over-used or not taken his in-possession medication.
80. The clinical reviewer points out that the man was well supported both clinically and emotionally. This view was endorsed by the man's long standing friend and legal guardian, in a conversation with one of my Family Liaison Officers. The clinical reviewer raises no significant healthcare issues and concludes in his review that the man was well looked after during his time at Bristol, the prison coping with the complex needs presented by his condition.

Accommodation for elderly and infirm prisoners

81. Both the 2005 and the 2008 reports by HM Chief Inspector of Prisons highlight the restrictions experienced by disabled prisoners in accessing facilities in Bristol's healthcare centre, and both make appropriate recommendations to the Prison Service.
82. The man was a category D prisoner and had been successfully living at Leyhill, despite the restrictions his health imposed on him. Once his health deteriorated beyond that which healthcare providers at Leyhill could manage, he was sent to Bristol (a category B prison) in the absence of a more suitable location elsewhere within the prison system. The responsibility for finding the man a place in a suitable prison rested with Leyhill and, until they could do so, he remained a "lodger" at Bristol.
83. The In-Patient Department Manager at HMP Bristol recognised in interview that general care for the elderly infirm at the prison is not adequate. She referred to the limited availability of facilities for bathing, wheelchair access and visits. She also said that staff do not receive sufficient training in handling the elderly and infirm. The chaplain, the Roman Catholic chaplain, holds similar views and considers that Bristol is more suited to handling prisoners with addictions and not for the care of the elderly sick. He also believes that staff at Bristol do not have the training and range of skills needed for the care of the elderly and disabled.
84. At Leyhill, as a category D prisoner, the man had been able to make his own decisions about large parts of his daily life and to move around freely, taking part in normal social intercourse in a relaxed atmosphere. Bristol has a much more physically restricted environment. While the man accepted those restrictions, mainly with good humour, this situation should have lasted only for a short period while alternative, more suitable, accommodation was found.
85. Leyhill explored the options for a more suitable placement for the man in a prison unit equipped to cater for the elderly/infirm as well as 'lifer' status, without success. (Although the man had either refused or been refused a place at Norwich in late 2005.) The man had also actively explored possible locations that would provide the medical supervision he needed and, from his

perspective, allow a different more favourable set of lifer reports to be compiled and submitted to support release on licence. He was similarly unsuccessful.

86. The provision of prison places for elderly and infirm people within Prison Service establishments is very limited. This is a matter on which I have commented in previous reports. HMP Norwich houses the sole unit dedicated to the accommodation of elderly and infirm prisoners, and has a capacity of just 15 men. There are also a number of other prisons with local initiatives that cater for the needs of this group of prisoners. However, there is no overall national strategy supported by mandatory standards for providing elderly and infirm prisoners with the level of care required. (Prison Service Order 2855 addresses the issues of management of people with disabilities and also seeks to give some guidance on the management of older prisoners.)
87. The clinical reviewer observes that the HCC was the only appropriate location in Bristol prison for the man to be supported over his final months. He adds that there is a need to develop more appropriate accommodation as the prison population becomes older. The clinical reviewer makes two recommendations which, with minor modifications, I endorse.

The Governor and Head of Healthcare at HMP Bristol should raise staff awareness of end of life planning.

The Prison Service should develop sufficient high quality facilities to cater for the ageing prison population and for the support of patients with severely incapacitating or terminal conditions.

Issues raised by next of kin

88. The man had lost touch with his immediate family many years before his death, and had assigned his friend as his legal guardian and next of kin with full powers of attorney over his affairs. During a telephone conversation on 1 August 2007 with my Family Liaison Officer the man's friend expressed some concerns about the circumstances surrounding the man's death. The man's friend also wanted to know whether there was any evidence to support the man's view that the psychologist at Leyhill had unfairly discriminated against him. He questioned whether the negative view of the man at Leyhill had adversely affected his chances of being released in early 2007.
89. The decisions of the Parole Board are outside my remit, and I have not explored that issue further. However, it may be useful to comment as follows. In common with all prisoners in similar circumstances, the man was expected to attend courses to explore and address his offending behaviour. Until those courses are completed, insights gained and sustained modifications to outlook and behaviour achieved, release is unlikely. It is for the professional reporters to use their expertise to assess the level of risk to the community. That said, I think it is questionable whether it was appropriate for Leyhill to have been

responsible for administering the man's sentence while he was a long term resident at Bristol.

90. The man's friend went on to ask if there was any evidence to support the view that the man had lost heart after his last application for release, thus hastening his death. It is true that the man was disappointed, having made much effort to gain his freedom. The In-Patient Department Manager said the man was resigned to the decision. The chaplain said that he felt the final refusal by the Parole Board in March 2007 affected the man's will to live and his health declined. The man's clinical record charts the decline in his physical health over the final weeks of his life, and it is clear that he understood that his medical condition was likely to lead to his death. On 13 June 2007, he told a doctor that he did not wish to be revived if his health deteriorated significantly. The previous day, he had told the same doctor that his solicitor was pressing for another parole review date. I do not think it is possible to determine whether the man had lost heart and if so, how it had impacted on his health. A view that the chaplain profoundly disagrees with.
91. Finally, the man's friend asked if the weight loss he detected during the man's last months of life had been noted by healthcare staff and, if so, what had been done about it. I have addressed this issue earlier in this report.

Issues raised by the Chaplain

92. The Chaplain who knew the man well, described him as a devout Catholic who felt that he had paid his debt to society and did not want to die in prison. The chaplain recognised that the man had "contradictions within him and he could be obstinate".
93. In the chaplain's view, the final refusal by the Parole Board resulted in the man losing the will to live and led to his decline. He believes it was inhumane not to have released the man to a care home in the last few months of his life. The man had liked Leyhill but felt that, as a result of being at odds with a prison psychologist there, he had to remain in prison. The chaplain believes that the Leyhill psychologist's reports to the Parole Board supported a negative attitude towards the man and that he should be held to account for his part in that refusal. I must reiterate my view above that it is for professional staff to assess the extent to which the prisoner has benefited from interventions and the risk to the community, and these are not matters on which I can sensibly pass judgment or comment.
94. The chaplain also contends that there were issues about the man's care in the last months of his life at Bristol. He believes that the prison is equipped to handle prisoners with addictions but staff do not have the training and skills needed for the care of old age and disability. He considers that, as a result, there had been no sympathy for the man. In interview, the chaplain referred to an incident reported to him by the man just before his death. The man had told him he had been unable to summon help to use the lavatory at night, and had suggested that this had not been an isolated event. The record makes no reference to this event but chronicles a single incident of incontinence on the

night of 16 May 2007. However, other events at night were recorded during that period and suggest that the man had proper access to medical help. It is true that Bristol HCC, with its physical limitations, was not an ideal situation for a man in the man's condition. Nevertheless, I judge that the man's healthcare needs were fully met.

95. At interview, the chaplain expressed his belief that frequent admissions to outside hospital made the man unpopular with staff, and that the nursing staff at Bristol have limited knowledge of or regard for religious beliefs. He cited insensitive comments and that he had sensed a distinct resentment of his presence in the man's cell on one occasion.
96. After the man's death, the Bristol chaplain helped to arrange his funeral with the Leyhill chaplain, and the man's friend and legal guardian. A Requiem Mass took place in the Leyhill chapel, after which the man's body was taken to the local crematorium. The Bristol chaplain said he found it strange that a governor from Bristol and the Deputy Governor from Leyhill were present but remained outside the chapel during the Requiem Mass. However, the Leyhill chaplain believes that they did so out of a wish to be discreet and not wishing to intrude.
97. The Bristol chaplain's observations reflect his perception that some staff at Bristol and Leyhill were less than professional in their attitude to and dealings with the man. Overall, I find that the man was dealt with fairly and sympathetically. However, it is possible that some exchanges between those involved with the man and attitudes in dealing with him both before and after his death were insensitive or misunderstood. Emotions at the time surrounding any death are heightened, and due care must be exercised by staff to avoid actions and words that result in the perception by others that they are uncaring.
98. The perception of insensitivity towards the man and his religious needs underscores the need for improved training and provision of facilities for the elderly/infirm and those approaching the end of their lives. However, there is insufficient evidence of deliberate incivility and I make no formal recommendations.

CONCLUSION

99. The man was a long term prisoner, both elderly and infirm, but mentally alert. He was not always co-operative either with his medication or administrative regimes. As a category D prisoner, he was used to the relaxed atmosphere of Leyhill but, because of his need for increased medical supervision, found himself in restricted category B conditions at Bristol's healthcare centre. The loss of Bristol's status as a prison handling life sentenced prisoners meant that the man was still under the control of Leyhill in sentence management terms, a situation that he and his supporters found frustrating. It is unfortunate that, despite attempts to accommodate him in more suitable surroundings within the wider prison estate, this had not been achieved before his death.
100. It is recognised by the clinical reviewer and staff interviewed during the course of this investigation that Bristol lacks appropriate facilities and training for the care of the elderly/infirm. The focus is on a younger, more able-bodied prison population with other needs. While the prisoner base is predominantly young and relatively fit, there is an increasing number of prisoners who are elderly or infirm, some of whom will end their days within prisons. There is a need for facilities to be developed that specifically cater for the needs of the elderly/infirm and for those who require specialist care as they approach the end of life. In tandem with the need for specialist facilities, there is a need for increased staff training.
101. Nonetheless, the clinical reviewer concludes that the clinical and emotional care the man received at both Bristol and Leyhill was appropriate. He had been well supported during a long and complex illness and there is no suggestion that his care was below current medical standards. I agree with the clinical reviewer's findings.

RECOMMENDATIONS

1. Bristol PCT and the healthcare manager should ensure that healthcare staff adhere to professional standards in the completing of medical records.

The recommendation is accepted and the following response was received:

“The local PCT and the healthcare manager are to originate an auditable document to be utilised to ensure that systems in place adhere to Professional Standards. This will be used to audit the establishment’s records to ensure that full compliance is met.”

The target date for this action is 1 April 2009.

2. The Governor and Head of Healthcare at HMP Bristol should raise staff awareness of end of life planning.

The recommendation is accepted and the following response was received:

“A Gold Standard Framework document will be completed for each patient to ensure that individual needs are taken into account for this plan. PCT/Disability Officer will liaise to ensure that a full analysis of accommodation is adequate for individual needs by utilising a care map.”

The target date for this action is 1 April 2009.

3. The Prison Service should develop sufficient high quality facilities to cater for the ageing prison population and for the support of patients with pre-terminal or terminal conditions.

The recommendation is accepted and the following responses were received:

“National response

The Dept of Health is working with NOMS to look to develop focussed services and facilities for groups of ageing or disabled prisoners as per the wider community. Dept of Health and NOMS are working on producing an end of life policy and care pathways for older prisoners which is due to be implemented in approx 12 months.”

The target date for this action is April 2010.

“Local response from Bristol

A Gold Standard Framework document will be completed to ensure that individual needs are taken into account for this plan. PCT/Disability Officer will liaise to ensure that a full analysis of accommodation is adequate for individual needs.”

The target date for this action was 1 April 2009.