Investigation into the circumstances surrounding the death of a man at hospital In October 2009, while in the custody of HMP Belmarsh

Report by the Prisons and Probation Ombudsman for England and Wales

September 2010

In October 2009, the man was found at 00.20am in his cell at HMP Belmarsh suffering from complications relating to diabetes. He was assessed by a doctor in the morning and taken to hospital. He was 60 years old. I offer my sincere sympathy and condolences to the man's family and friends for their loss.

The investigation was carried out on my behalf by my colleague. A clinical review of the man's healthcare was undertaken by the clinical reviewer on behalf of NHS Greenwich. I am grateful for their review. I would also like to thank the Governor of Belmarsh and his staff for their co-operation and assistance. Particular thanks go to a duty governor for his help during the investigation.

The man was arrested in 2003 and charged with serious offences. He did not cope well in prison and made attempts to harm himself. Staff intervened and he was monitored using the Assessment, Care in Custody and Treatment (ACCT) processes. Following his sentencing in January 2005, he was diagnosed with diabetes. He frequently refused treatment and ate unsuitable food. Despite staff attempts to care for him, his physical health deteriorated over the years and he spent time in hospital. In October 2009, he was taken to hospital where he died three days later.

The man was serving a long sentence. Healthcare staff found him a difficult patient as he was inconsistent about accepting treatment. However, I am satisfied that they responded appropriately to give him the care he required. This report contains four recommendations regarding record keeping, training and the use of advance directives.

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

Jane Webb
Acting Prisons and Probation Ombudsman **September 2010**

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SUMMARY

The man was born on 15 July 1949. He was arrested in 2003 regarding a number of serious offences. He told the police that he had attempted to take an overdose earlier that day and was taken to hospital. His early time in prison featured several instances where he expressed self-harming thoughts or actions. Staff intervened and he spent some time in a mental health clinic in London.

He was sentenced to 16 years in prison in January 2005. Soon afterwards he became lethargic and complained of being thirsty. He underwent tests and was diagnosed with diabetes in the summer. He reacted badly to the news and refused to accept treatment. Despite being told repeatedly by staff to moderate his diet, he regularly ate large amounts of sugary food.

At the start of 2007, the man signed an advance directive explaining that he did not wish to be treated for diabetes. (This is a document which outlines the actions the person would like to happen should they become incapacitated and unable to make decisions for themselves.) He did not cooperate with his treatment until August 2008 when he was taken into hospital. Once there, he began to accept insulin treatment. The investigator was told by the Head of Healthcare at Belmarsh that, once he began accepting insulin treatment, it invalidated his advance directive. From this time on, he was treated as any other patient who refused treatment.

For the next year, the man gradually became weaker and was taken into hospital on a number of occasions. His attitude towards treatment varied, but the prison healthcare staff continued to offer the options available. The prison also provided him with several practical items to aid his well-being such as a new bed and a walking frame.

The man spent much of the last year of his life in bed which presented other concerns, such as bed sores. In the early hours of 17 October 2009, he was heard by another prisoner to be in pain. Staff went to him but he refused any pain relief medication. He was reviewed throughout the night and, following an assessment by a doctor, taken to hospital in the morning. His brother, his next of kin, was contacted and travelled to the hospital to be with him in his last days.

Three recommendations are made in this report regarding record-keeping, staff training and the management of advance directives.

THE INVESTIGATION PROCESS

1. The investigation was carried out by my colleague. He arranged for HMP Belmarsh to send him the documents relating to the man. Notices of the investigation were issued to staff and prisoners, inviting those who wished to provide information regarding his death to make themselves known to the investigator. No-one came forward with regard to the notices.

2. The investigator asked NHS Greenwich to undertake a review into the clinical care received by the man. The clinical reviewer coordinated the writing of this review with her colleague. The clinical review was received in April 2010 which resulted in a delay in the publication of my report.

3. The investigator and the Ombudsman's Senior Family Liaison Officer tried to contact the man's brother to discuss the investigation, but he did not respond to the letters sent to him.

4. The investigator travelled to Belmarsh on 26 November to interview healthcare staff. The clinical reviewer accompanied him.

HMP BELMARSH

5. HMP Belmarsh was opened in April 1991, and operates as a local prison serving the courts of South East London and South West Essex. It contains a healthcare centre with beds for 33 prisoners.

Assessment, Care in Custody and Treatment

6. Assessment, Care in Custody and Treatment (ACCT) is a care planning tool used by the Prison Service to help support and monitor those prisoners identified as being at risk of suicide or self harm. The ACCT process encourages staff to work together to provide individual care to prisoners in distress and help to diffuse circumstances where self harm or suicide may occur.

Advance directive

7. An advance directive is a document outlining the actions the person involved would like people to take in the event that they are incapacitated and unable to make decisions for themselves.

Independent Monitoring Board

8. Each prison has an Independent Monitoring Board (IMB) made up of members of the community. The Board's role is to ensure that the prison is properly run and that prisoners are treated decently. Each Board produces an annual report for the Secretary of State. The most recent report from the Belmarsh IMB covers the period 2007 - 2008. The report makes reference to security issues being paramount at Belmarsh, something understandable in a category A prison. However, the IMB make the point that the prison now needs to focus more on the needs of individuals.

Her Majesty's Chief Inspector of Prisons

9. HM Chief Inspector of Prisons conducted an unannounced full follow-up inspection from 27 April to 1 May 2009. The report said that: "Healthcare services had deteriorated since the last inspection, and there was an urgent need for re-engagement between the prison and the primary care trust." It went on to explain that, at the time of the inspection, primary health could be improved due to the ending of the current GP contract, poor management of clinical records and some problems in the pharmacy service. However, the report noted that in the in-patient unit: "Relationships between staff and prisoners appeared appropriate and relaxed."

Previous deaths at Belmarsh

10. Prior to the man's death, there were two deaths due to natural causes in 2008. In one case in particular, the prisoner, like the man, did not cooperate with his treatment and would not take his medication. Both of these men also died in an outside hospital.

KEY FINDINGS

11. The man was born on 15 July 1949. He left school aged 15 and worked as a carpenter throughout his life. He suffered from alcoholism and had been assaulted in the past, suffering a head injury from a hammer.

12. On 30 June 2003, he was arrested and taken to hospital as he told the police that he had taken an overdose of paracetamol and vodka. He was remanded into custody at HMP High Down on 5 July. Although his initial healthscreen did not reveal any concerns about his physical health, he was admitted into the healthcare centre due to concerns about his alcoholism and depression. A F2052SH form was opened on 8 July as staff were concerned that he might harm himself. (The F2052SH form was the process prisons used to use to monitor those at risk of harming themselves. It has now been replaced by the ACCT process.) He made a noose and showed it to staff in the early hours of 9 July. He returned from court on 14 July and was described as appearing very down. He was taken back to the healthcare centre where he threatened to kill himself should he get the opportunity.

13. The man was transferred to HMP Belmarsh the following day. Up until 24 July, he continued to make veiled references to committing suicide. On 17 December 2003 he underwent an urgent psychiatric assessment by a psychiatrist. He was found to have a low mood and strong suicidal ideas and was placed on the waiting list to the mental health centre at the local hospital.

14. In the early hours of 26 February, the man made a noose and activated his cell bell. He told staff that he wanted to kill himself as he had no faith in the outcome of his trial. He was moved to a special observations cell. He was transferred to the mental health centre on 4 March due to his disturbed sleep, poor appetite and threats to kill himself. At the end of April, it was decided that he was not suffering from any mental illness and he returned to Belmarsh in May.

15. He was convicted and sentenced to 16 years in prison in January 2005, (although having served 18 months on remand, his tariff was 14 years six months.) A report was made in his medical record on 16 September 2005, noting that his physical health appeared to have deteriorated. He was tested for diabetes as he complained of being thirsty and lethargic. He was told in June 2006 that he was suffering from diabetes. A nurse described the events prior to his diagnosis:

> "it was leading up to him having semi passing out periods where he complained of being very thirsty, very lethargic. And that's when we decided the symptoms were similar to that of diabetes, let's test him and do the full test. And then it was confirmed."

16. The nurse remembered that the man took the news badly:

> "Negative, he was very angry and at that time when he first came into the prison system, up to his sad death. He was very defiant, very

argumentative, very angry. And at times would be very hostile in nature to anybody who attended to his care, i.e. the nurses at one point."

17. The man was admitted to the healthcare centre following his diagnosis. Staff advised him to reduce his intake of sugary foods, drink plenty of water and eat healthily. Despite this advice, it was noted by staff that he did not follow medical advice and restrict his diet. The nurse told my investigator that the man was generally uncooperative and said that he was not interested in moderating his diet:

> "To the point where we had care plans implemented by myself and my colleagues. And we would sit down with him and explain to him the negative aspects of non-compliance. … And most of the time would tell you 'just leave me alone, get out of my cell'."

18. At the start of November, the man refused to have a sample of his blood taken for testing, and later refused to go to hospital. He wrote a letter to the coroner on 16 November explaining that he was entirely responsible for the timing and nature of his death. He praised the staff and explained that everything that happened was his decision.

19. He refused to go to hospital on 4 December to discuss changes to his treatment and signed another disclaimer, stating that he did not want to take his medication. However, he was taken to hospital on 17 January 2007 as he was found semi-conscious in his cell. Insulin treatment was given. He returned to the healthcare centre on 19 January, with no signs of ill health. Two days later, he refused his insulin medication, despite staff explaining the consequences to him. He refused the insulin again the following day, and this led to ACCT monitoring procedures starting on 23 January. The nurse explained to the investigator the reason for the ACCT being started:

> " … his ACCT document was opened as a form of precaution and because of his negative aspect saying I just want to die."

20. The psychiatrist wrote that, in his view, the man was fully competent to make his own decisions and was not suffering from depression. (Competent, in this context, is used to describe people who are of sound mind and able to take responsibility for their own actions.) The nurse recalled that he would buy a lot of sugary foods despite staff advice about the consequences:

> "Well at that time, he started having a lot of sugary substances and he started buying in the canteen which all prisoners are entitled to. And he starts stocking up his sugar and would constantly take sugar, excessive amounts of sugar, and not taking his insulin, he would from time to time go into a diabetes coma.

21. On 28 January, the man spoke to the Head of Healthcare and explained that he was sure that, in a medical emergency, he did not want any intervention other than pain relief. He said that he would write this down so that it was

clear. Two days later, in the presence of the Head of Healthcare, he signed an advance directive outlining his wishes.

22. A case review meeting was held with the man, the prison GP and the nurse on 7 February. The doctor explained the implications of refusing insulin to the man. The man accepted responsibility for his actions, and the doctor believed that he understood the consequences. At a further meeting a week later, he confirmed that he did not want his diabetes medication. Staff discussed his decision with him again on 9 March. Although he said that he wished to die, staff explained that refusing insulin might not result in death but could lead to blindness or other degenerative conditions that could limit his independence. He agreed to consider this advice. Staff met again later in the month to consider the implications of his wishes.

23. The man asked to vary the terms of his advance directive in mid-April. The previous directive had requested that no contact be made with his family until after his death. He explained that his brother was living in the United Kingdom again, and he wished his brother to be told if his condition worsened. He also said that he did not want to be taken to hospital. The staff explained that, if he was taken there, hospital staff would presume he would want treatment unless they were told otherwise.

24. In June, a letter was received from the medical director at the hospital explaining that both the prison and the hospital would adhere to the man's wishes. A case conference was held on 31 July and the medical director was present. It was reported that the man had been assessed by psychiatrists who agreed that "he has capacity and is able to make this decision of his own volition".

25. It was agreed that, should the man's health worsen, he should be transferred to hospital with a copy of his advance directive. Another case conference took place in December and noted that the man's physical health had deteriorated. He had been prescribed morphine to counter the pain. The prison agreed to provide him with a walking frame, new mattress, pillow and duvet, and invite his brother into the healthcare centre for a visit. He was also offered a telephone call to his brother.

26. Throughout the first six months of 2008, the man's health continued to decline. He refused his insulin medication, although he did accept morphine. He was given Fortisip drinks to provide him with extra nutrition. He agreed to go into hospital in August as he felt unwell. He was emaciated and suffering from painful feet. During his stay in hospital, he accepted insulin treatment. He returned to Belmarsh on 2 September, and continued to take his insulin. His acceptance of insulin was spasmodic but it appears that, by October, he generally accepted it.

27. The man spent another day in hospital in February 2009 suffering from a respiratory infection. The nurse explained that, in his view, the man's decision to start taking his insulin again was prompted by a realisation of how easily he could die.

28. However, the man signed a form in March again refusing treatment for diabetes. In May, he said that he wished the advance directive to be binding on the hospital when the time came. A second prison doctor explained that, as he was now taking insulin, the directive no longer applied. The doctor said that once the man accepted some treatment, the advance directive was nullified. The Head of Healthcare at Belmarsh explained this to the investigator:

> "At that point in time, our view was that the advanced directive was no longer valid, and although after that period he often refused treatment or was uncooperative, we dealt with that in the normal way that we would in terms of someone withholding consent. Not as someone who was on an advanced directive, just a difficult to manage patient. But generally speaking, from that point, the central element of his treatment, the injections of insulin, he did accept and he allowed nurses to test his urine and test his blood etc. So the central tenet of his treatment was, he was consenting to."

29. The man was taken back to hospital on 21 May after being found in his cell in pain. However he discharged himself from hospital the next day, against medical advice. A further case conference was held on 31 May. It was confirmed that the advance directive remained invalid. He spent much of the last year of his life in his bed. The nurse explained that this amount of time in bed resulted in sores on his body, which could be helped by time spent out of bed. Tissue viability nurses from the hospital visited him to attend to these problems.

30. He was taken to hospital again on 14 July as he had been vomiting. He discharged himself against medical advice on 21 July. He was described as frail, dehydrated and unsteady on his feet. A note in his medical file written in August said that he continued to decline as he was not taking his medication properly and had a poor diet. He returned to hospital on 3 September suffering from diarrhoea and vomiting.

31. A case conference was held the next day and staff considered whether to refer the man for end of life care at hospital. The nurse explained to the investigator that the man was not keen on this idea:

> "I think he was scared. He didn't want to die anywhere strange and even when at times we mentioned going out for palliative care, he would say 'I don't want to go, I would rather stay where I am'. But I think basically it was that because he knew while he is in the prison, there are people around him."

32. A letter was written by a third doctor on 25 September which said that, as the man was contradicting his advance directive and it was no longer valid. Belmarsh continued to treat him as any other prisoner withholding consent.

33. Staff were alerted by another prisoner that the man required assistance at 00.20am on 17 October. Although he said that he was in pain, he refused to take any pain relief medication. His blood pressure was recorded as 96/77 (this is a low blood pressure reading) with a pulse of 125 beats per minute (this is a high pulse reading). Staff checked on him every 30 minutes and told him that he would see a doctor in the morning. The findings of the 30 minute checks were not recorded.

34. The doctor went to the man's cell at 8.45am. He did not respond and so an ambulance was called which took him to hospital. The hospital staff asked for his next of kin details at 1.45pm and they were provided at 3.00pm. His brother was contacted at 7.15pm, and he said that he would decide whether to visit once the consultant had reviewed him. The escort staff made a note on the morning of 18 October that restraints were not required as he was so poorly. His brother arrived at 2.00pm. His breathing was assisted by a ventilator.

35. The man's brother returned to the hospital at 7.15am the following morning as his brother's condition had worsened. At 4.50pm, the man's brother asked if the prison chaplain could come to the hospital. The man died at 1.20am, after his ventilator was switched off.

36. The prison met the man's brother and offered to contribute to the costs of the funeral.

ISSUES

Clinical care

37. The clinical review noted that:

> "Although the man accepted treatment only intermittently he was always offered medical care that was appropriate to his needs. When he developed diabetes in 2006 and subsequent complications, the health care team endeavoured to work with him proactively and intensively."

38. Therefore, the clinical reviewer's overall opinion of the care the man received, was that:

> "In the opinion of the clinical review team, other than those areas highlighted elsewhere in this report, the man received care that in the main was equitable to that which he could have expected to have received in the community."

39. However, as noted, there were several aspects that the clinical review draws attention to.

The advance directive

40. The clinical review report raised no concerns that the man was incapable of deciding whether to implement an advance directive. The Head of Healthcare at Belmarsh, explained this further to the investigator:

> " … all the way through the advanced directive, we went back and re-tested the assumption that he had capability to consent to that process. … And there was never any indication that that wasn't anything other than the case. The second element that you have to be able to demonstrate within that process that the man was aware of the implications of his decisions. And we did that through one of the GPs who had a particularly good relationship with him. And she sat and talked to him about the implications of having a blood sugar level of a very high level for a long period of time and what that might do to his eyesight and to the condition of his veins and arteries, in the most minute detail. To make sure that he understood the implications of his decision, and he did. So he had in place an advanced directive, which was a document that he signed that was witnessed, and we dealt with issues of capacity and issues of understanding."

41. However, the clinical review does raise concerns that the staff involved in the man's care were not always aware of the conditions of the advance directive. Despite the continuous efforts of the Head of Healthcare to share understanding of the man's situation, one element of confusion was caused by the advance directive lapsing when he began to accept insulin treatment. The Head of Healthcare commented that he frequently went to case

conferences which said that the man was subject to an advance directive, although it was actually invalid. The clinical review make the recommendations which I include as:

There should be a policy for the development and management of advanced directives. Training and support should be given to staff who implement and manage advanced directives.

Managing the man's diabetes

42. I am told that the man was not an easy prisoner to treat as he frequently refused treatment. Despite this, I am satisfied that staff tried hard to engage with him and ensure that he was always offered the appropriate treatment. Also, it is pleasing to hear that the prison made practical adjustments to aid his physical well-being such as providing him with a special mattress and walking frame. However, the clinical review notes the opinion of the prison doctor who said that staff required further training in the treatment of the condition. I endorse the recommendation made by the clinical review team:

Healthcare staff should receive ongoing training and supervision in chronic disease management such as diabetes.

Quality of healthcare records

43. The clinical review report says that the healthcare records were not always legible, and were not always clearly dated and signed. This is an issue that has appeared in many of the Ombudsman's reports. Record keeping was not helped by the lack of a computerised system at Belmarsh. I encourage the Head of Healthcare to consider the recommendation made in the clinical review regarding this issue. I make the following recommendation:

The Head of Healthcare should review record keeping and ensure that records are consistent with the Nursing and Midwifery Council guidelines.

Healthcare response on 17 October

44. The clinical review team consider that the man should have been assessed by a doctor when he was first found at 00.20am on 17 October. This would have advised healthcare staff on the most appropriate treatment of his symptoms and declining health. Despite their judgement, the reviewers are satisfied that, even if a doctor had been called, there is no certainty that the outcome would have been any different. In response to the draft report, the Head of Healthcare said:

> " … it is Belmarsh's policy is to provide an immediate nursing assessment and if necessary summon an emergency ambulance and transport the patient to A&E."

45. The clinical reviewers describe the emergency clinical response at 8.45am as reasonable and appropriate. The man was taken quickly to hospital.

CONCLUSION

46. The man was serving a long sentence and clearly considered suicide at the start of his time in custody. He did not follow these thoughts through, but did refuse to accept treatment once he was diagnosed as suffering from diabetes. The care of a prisoner suffering from a long term illness is challenging, and this is made more so where the prisoner refused to accept treatment. However, the report shows how the healthcare staff at Belmarsh consistently tried to help him and encourage him to accept treatment. The use of an advance directive over such a long time is unusual in a prison setting and the findings of this case may be useful learning points for the service.

RECOMMENDATIONS

1. There should be a policy for the development and management of advanced directives. Training and support should be given to staff who implement and manage advanced directives.

The National Offender Management Service partially accepted this recommendation:

> “The management of a prisoner involving an advance directive is extremely rare, if not unique. The management of the man presented an immense challenge and in many ways was groundbreaking. Any policy development and subsequent training and support must be nationally coordinated.”

2. Healthcare staff should receive ongoing training and supervision in chronic disease management such as diabetes.

The National Offender Management Service partially accepted this recommendation, but wanted it to be more specific. I hope that the PCT and Head of Healthcare continue to take this forward.

3. The Head of Healthcare should review record keeping and ensure that records are consistent with the Nursing and Midwifery Council guidelines.

The National Offender Management Service accepted this recommendation:

> “System 1 has been implemented as of May 2010, which significantly addresses the concerns raised in the recommendation.”