Investigation into the circumstances surrounding the death of a man at St James University Hospital, whilst in the custody of HMP Leeds

Report by the Prisons and Probation Ombudsman for England and Wales

June 2010

The man died on 5 September 2009 at St James University Hospital Leeds. He was 72 years old. He was admitted to hospital on 1 September after staff found that he was confused and dazed. The man was a long time sufferer of Chronic Obstructive Pulmonary Disease (COPD) related to smoking. His cause of death was acute respiratory failure due to COPD. I offer my condolences to the man's family and friends affected by his death. I am sorry that my report has been delayed and apologise for any additional distress that this may have caused.

One of my colleagues was appointed to investigate the man's death. I asked for a clinical review to be carried out into the medical care and treatment the man received in custody. A doctor was appointed by Leeds Primary Care Trust (PCT) to undertake a clinical review on my behalf. The focus of this investigation was primarily clinical because of man's poor health and his location in the health care centre. I have therefore relied greatly on the clinical reviewer's report. He judges that the man's care was exemplary and probably better than that which he could have expected to receive in the community. I am grateful to the PCT and the clinical reviewer for their assistance.

Since taking over responsibility in April 2004 for the investigation of all deaths in prison custody, there have been 42 deaths at HMP Leeds, including that of the man. Of those deaths, 17 were from natural causes. The man's care was very individual and therefore I do not identify any other similar recommendations.

I made two recommendations in this investigation. The first related to resuscitation and the other to dispensing medication during the night. At draft consultation stage the prison accepted the recommendations (one fully and one partially).

Jane Webb
Prisons and Probation Ombudsman **June 2010**

CONTENTS

SUMMARY

Although sentenced to life imprisonment with a ten year tariff, which normally means progression through the prison system to lower categories as appropriate, the man remained at HMP Leeds for the entire eight years he was in prison. This was in part because of his physical health and his hospital appointments. In addition, Leeds experienced difficulty negotiating with other prisons to accept him.

The man was in quite poor health when he arrived at prison. He suffered from Chronic Obstructive Pulmonary Disorder (COPD), a lung disease, predominantly as a result of smoking. The clinical reviewer explained in his report how the damage to the man's lungs was severe and would have occurred over a long period. He also explained that sufferers experience shortness of breath after minimal exercise, excessive mucus production, a higher risk of infection and, when severe, general poor health.

Whilst in custody at Leeds, the man was under the care of a consultant respiratory physician at Leeds Teaching Hospital Trust. He saw a consultant several times in 2001 and was then required to attend for an annual review. His disease progressed rapidly, primarily because he continued to smoke. In the last three years of his life, he became increasingly dependant on oxygen therapy[1] and, in the year leading up to his death, used it almost constantly.

Along with the majority of suffers of COPD, the man's damage to his lungs was caused by smoking. To slow or halt the progression of COPD a patient would need to stop smoking completely. There are a few recorded attempts of him stopping smoking, but these were never for any significant period. In fact despite repeated advice to stop smoking, the man remained stubborn and quite vehement that he wanted to smoke, to the point where he would hide his tobacco from staff. Medical staff could only treat his symptoms with the necessary medication and equipment – such as oxygen, steroids and inhalers.

From the records and discussions with staff and the man's friend, it is clear that he could be quite challenging to look after. He often refused to take advice or help as well as his medication and treatment. The clinical reviewer highlights that staff used various methods to attempt to get him to accept assistance and treatment, and were tactful in their negotiation with him.

The clinical reviewer concludes in his review that, from a medical point of view, he found the man's care "excellent if not exemplary". He added that if the man had been in the community he would not have had the amount of daily attention and review of his condition. As a result of the care and attention received, the clinical reviewer believes that the progression of the

[1] The doctor has explained oxygen therapy for patients of severe COPD. The therapy is necessary to maintain a sufficient amount of oxygenated blood to reduce breathlessness, prevent hypoxic damage to major organs and treat acute deterioration of the condition. As the disease progresses patients can become dependant on oxygen treatment to carry out basic daily tasks such as dressing or washing.

man’s disease was slowed to some degree, thus prolonging his life.

THE INVESTIGATION PROCESS

1. All the man's relevant prison documentation including medical and core prison records were requested following notification of his death. The man was in prison for over eight years. He suffered from ill health throughout that time so as a result there was a lot of documentation. The man was also a life sentenced prisoner which itself creates a lot of documentation. For this reason, my investigation concentrated on the last nine months of the man's life in this report.

2. The records arrived in the Ombudsman's office in October and were in a confused order. Some paperwork appeared to be missing but there were comprehensive electronic notes of the daily contact with healthcare staff in the man' medical record.

3. The investigator visited HMP Leeds to see where the man lived and met some of the staff who had known him. She also examined the records held by the Head of Healthcare but they too were in a rather confused order and did not seem to be complete.

4. Notices to staff and prisoners were sent to the prison to be displayed. They invited anybody with information to talk to the investigator. A prisoner who had been a friend of the man wrote to this office about his knowledge and information concerning the man. The man's friend has since moved prisons and another of my investigator's interviewed him for this investigation.

5. A clinical review into the man's clinical care in prison was carried out by a doctor on behalf of Leeds PCT. The clinical reviewer was not appointed until November 2009. I am grateful that he was able to provide the investigator with his report by February so as to avoid further delay.

6. HM Coroner for the County of West Yorkshire was informed of my investigation and kindly provided my investigator with the man's official cause of death. The Coroner has received a copy of this report.

7. One of the Ombudsman's Family Liaison Officers contacted the man's stepdaughter who was acting as the point of contact for the man's wife and family. They were offered the opportunity to be involved in this investigation and raise any concerns they might have. The man's stepdaughter told my family liaison officer that the family did not have any specific concerns about the care the man received. She added that they were aware of the man's ill health and believed that he had been well looked after.

HMP LEEDS

8. HMP Leeds is situated in Armley, close to Leeds city centre. Built in 1847, the prison has undergone a great deal of refurbishment and extended from four to six wings. It has accommodation for up to 1,008 prisoners.

9. Leeds is a local prison serving the courts of West Yorkshire. As a local prison it receives and discharges a large number of prisoners each day. Healthcare is commissioned and provided by Leeds Primary Care Trust. The healthcare services are now part of a cluster with HMP Wealstun and HMP Wetherby.

10. The staffing make up of the in-patient wing (H3) is two senior officers (discipline officers) with nurse training and 13 officers. Four of the officers have nurse training (three general nursing and one mental health nursing), and the remaining nine are discipline officers. The staff work according to a shift pattern.

Her Majesty's Chief Inspector of Prisons' report

11. Her Majesty's Chief Inspector of Prisons reports on all Prison Service establishments. The majority of inspections are pre-announced and allow the prison to prepare for inspection. However, a small number are unannounced, meaning the prison concerned has no prior knowledge that the Chief Inspector's team is visiting until they arrive.

12. In December 2007, the Chief Inspector carried out an unannounced inspection of HMP Leeds. In her summary the Chief Inspector wrote:

> "This inspection showed that there were still fundamental problems that needed to be addressed at Leeds. We did, however, find a management team that was committed to working methodically and vigorously to tackle the underlying causes as well as the symptoms. This is no easy task, in a prison system that is creaking at the seams and facing considerable challenges over the next few months. They, and the many good and committed staff in the prison, will need considerable support."

13. Nearly two years had passed since the last inspection. In a busy local prison there are continuing changes, therefore I have not reproduced the HMCIP report here. Full details can be found on the HMCIP website www.justice.gov.uk/inspectorates/hmi-prisons

Independent Monitoring Board (IMB) report

14. Each prison in England and Wales has an Independent Monitoring Board (IMB). Their role is to monitor the prison and to report any concerns that they have regarding the prison or how prisoners are treated. Board members are able to visit any area of the prison at any time, and have direct access to any prisoner who they wish to see or who asks to see

them. The Chair of the Board produces an annual report to the Secretary of State for Justice.

15. The full 2008/09 IMB report can be found at www.imb.gov.uk. However, the executive summary concluded:

> "The Board judge that, within the constraints of budgets and staff selection and recruitment, HMP Leeds is providing a generally safe environment for prisoners and slowly improving the respect shown to them by staff."

KEY FINDINGS

16. The man was remanded into Leeds in May 2000. On his reception into prison, he was already suffering ill health. In the clinical review, the clinical reviewer noted that in view of the severity of the man's condition he was admitted to the healthcare centre for assessment. The man used an inhaler but still became breathless with exertion. During the first few weeks, his mood was low and he was prescribed anti-depressants which improved his mood. His chest condition was sufficiently stable for him to be moved to one of the residential wings. By August 2000, the man had moved to B Wing.

17. In January 2001, he was referred to Leeds Teaching Hospital Trust where he saw a consultant respiratory physician for a review of his condition. His medical notes describe how his condition was deteriorating. The clinical reviewer has described "exacerbations" of the COPD which included increased breathlessness, reduced exercise tolerance and coughing. They were dealt with using a variety of treatments.

18. Also that month one of the prison doctors wrote to the man's solicitors. In the letter, the doctor described the man's condition and the outlook prognosis. This was that the man would ultimately have a shortened life span and would become a "respiratory cripple". The doctor explained that the man would need oxygen therapy to try to manage his condition and improve his quality of life. He added that this was difficult in a custodial setting. The man was a heavy smoker and continued to smoke regardless of his health and the advice and support offered to him.

19. Later that month, the man received a life sentence for the offence of murder. He initially received a tariff of eight years by the trial judge, but this was later raised to ten years by the Secretary of State.

20. Between January and July 2001, the man saw the consultant physician twice and underwent several tests which confirmed the diagnosis of COPD. A computed tomography (CT) scan also showed small "asbestos induced pleural plaques" which the clinical reviewer explains as markings on the edges of the lungs. However, this was thought to be an incidental finding and the man was told by the consultant physician that the COPD was entirely a result of smoking. The man was only able to move about 50 yards before becoming breathless.

21. The following year, January 2002, the man saw the consultant physician again for a review. The man continued to smoke and it was noted that his exercise tolerance had reduced to 40 yards. The consultant physician recommended a yearly review. In line with this the man saw the consultant physician in February 2003. Again it was noted that he continued to smoke and at this point his exercise tolerance was 30 yards. He had by now been prescribed oral steroids to help with breathing problems.

22. In November 2003, following a complaint of pain in the left side of his chest, the man was referred back to the consultant physician. He was seen again in December. The consultant physician was pleased to note that there was no deterioration and concluded that the pain was due to a recent bout of bronchitis. The annual review arrangement resumed. It was also noted that the man's exercise tolerance had risen to 100 yards but the clinical reviewer highlights that the man's lung function had declined since the measurement taken in February 2003. It declined further by the time of the man's next review with the consultant physician in December 2004. The man had also lost approximately 6kgs in weight, which the consultant physician linked to the severe COPD.

23. Particularly being a life sentence prisoner, the man should have transferred through the prison system on progressive moves working towards his parole date. However, staff at Leeds struggled to move him to another prison because of his medical conditions. Due to the inability to transfer the man and because of his ill health, his participation in offence focused programmes and other sentence planning work was limited. This would ultimately have affected his chances of parole.

24. A transfer to HMP Manchester was arranged in 2005 but when the man arrived there, he was returned straightaway to Leeds because of his 'health needs'. The arrangement seems to have been inadequately managed particularly as the prisons corresponded beforehand about the man's health needs. The clinical reviewer has also highlighted this transfer in his report. The man was found to be unable to move 20 yards without needing to stop. Manchester said that they could not locate the man in a ground level cell or provide a single cell. (A single cell was required so that the man's nebuliser, which could be noisy, did not disturb his cellmate.)

25. Whilst at Leeds, the man remained under the care of the consultant physician and was reviewed by his team again in September 2005. The clinical reviewer has considered the findings of the review and noted that they are in keeping with the deterioration of the man's medical condition. Four months later, 20 January 2006, he was transferred to the healthcare unit in the prison after staff became concerned for his health and welfare because he found basic daily tasks increasingly difficult. The man had become reliant on staff and prisoners to bring his meals and medication.

26. Although much of the man's documentation was received by my office in a muddled state, there are extensive medical notes during his time in the healthcare unit. The clinical reviewer has commented that the man appeared to settle well and was monitored regularly. The clinical reviewer noted that appropriate interventions for the exacerbation of the man's COPD and increasing breathlessness took place. At this point the man was smoking 30 – 40 cigarettes per day with no sign of giving up, despite medical advice. Following another review with the consultant physician in October 2006, the man was discharged from the routine follow ups. His

lung function had increased marginally and he was again given encouragement to stop smoking.

27. One of the duty prison doctors noted in the medical record in March 2007 that the man still had no intention to stop smoking and would need oxygen treatment on a more permanent basis. There was a period in 2007 where the man did stop smoking, but only for a few months at most. Staff had explained the combined dangers of smoking and using oxygen, but the man ignored it. On one occasion he lit a cigarette whilst the oxygen was still switched on. This resulted in burns to his face, although no serious injuries were noted. As a result staff banned the man from having tobacco in his cell. He responded to the ban by cutting his arms. He was monitored under the suicide and self harm procedures for a couple of weeks, but it would appear that his actions were solely a response to not getting his own way rather than any self harm ideas. The man began to hide his tobacco so that staff could not remove it. Eventually a compromise was reached whereby the man only used oxygen when he was not smoking.

28. The clinical reviewer described how by the end of 2007 the man had to sleep in his chair due to excessive breathlessness. This was an issue that the man's friend raised in his letter to the investigator. Having spoken to staff in the healthcare unit and taken into account the friend's view, I am satisfied that the man was offered a specialist bed but had declined it. This appears to be characteristic of the man's stubbornness at times.

29. In a Parole Board review in August 2008, the man was not recommended to transfer to open prison conditions primarily due to not having completed offence focused programmes. This was in part due to his physical condition, partly the inability to transfer him and in part, the assessment that his acceptance of responsibility for his offence was limited. In his probation parole review in August 2008, the author wrote that there was an opinion by various people who assessed the man that he believed his ill health would secure his release without the need to be actively involved in offence focused work. The writer referred to the efforts to move the man from Leeds which had failed because of his physical care needs. It was also noted that a transfer to HMP Wakefield had been requested and that a space was awaited. It was felt by the report writer that the man would spend whatever period he had left in custody, within a healthcare centre.

30. In January 2009, the duty prison doctor prepared a summary for the man's sentence planning and review report. In this the duty doctor wrote,

> "I have known the man for over 2 years in my capacity as Medical Officer. He has very severe chronic lung disease and gets extremely short of breath on the slightest exertion. He sometimes requires oxygen even after using the toilet. I have not seen him walk more than a couple of paces for 2 years. He

requires assistance with bathing and his food is taken to him. He has leg swelling as a result of his immobility."

31. By this stage, the man had been given a zimmer frame to assist his mobility, although reports from staff would suggest that he only used it when it suited him. As the duty doctor wrote in his report, the man had swollen legs because of his immobility and so needed extra medical attention. He was becoming increasingly frail and using oxygen much more. His lack of mobility meant that he often neglected his personal hygiene, and staff needed to coax him to look after himself.

32. In April 2009, the man was admitted to hospital with severe exacerbation of the COPD. There appears to have been a Do Not Attempt Resuscitation (DNAR) form with the ambulance paperwork. Neither the clinical reviewer nor the investigator found any entry or other notes of a discussion about this in the man's prison records. The healthcare officers the investigator spoke to were also unaware that it had been considered.

33. The following month, a respiratory consultant reviewed the man's condition. There were no new recommendations or changes to the man's treatment, but he was advised to make 'lifestyle' changes such as stop smoking, increase his exercise and improve his diet. The clinical reviewer noted that overall the man's health was deteriorating quite quickly and he spent more and more time in his cell sitting in his chair. He needed a lot of assistance with daily activities but would often decline offers of help from staff.

34. In the doctor's view, it was obvious that the man was in the final stages of his disease and any exacerbation could result in his death. However, he survived two acute exacerbations in July and August 2009. He was admitted to hospital on each occasion for treatment, remaining there for two weeks in August.

35. The medical records show an entry at 5.30pm on 1 September, that the man had raised his personal alarm because he had been incontinent of faeces. He was advised that the best way to get clean would be to bath but he refused and threw a mop bucket. In the end he was given a hand wash by staff. It was noted that he was quite volatile and unhelpful throughout.

36. A short while later a Healthcare Officer walked past the man's cell. She told the investigator that the man's oxygen mask was not over his mouth and that he looked cyanosed (bluish discoloration). She added that she just felt something was "not right". She called for a nurse and they went in to the man's cell. The nurse took the man's clinical observations of his pulse, blood pressure and temperature. She called the duty doctor for advice because his oxygen saturation levels were low. The nurse thought that he appeared confused and his eyes were "glazed". The doctor recommended that an ambulance be called to take the man to outside hospital.

37. The escort log shows that the man left the prison at 7.00pm. Nearly an hour later, he was still in resuscitation. One of the hospital doctors told escort staff that it was unlikely the man would survive the night. The doctor contacted the man's wife, who visited him later that evening. The escort risk assessment shows that restraints were not applied but two officers remained with the man.

38. In the bedwatch log[2] it is recorded that at 6.25am on 2 September, the man was unconscious and was assisted to breathe by machines. A few hours later man's stepdaughter telephoned to check on his condition. At 11.25am, the man was breathing on his own but had a machine for backup. He remained unconscious. Later that afternoon, at about 3.15pm, the man began to waken. He was given reassurance by the hospital nurse.

39. At 9.15am on 3 September there is an entry by one of the escort officers commenting that there was still no significant improvement in the man's health. He was continuously monitored by nurses but was recorded as Not For Resuscitation. It is not clear where this information came from or if it was discussed with the man or his family. The investigator asked some healthcare staff if they were aware of this instruction because it was not in his medical record. She was told that they were not aware and indeed, if healthcare staff thought the man was not to be resuscitated, they would not have called for an ambulance to take him to hospital on 1 September.

40. The records of the rest of the day show that the man was breathing with the assistance of an oxygen mask, he spoke with nurses and the doctor and then slept. At 6.05pm it is recorded that the doctor told the man he would not be resuscitated if he deteriorated again. The man was reported to be upset about this. Later that evening he was visited by his wife and a friend.

41. The following morning the man's family were asked to go to the hospital as his condition had deteriorated. His wife and stepdaughter arrived at approximately 10.35am and remained there for most of the day. That evening his brother visited him.

42. Two Officers arrived at the hospital for duty at 6.30am on 5 September. Officer 1 has written in the bedwatch log at 6.34am that the man's breathing was "shallow and quite heavy". The man was given pain relief on several occasions throughout the morning and slept intermittently. At approximately 11.40am, the man woke in pain and was given more painkillers, but his breathing became shallow and faint. The hospital nurse tried to contact the man's family but could not reach anybody on the telephone. Officer 2 wrote in the bedwatch log that the man appeared to

[2] A log kept by staff on escort during any prisoner's admission to hospital. It logs all contact and events involving the prisoner such as doctor's rounds, treatment, risk assessment review and visitors.

be more peaceful. At 12.30pm a hospital nurse said that the man's breathing had stopped but she needed a doctor to confirm death. The man's wife and stepdaughter arrived at 1.00pm. A doctor pronounced the man's death at 1.25pm.

43. A post mortem gave the man's cause of death as "Acute respiratory failure due to exacerbation of Chronic Obstructive Pulmonary Disease".

44. Following notification of the man's death, the Head of Healthcare contacted the staff on duty at the prison to check their welfare. Staff were also offered the services of the Staff Care and Welfare team.

Information received as part of the investigation

Health care officer A

45. HCO A was unfortunately not available the day that my investigator visited the prison. He kindly arranged to telephone her the following week while he was on night shift. HCO A has worked in the healthcare unit at HMP Leeds since 2000. He also has a role working with life sentence prisoners and as a Family Liaison Officer in deaths in custody. HCO A knew the man well both in his capacity as a lifer officer and a personal officer.

46. HCO A told my investigator that the man initially lived on B wing – a main residential wing but that due to his health, found it increasingly difficult getting to the heathcare unit, which is where he used to bath. In 2004, the man moved to live in the healthcare unit. HCO A, and other staff, said that the man could be difficult and stubborn. For example he would not accept that his 'tariff' was the minimum time he would spend in custody. He did not appreciate that he would need to work towards parole by addressing his offending behaviour. Naturally there were health implications which would have prevented him attending some programmes but he showed no willingness to engage in the process. Additionally, HCO A said that the man did not show any remorse or compassion over his offence and therefore would not, at any time thus far, have been recommended for release.

47. My investigator asked HCO A about the prison's efforts to transfer the man to a different prison because he had been at Leeds for far longer than is normal for a local prison. HCO A confirmed that attempts had been made to transfer the man to HMP Manchester and HMP Wakefield, but that it had been difficult to persuade another prison to take him, probably because of his health needs. HCO A added that the man was reluctant to move and was known to give different excuses why he should remain at Leeds.

48. During their conversation, my investigator asked about the deterioration in the man's health and whether or not it had been sudden. HCO A explained how the man's condition deteriorated gradually over about two years. He also spoke about the oxygen that the man needed to take and how the prison had ensured that he could reach all parts of his cell, toilet included, with his oxygen mask attached so that he could move around. HCO A referred to the time when the man injured himself by smoking while the oxygen was switched on and the staff tried to ban him from smoking in his cell to reduce the risk. However, the man got around this by hiding his tobacco – in some instances hiding it in his inhaler.

49. My investigator asked about care plans (a written record of the agreed care to be given to a specific prisoner). They are mentioned in the medical record but were not included in the documentation received by this office or in the paperwork at the healthcare unit at the prison. It appears that during the time the man was in Leeds, there was a move

from paper files to electronic and again onto a different electronic system. The structure of healthcare has changed since the man's death and the primary care nurses are now based on the main residential wings rather than with the in-patients. I can only assume that the paperwork has become lost. However, HCO A said that although he did not know where the care plans would be, he remembers that they did set out actions for the man's exercise, personal hygiene and diet – which HCO A described as poor because the man would not eat fruit or vegetables.

The friend's information

50. A friend of the man wrote to this office shortly after the man's death offering background information. My investigator spoke to the man's friend about four particular aspects of his letter.

51. The first was that the friend said the man always slept in a chair and had asked for a bed. My investigator asked HCO A about this. He confirmed that the man slept in a chair and refused to sleep in the bed as it was more uncomfortable for him to breathe whilst lying down. HCO A added that pillows and/or a specialist bed were offered but the man still refused. The HCO said he went with the man to a community chest clinic appointment in February 2008. He witnessed the man tell the nurse that he needed a commode although his toilet was only about nine feet away. Additionally, the man had been told by doctors and others that it would help his health if he made the effort to walk to the toilet. There is already a specialist bed in the healthcare unit and a more appropriate chair was given to the man to make him comfortable. I am inclined to think that he was perhaps being stubborn by refusing to get into a bed and told his friend otherwise. The clinical reviewer also concluded that the man was offered a specialist bed but was likely to have remained in his chair even if the bed was in the cell.

52. Secondly, the man's friend said that on occasions he would go to the man's cell in the morning and find his night medication on the floor. My investigator asked the staff about this. HCO A said that the medication is passed through the observation hatch at night. If a person is unable to go to the hatch the door should be unlocked. HCO A did add that the man chose his 'friends' amongst staff and would be defiant at times with those he chose to be. It might have been on occasion with these staff that the man did not collect his medication, but it is difficult to be sure. I go on to discuss this later in my report.

53. In his letter the man also said that the man would refuse baths because he believed the cleaners would steal items from his cell. There is no suggestion of this in the medical notes. Both his friend and staff commented that the man could be very stubborn and therefore I think it is more likely he was just refusing to move to have a bath.

54. Lastly, my investigator asked about the man's friend lay opinion of the man's general health. He confirmed that the man had generally poor

health and it was not a surprise to him to learn that he had died as a result.

ISSUES CONSIDERED

Medical records

55. The Head of Healthcare explained that Leeds were trying to consolidate handwritten and electronic medical notes from the previous system into the current electronic system 'System One'. There are often teething problems in a process like this. As with some of the man's paperwork, documentation can be misplaced or lost.

56. The staff working on the in-patient wing said they needed training on System One to ensure that they could effectively complete care plans and other information. The Head of Healthcare has since told my investigator that training is available for staff. This is crucial to ensure the continuity and appropriate care of a patient, particularly if there are no primary care staff based on the wing. Although, as the Head of Healthcare has said, training has been undertaken and is available, staff clearly feel they are missing some skills. I do not make a formal recommendation but invite the Head of Healthcare to take further steps to identify any unmet training needs amongst the staff group on the in-patient wing.

Administering medication at night

57. There may well have been occasions when the man did not get his night medication because it was on the floor. As HCO A described, it is given through the medical hatch at night but if a prisoner is unable to go to the hatch, the door should be unlocked and the medication handed to the prisoner. It is not possible to tell whether the man's medication was thrown on the bed and rolled off, he knocked it off or if he chose not to take it and leave it on the floor. I am satisfied that the man was able to move short distances and therefore could have collected the medication from the hatch. However, I do not condone the practice of throwing medication through a hatch, if that is what happened.

58. However, the fact that the man did not have certain medications in his possession and was given them at night meant that he should have been observed taking them. There should have been no reason for his medication to have been found on the floor of his cell at any time.

    The Governor and Head of Healthcare should ensure that medication is appropriately dispensed and seen to be taken during the night.

Resuscitation

59. My investigator asked for a copy of the 'not for resuscitation' policy at Leeds at the time of the man's death. She was only able to obtain a more recent NHS Leeds policy. That said, it is not clear whether or not the man was ever subject to these procedures.

60. In April 2009, ambulance paperwork following the man's admission to hospital claims that at Do No Attempt Resuscitation (DNAR) order was held on the man's notes. It is not clear if this refers to the prison or the hospital records. Neither is it clear whether the medical professional responsible for the man's care signed the DNAR or that the man or his family were aware of it. There is no evidence anywhere else in the prison records that confirms that this was the man's wish or that it had ever been discussed with him in the prison.

61. Additionally, when my investigator asked the prison if there was an agreed decision not to resuscitate the man, she found that this was not the understanding of staff. In fact, the response was the opposite, with staff commenting that if he was not to be resuscitated they would not have called for an ambulance on 1 September when he was subsequently admitted to hospital.

62. The clinical reviewer also commented on the DNAR dated April 2009. He found that it did not seem an unreasonable decision under the circumstances. The man would have been aware of the severity of his condition and those treating him would have known that he was in the terminal stage of his illness. The clinical reviewer said that resuscitation following any sudden collapse would probably have caused the man more suffering or serious other damage. However, he too could not find any documented evidence that these were the man's wishes or that the matter had been discussed thoroughly with him at any point.

63. I can only assume that the decision was made at the hospital in April 2009. Certainly in the bedwatch log in September 2009, it is the hospital doctor who makes mention of it. Nonetheless, the DNAR order could and should have been followed up by prison healthcare staff in April following receipt of the ambulance paperwork. I therefore endorse the clinical reviewer's recommendation.

    I recommend that Do Not Resuscitate Orders are clearly marked in a patient's medical file and that discussion and decisions surrounding one are appropriately documented.

Smoking cessation

64. The clinical reviewer's only additional comment about the man's care was what he has termed "historical issues" regarding the apparent lack of documented smoking interventions in the man's medical record during his first years in prison. Although there are references to his smoking status it was mostly at outpatient attendances.

65. That said (and the clinical reviewer also comments) the likelihood is that the man's smoking status was discussed in consultations and that he declined to give up. Additionally, it is only in more recent years that smoking cessation interventions have been widely available in prisons. The clinical reviewer concluded that HMP Leeds has taken steps to

provide this service to the prisoners in its care. I agree with these comments, particularly as trying to persuade the man to stop smoking was a big focus of his care during his last few years. I therefore mention this only as a finding of doctors' and make no recommendations in respect of this.

Length of time at Leeds

66. There is little dispute that the man was held at HMP Leeds for far longer than he should have been. There were a number of attempts to transfer the man but none came to fruition. One can speculate as to why this was but one suggestion was that he was a difficult prisoner with complex health needs. This should not be a reason for another, more suitable prison not to take him.

67. However, the important factor for consideration in this investigation was the appropriate care and treatment for the man's health needs. There is no evidence to suggest that his needs were not met at Leeds and indeed he often gave excuses so that he could remain at the prison. The man was elderly and frail. Keeping him in familiar surroundings with staff and prisoners who he knew was, in my view, more decent than a transfer to somewhere unfamiliar. I have already commented on the clinical reviewers' finding of the man's care and treatment. I am satisfied that remaining at Leeds was not detrimental to the man's health and his death was unavoidable.

CONCLUSION

68. The man was an elderly man in poor health. He suffered from a respiratory disease for some considerable time and during his period in custody was regularly reviewed by hospital consultants for the condition.

69. As the clinical reviewer explained, stopping smoking would have been the best course of action for the man to prolong his life and slow the disease but he chose to continue smoking despite this advice. As his condition deteriorated, the man was cared for and treated well and appropriately by healthcare staff at Leeds. He was sometimes difficult to manage but as the clinical reviewer commented, the man would have had more daily contact and reviews in prison than he would have had in the community. This regular and close contact and treatment probably prolonged the man's life albeit perhaps for a short time.

RECOMMENDATIONS

1. The Governor and Head of Healthcare should ensure that medication is appropriately dispensed and seen to be taken during the night.

At draft consultation stage Leeds accepted this recommendation and said, "All staff are aware that unless given `in possession' medication administration should be supervised. Where possible healthcare staff will supervise this via observation hatch at night, but where there is a clinical requirement night orderly officer will be contacted and cell opened to facilitate supervision of night medications. E mail to be sent to all inpatient unit staff communicating this."

2. I recommend that Do Not Resuscitate Orders are clearly marked in a patient's medical file and that discussion and decisions surrounding one are appropriately documented.

At draft consultation stage Leeds partially accepted this recommendation and said, "Accepted in principle, however, there was no DNAR for the man whilst at HMP Leeds. DNAR was decided following his transfer to LGI. Any DNAR in place at HMP Leeds has always been clearly communicated to all staff and documented on records. Communication will be forwarded to all healthcare staff informing of the importance of clear communication of any such clinical instruction and referring them to NHS Leeds DNAR policy."

I also draw paragraph 59 to the attention of the Governor and Head of Healthcare.

At draft consultation stage Leeds said, "Following a training needs analysis at the end of 2009, the majority of Inpatient staff have now received recent SystemOne training, including the compilation of care plans using SystemOne. Two staff still require training and will be trained by end March 2010."