Investigation into the circumstances surrounding the death of a man in December 2010, in hospital while on remand to HMP Woodhill

Report by the Prisons and Probation Ombudsman for England and Wales

July 2011

This is the report of the investigation into the circumstances surrounding the death of a man in hospital in December 2010. At the time of his death, he was being held on remand at HMP Woodhill. I extend my sincere condolences to his family and friends for their loss.

The man was 73 years old and had suffered ill health for a number of years. He died of chronic obstructive pulmonary disease (COPD), a condition which affects the lungs and restricts breathing. He was a heavy smoker and COPD is most commonly caused by smoking tobacco. He also suffered with ischaemic heart disease (IHD).

He arrived at Woodhill a little over ten weeks before he died. In the preceding year he had been admitted to hospital on 15 separate occasions. During his time in custody he spent a further two periods in outside hospital including what was to be his last admission to hospital on 16 December, where he remained as a patient until he died on Christmas Day.

The investigation was carried out by two of my colleagues. I would like to thank the Governor of Woodhill and his staff for their help during the investigation. I am particularly grateful the member of staff who liaised with the investigators.

A clinical review into the man's medical care and treatment in prison was conducted by the clinical reviewer from Community Health Services. I am very grateful for his thorough and timely review.

I make seven recommendations. Three of my recommendations concern the provision of inpatient healthcare at Woodhill and two relate to liaising with prisoners' families. Importantly, however, both my investigation and the clinical review conclude that the man received an equitable level of care in prison to what he might have expected in the community.

I am very grateful to the man's family, who carefully considered the contents of the report at the draft stage. This version of the report has been amended to reflect their views and the National Offender Management Service (NOMS) response to the recommendations made.

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.

Thea Walton
Acting Deputy Ombudsman **July 2011**

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SUMMARY

1. The man was remanded into the custody of HMP Woodhill on 14 October 2010. He was 73 years old and had been in poor health for a number of years. On his arrival, staff noted that he suffered with emphysema and chronic obstructive pulmonary disease (COPD). Because of this, Woodhill considered him unsuitable for normal cell occupancy, or work, and he was allocated a place in the prison's inpatient health centre.

2. His illness made breathing difficult which severely restricted his mobility. His condition was initially treated with tablets and inhaled medications. On 16 October, after his breathing had become more laboured and wheezy, he was taken to hospital. He was prescribed a course of antibiotics for a chest infection and released back to the prison in the early hours of the following day.

3. By 20 October, his condition had deteriorated and he was admitted to hospital and treated by intravenous antibiotics for a bacterial infection in his lungs. He returned to Woodhill on 8 November and his condition was managed there by regular medications.

4. He was admitted to hospital again on 16 December. His health continued to deteriorate in hospital and, by 22 December, hospital staff considered him to be terminally ill. At this point, his medications were halted and he was given morphine to relieve his breathing problems. He died at hospital.

5. This investigation and the accompanying clinical review conclude that, during his relatively short time at Woodhill, the man's health was managed appropriately. He received an equitable level of care to that he might have experienced had he not been in prison. In fact, it is likely that he received a better level of care and attention at Woodhill, simply because he had greater access to healthcare professionals and medical interventions.

6. Despite these welcome findings, I make seven recommendations. Three of my recommendations concern the provision of inpatient healthcare at Woodhill and two relate to liaising with prisoners' families.

THE INVESTIGATION PROCESS

7. The Ombudsman's office was informed of the man's death on 26 December 2010. Two investigators were assigned to carry out the investigation into his death.

8. They both visited HMP Woodhill on 11 January 2011. The investigators spoke to the Governor and Deputy Governor, members of prison and healthcare staff and representatives of the Independent Monitoring Board (IMB) and Prison Officers' Association (POA). The investigators visited a number of areas of the prison, including the healthcare centre and first night centre.

9. The investigators were provided with copies of the documents covering the man's time at Woodhill. They included his core prison record, his patient record, bedwatch logs and statements made by the two members of staff with him when he died.

10. Notices inviting staff and prisoners to contact the Ombudsman's investigators with any information they felt might be relevant to the investigation were displayed at the prison. However, there was no response to these notices.

11. The NHS appointed a clinical reviewer to review the clinical treatment and medical care the man received at Woodhill. On 7 February 2011, the investigator and clinical reviewer interviewed members of prison and healthcare staff at Woodhill.

12. HM Coroner for Buckinghamshire was informed of the nature and scope of the Ombudsman's investigation. A copy of this report will be sent to the Coroner to assist with his inquiries.

13. One of the Ombudsman's family liaison officers contacted the man's sister and invited her to be involved in the investigation process. She said that her brother's death had not come as a surprise and she had no particular concerns or questions about the care he received while in custody. However, I hope that this report will provide the family with a picture of his relatively short time at Woodhill and the weeks leading up to his death.

14. In response to the draft investigation report, the family explained that they believed one of the interview transcripts was factually inaccurate. However, as the interview transcripts are an individual's record of account and opinion, we are unable to make amendments to any transcripts.

15. My investigation assesses the following aspects of the care and treatment:

    a. Whether his diagnosis was made in a timely fashion?
    b. Whether he was told about his condition and the treatment which followed?
    c. Whether he was treated properly and attended hospital appointments as necessary?
    d. Whether the liaison with the family was appropriate?

e. Whether he was accommodated in the most appropriate part of the prison?
f. Whether consideration was given to compassionate release from prison?
g. Whether appropriate palliative care was provided?

HMP WOODHILL

16. HMP Woodhill is a core local prison which holds adult and young adult men. The prison opened in July 1992 and in the late 1990s joined the High Security Estate. The establishment holds a number of category A prisoners and one wing is designated as a close supervision centre (CSC) which holds a small number of prisoners who are among the most difficult and disruptive in the prison system. However, the majority of prisoners at Woodhill are category B or on remand. (Category A prisoners are those who are considered to pose the greatest risk to the public should they escape. They must be held in the most secure conditions. Category B prisoners do not need to be held in such secure conditions, but their escape must still be made difficult.) During his time at Woodhill, the man, who was not a category A prisoner, lived either in the healthcare centre or the first night centre.

17. The healthcare centre provides a total of 15 inpatient beds. There is 24 hour nursing cover and a doctor is available on site from 10.00am to 5.00pm, with an on-call service operating outside of these times.

18. The prison last underwent a full announced inspection by Her Majesty's Chief Inspector of Prisons (HMCIP) in September 2007. The Chief Inspector praised the prison's management team and the Director of the High Security Estate for focusing appropriately on the prison's principal role, as a local prison, without losing sight of the security and control needed to safely contain its small high risk population. The Chief Inspector charted a number of improvements since the establishment's previous inspection.

19. However, except for the inpatient unit which had made considerable progress, healthcare was of concern to the inspection team. The inspection report noted that, in general, the standard of care had deteriorated since the previous inspection. In particular, mental health care was assessed as limited and ineffective and waiting lists for the doctor, dentist and optician were highlighted for criticism.

20. Each prison in England and Wales is also monitored by an Independent Monitoring Board (IMB) formed of volunteers from the local community. The IMB must produce an annual report for each establishment, with the last available for Woodhill covering June 2009 to May 2010. The IMB noted that Woodhill is a "complex, diverse" establishment, posing many management challenges. It highlighted that the Head of Healthcare was making "steady progress" to improve the provision of healthcare, which had been criticised at inquest into the deaths of other prisoners. The Board highlighted some "excellent" initiatives targeting the prison's older population.

21. The Board continued to request that additional funding be secured to provide more Disabled Designated Accommodation (DDA – specially designed to meet the needs of prisoners with disabilities).

22. Since the Ombudsman began investigating all deaths in prison in 2004, 11 prisoners (including the man) have died of natural causes while at Woodhill.

While the circumstances of the previous deaths have no particular similarities with the man's, the Ombudsman has made recommendations concerning record keeping in five previous investigation reports. It is disappointing, therefore, that the issue of full and accurate record keeping arises once more in this investigation.

ISSUES

The diagnosis of the man's terminal illness

23. The man was born in Scotland and was one of 14 children. On 14 October 2010, the Crown Court remanded him into custody at Woodhill in relation to offences alleged to have been committed at the end of the 1990s. At the age of 73, this was his first time in custody.

24. He had been in very poor health for a number of years and was admitted to hospital on 15 separate occasions in the preceding year, most recently on 10 August 2010.

25. Following this period of hospitalisation, doctors at the hospital confirmed that he was suffering with chronic respiratory disease and made the diagnosis of COPD. (COPD causes the narrowing of the airways leading to the lungs. As a result sufferers have difficulty getting enough air into their lungs, leading to a range of symptoms including shortness of breath.) The diagnosis was related to his long-term tobacco smoking, high blood pressure and hypernatremia (an excess of sodium and lack of water in the body). In September 2010, a consultant chest physician at the hospital categorised his COPD as "very severe" based on an assessment of his lung function. The consultant commented that his symptoms would persist and be made worse by continued smoking, infections and times of anxiety or stress.

26. On the day he arrived at Woodhill, nursing staff made an entry in his patient record, noting that he suffered with emphysema (a progressive disease of the lungs causing shortness of breath). After an examination the following day, diagnoses of chronic obstructive airways disease (COAD, another term for COPD), ischaemic heart disease (IHD – a condition where fatty deposits build up in the coronary arteries, reducing blood flow to the heart) and a chest infection were noted in his medical record.

27. In the days that followed, his records show that he periodically became short of breath and had difficulty breathing. His breathing became particularly laboured late in the evening of 16 October and an ambulance was called to take him to hospital. He returned to Woodhill in the early hours of the following day. Hospital staff prescribed antibiotic tablets for a chest infection and exacerbation of his COPD.

28. On 20 October, his breathing deteriorated again and he was admitted to outside hospital once more, where he stayed until 8 November. During this admission, medical staff diagnosed him as suffering from a bacterial infection in his lungs which they treated with intravenous antibiotics. He was also diagnosed as suffering from end stage COPD. In other words, although treatment might, to some extent, alleviate his symptoms, his condition was assessed as irreversible and would inevitably worsen over time. Soon after his admission, medical staff took the decision that, because of his poor health, he should not be resuscitated if his heart stopped. (He and his family were not involved in making this decision, which I comment on later in my report.)

29. On 16 December, his condition worsened and his breathing became more difficult and laboured and he was admitted to hospital for the third time. By 22 December, the hospital had assessed his condition as extremely critical and doctors put in place end of life procedures for the final days of his life.

30. The clinical reviewer notes that a national strategy for identifying COPD was published for consultation in 2010. The strategy suggests several criteria against which to assess whether a patient with COPD is at the end stage of the disease. These include severe airflow obstruction, respiratory failure, low body mass index (which assesses ideal weight) and a history of two or more admissions to hospital for severe episodes of the condition in the last year.

31. When he was admitted to hospital in October 2010, he met those criteria. On that basis, the clinical reviewer concludes that it was reasonable for medical staff to classify his disease as at end stage. However, although by this stage his prognosis was poor, he could still have responded positively to treatment. The clinical reviewer notes that staff could not reasonably have concluded that his death was imminent, until his condition significantly deteriorated a few days before he died.

32. I am satisfied that the diagnosis of his illness and the decisions about whether his condition was terminal or not were appropriate and made principally by hospital and not prison healthcare staff.

Informing the man about his condition and treatment

33. The man suffered from a serious illness for a number of years which, amongst other things, had led to frequent hospital admissions. There can be little doubt that he knew that he was extremely unwell when he came into prison and was familiar with the types of treatment designed to alleviate his symptoms.

34. Healthcare staff have said that he was aware that his condition was probably caused, and certainly made worse, by his heavy smoking. A number of entries in his patient record at Woodhill indicate that he was repeatedly encouraged to stop smoking. However, it seems that, perhaps understandingly having smoked for so many years, he chose to ignore the advice.

35. As noted above, the clinical reviewer concludes that his condition could not reasonably have been viewed as being terminal until a few days before his death. However, there are no prison healthcare or hospital records to show that nursing staff or doctors spoke to him specifically about the seriousness of his illness. The clinical reviewer notes that there is no clear indication that, for example, the potential implications of reaching end stage COPD were ever formally discussed. He says:

> "This does not mean that [the man] was not involved in the day-to-day management of his care and was unaware of his current situation, but there is no clear record either way."

36. Hospital records show that on both of the man's admissions to hospital a clinical decision was taken not to resuscitate him in the event of cardiac arrest. The clinical reviewer is critical of the hospital as, contrary to best practice, these decisions were not discussed with him or his immediate family. Whilst outside the remit of this investigation, it is worth highlighting that the hospital assured the reviewer that it is "usual practice" to involve patients or family members in end of life decisions. Hospital staff were not able to explain why the man had not been included in discussions.

37. I have considered whether healthcare staff at Woodhill did all they could to involve him in decisions about his condition and treatment. Healthcare staff at Woodhill said that they were unaware of the hospital's clinical decision not to resuscitate him, which was taken during his first hospital admission. However, his patient record clearly shows that they were aware his COPD had been categorised as reaching an end stage.

38. I acknowledge that, when an individual is probably nearing the end of their life, such conversations may well be difficult and must be handled very sensitively. Nevertheless, Woodhill would have been aware of the implications of someone reaching end stage COPD. I am, therefore, similarly critical that there is no indication that the subject was ever formally discussed with him while he was at Woodhill.

39. I understand that the healthcare unit at Woodhill are currently developing a new end of life policy and protocols. However, I make the following recommendation:

    The head of healthcare should remind healthcare staff of the proper protocols for informing seriously and terminally ill patients about their condition and treatment and are reminded of the importance of full and accurate record keeping in such matters.

The man's medical appointments and treatment

40. The man came to prison with a history of chronic health problems. His condition was treated at Woodhill, as it was in the community, principally with prescribed tablets and medications administered using inhalers and nebulisers (which create a mist of medication, breathed in through a face mask).

41. On 16 October, he was taken to hospital and prescribed a course of antibiotics for a chest infection. His COPD deteriorated again and, on 20 October, he was admitted to hospital where he underwent a course of intravenous antibiotics. After returning to Woodhill, his condition stabilised for several weeks.

42. However, he was readmitted to hospital on 16 December and, shortly afterwards, diagnosed with a further chest infection. Unfortunately, his condition continued to deteriorate and, on 22 December, hospital staff decided that he was close to death. A decision was then taken to place him on a Liverpool Care Pathway, a nationally recognised set of protocols designed to guide the treatment of terminally ill patients. As a consequence, his medications were stopped and he

was given morphine (a commonly prescribed medication during the end stages of COPD) intravenously.

43. The clinical reviewer concludes that the man's care during both periods in hospital was responsive and appropriate throughout. Amongst other things, he notes that the decision made by hospital staff to put him on the Liverpool Care Pathway was justified. He also concludes that he received excellent health care while in custody and that Woodhill monitored, reported and managed his changing health needs properly and promptly.

44. Importantly, the clinical reviewer concludes that the man received an equitable level of care at Woodhill compared to what he might have expected in the community. Indeed, given the amount of medical care and attention he received in the establishment's healthcare unit, it is likely that he received better, more prompt, access to medical interventions than would have been the case had he been living alone in the community.

45. The clinical reviewer's only substantive criticism of the man's treatment at Woodhill concerned the apparent absence of any vaccinations. In particular, he highlights the Government Chief Medical Officer's advice to offer influenza and pneumococcal (bacterial) vaccinations to people with conditions such as those which he suffered from. The clinical reviewer found no record that the man was offered, or received, these vaccinations while in custody. Accordingly, he makes the following recommendation, which I endorse:

    The head of healthcare should ensure that influenza and pneumococcal vaccines are made available to all patients with chronic illnesses and conditions and that this is recorded in the chronic disease register.

The medication and pain relief given to the man

46. Clearly, the extent of the man's emphysema and breathing difficulties would have caused him discomfort and, perhaps, distress. Nevertheless, the clinical reviewer concludes that there was no indication that, during his illness, he was ever in pain. As noted above, morphine was administered in his final days in hospital as it is an accepted treatment for the symptoms of end stage COPD and not because he was in pain.

47. The clinical reviewer also found that all the medication and prescriptions given both at Woodhill and at hospital were in line with the clinical picture presented by the man and with national clinical guidelines.

48. Although healthcare staff often reminded him of the harmful effects of his habit, it appears that he chose to continue to smoke throughout his time in prison. Nevertheless, I am satisfied that, given his age and poor prognosis, there was little to be gained from denying him the pleasure and satisfaction cigarettes clearly gave him.

Liaison with the man's family

49. According to Prison Service Order (PSO) 2710, Follow up to a death in custody, a family liaison officer must be appointed in the event of a prisoner's death. Family liaison officers are specially trained to make contact with and provide information to the prisoner's family. However, I consider it to be good practice for a family liaison officer to be appointed when a prisoner is known to be seriously unwell and certainly when they are considered to be close to death.

50. On 22 December, when hospital staff confirmed that the man's condition was deteriorating, two officers were appointed as family liaison officers. According to their log of contact, Officer A first tried to telephone the man's nominated next of kin (his sister) that day. However, the telephone number Woodhill held for his sister was unobtainable. The officer then telephoned the man's brother, whose details were also held by the prison. The officer spoke to the sister-in-law, who agreed to contact the man's sister and update her.

51. The officer said that, when he notified the family that the man was in hospital, he told them that they could not visit because they had not been to the prison before and so had not been security cleared and allowed to visit. In these circumstances it is not surprising that members of the family went against this instruction and visited him in hospital later that day. Plainly, informing his close family out of the blue that he was gravely ill in hospital and, at the same time, saying they were not allowed to see him, is an unsatisfactory state of affairs and so I make the following recommendation.

    The Governor should ensure that the prison's policy for liaison and contact with the families of seriously ill or hospitalised prisoners is reviewed to ensure that any visiting restrictions are appropriate and justified.

52. On Christmas Eve, the man's sister telephoned Officer A and asked if a Roman Catholic priest could give him the last rites at the hospital. (According to prison staff logs, a priest visited him at 2.50pm that day.) The officer also told the sister that the prison could help with the cost of funeral arrangements, flowers and taxis to the hospital.

53. The officer telephoned the family early on Boxing Day morning and informed them that the man had died the previous day. The officer arranged transport for members of the family to visit him at the hospital's Chapel of Rest on 27 December 2010. Both officers accompanied the family on the visit and returned items of his property to them.

54. When the man returned to Woodhill from hospital in October, his COPD had been assessed as reaching an end stage and a decision taken not to resuscitate him if his heart stopped beating. However, as discussed earlier, it was by no means certain at this stage that his death was imminent. In addition, my investigators were told that he had said that he did not want any of his family to know that he had been remanded into prison.

55. Without his consent, I am satisfied that staff at Woodhill were not in a position to contact his family before 22 December, when his condition became critical. However, in such important matters, as a minimum I would expect his wishes to have been fully and accurately documented in his patient or other prison records. The absence of any records on this point does not mean that the prison went against his wishes. However, once again, there is no clear indication either way.

    The Governor should remind healthcare and other prison staff working with ill or elderly prisoners that it is essential to keep full and accurate records about the individual's wishes about notifying their next of kin or other family members about their health and personal circumstances.

The man's location at Woodhill

56. The man's patient record indicates that, on the day he first entered Woodhill, he was assessed as unfit to live in a normal prison wing and so he was located in the prison healthcare's inpatient unit. He stayed in the unit for two days until, when his condition worsened, he was taken to hospital by ambulance, late in the evening of 16 October. After a few hours, he was discharged and he returned to the inpatient unit in the early hours of 17 October.

57. On 19 October, a doctor decided to move him to a cell in the first night centre (FNC), which is in an adjacent block. The first night centre cell given to him is designated as a "disabled" cell. It is significantly larger than most of those found in both the prison's houseblocks and in the inpatients unit. The cell door is wider than normal to enable wheelchair access and there is an en-suite toilet and shower area.

58. When he returned from hospital for the second time in November, he returned to the cell in the first night centre. On the advice of doctors, he was moved back to a bed in the inpatients unit on 11 November.

59. On 16 December, his condition worsened and his breathing became more laboured. He was admitted to hospital for the third and, ultimately, final time.

60. The clinical reviewer concludes that the inpatients unit was the most appropriate place for him to live whilst he was at Woodhill, other than when his condition dictated that he needed greater levels of treatment and care in hospital.

61. He was moved to the disabled cell in the FNC because of the demand for beds in the inpatients unit and because the only disabled cell in inpatients had been occupied for some time by another seriously ill prisoner. It is unfortunate that he had to move between cells and, indeed, wings during his short time at the prison. Frequent moves reduce the opportunities for prisoners to build relationships and support networks (both with staff and other prisoners). On that basis, it would have been preferable for him to have remained in the same wing, if not the same cell, whilst he was in prison. However, healthcare staff told my investigators that there are only two disabled access cells in the prison, one of which is in the inpatients unit and one in the FNC. This means that prisoners sometimes have to be moved between cells according to their needs. Undoubtedly, the first night

centre cell allocated to him offers a degree of space and convenience that exceeds most of the accommodation available in the prison's inpatient unit, but this should not be a long term solution for the lack of appropriate facilities in the inpatients unit.

62. The clinical reviewer agrees that, had there been more facilities in the inpatient unit, some of the man's internal moves between there and the first night centre might have been avoided, affording him a greater consistency in his treatment. The need for more designated disabled accommodation at Woodhill has also been highlighted by the IMB, as noted earlier. The clinical reviewer and I add our voices to that argument:

    The Governor and the head of healthcare should consider whether there is any scope for providing more disabled access cells in the inpatient unit.

Compassionate release and bail

63. The man was being held at Woodhill on remand by order of the Crown Court. All remand prisoners are held in custody on behalf of the courts and, under the legislation covering the early release of sentenced prisoners, there is no power for governors to release remand prisoners on compassionate grounds, or under any other licence conditions.

64. It appears that the day before he died, Woodhill contacted the man's criminal defence solicitors and notified them of their client's deteriorating condition. By all accounts the solicitors tried to secure a listing at the Crown Court to apply for bail, but were unable to obtain a hearing date in time. I am sure that the solicitors would have been aware of his existing health problems before he was remanded into custody. I am satisfied that Woodhill did all that could have been expected of them.

Palliative care plans and the end of life pathway

65. The man was placed on the Liverpool Care Pathway by hospital staff on 22 December, because of his deteriorating health and lack of response to treatment. The aim of the Pathway is to improve the quality of care which an individual receives in the last hours, or days, of life and has been formally recommended by the Department of Health (DoH) since 2008.

66. As has been mentioned in earlier sections of this report, the clinical reviewer concludes that the timing and clinical justification for initiating an end of life pathway for him was in line with DoH and best practice guidelines.

Restraints, security and bedwatch

67. When he was taken to hospital on 16 December, staff completed an Escort Risk Assessment (which highlights any risks the prisoner poses to themselves or members of the public and what level of restraints should be applied). They concluded that a standard escort strength of two officers was necessary and that he should be double cuffed to one of the staff. (This means that the prisoners'

two hands are cuffed together and one hand is also cuffed to a member of prison staff.) The paperwork shows that escort staff had to gain the prior approval of a duty governor before removing any restraints.

68. Later in the afternoon, it became clear that he was going to be admitted to hospital and the prison formally changed the escort to a "bedwatch". For the next few days, two officers remained with him at his bedside and he was cuffed to one of them at all times by an escort chain. (This is a piece of chain approximately six feet in length with a handcuff on each end. One cuff is placed on the wrist of the prisoner, the other is attached to a member of staff.)

69. His risk assessment was reviewed on 22 December, after his condition was assessed as critical and nursing staff said that he probably had only hours left to live. The Deputy Governor formally approved the review and, at around 11.00am, the duty governor authorised the removal of the escort chain. Two officers then remained with him until he died, three days later.

70. Guidelines on the security measures to employ when prisoners are escorted outside establishments are contained in the Prison Service's National Security Framework (NSF). Clearly, prisons must ensure that staff keep all prisoners under escort in secure custody and prevent any escape. This includes prisoners on their way to and from hospital, and during their stay there.

71. There are several security options available to prison managers in relation to hospital admissions, including:

- bedwatch with two officers or more with restraints applied
- bedwatch with two officers or more without restraints
- when the prisoner's medical condition or lack of mobility is such that they cannot escape unaided and there is no evidence that an escape attempt is likely, bedwatch with one officer without restraints.

72. There is nothing to suggest that the restraints used on the man during his hospital admissions ever hampered the medical treatment or care he was afforded. Furthermore, I appreciate that he had been charged with a sexual offence and that public protection must be a primary concern when making restraint related decisions. However, he was 73 years old, weighed little more than six stone and had severely impaired mobility through long term chronic lung disease causing him to become breathless with even the slightest exertion.

73. It is my view that, although they were properly authorised and used appropriately, the use of restraints on him while at hospital was an unnecessary and excessively risk averse precaution. On that basis, I make the following recommendation:

The Governor should remind all staff undertaking risk assessments of the options available under the NSF. The level of restraints and escort or bed watch staff must be necessary and proportionate.

74. My investigator has examined the logs compiled by the bedwatch officers from the time of his admission until his death. The documents form a continuous account of his stay. Two other officers were with him when he died on Christmas Day. Officer B recorded that he was unconscious and being kept clean and comfortable by nurses. An entry made very shortly before he died, describes the officer alerting a nurse to protracted periods when he appeared not to be breathing. In Officer B's subsequent statement (a requirement of PSO 2710), he made it clear that, along with their other duties, both he and his colleague felt it was their responsibility to protect his dignity during his final hours. I am pleased that bedwatch staff carried out their duties with an appropriate degree of respect and sensitivity.

75. During the investigation, a Prison Officer Association representative at Woodhill suggested that insufficient support was offered to staff who are assigned to carry out bedwatch duties. There is no evidence that any of the officers who were with the man when he died, or in the days before, needed, or were unable to obtain, support or counselling. Nevertheless, I recognise it can be a very stressful and upsetting role and that it is important to publicise the counselling and support services available to staff.

The Governor should amend the bed watch occurrence logs to include the contact details for the prison's care team and area employee support section.

CONCLUSION

76. The man arrived at HMP Woodhill in October 2010, already a very poorly man. He was 73 years old and had been diagnosed with COPD, resulting in numerous hospital admissions in the preceding year. While on remand at the prison, he was taken to hospital three more times, and admitted as an inpatient on two of those occasions. His stays in hospital were the result of his condition worsening, and hospital staff concluded that his COPD was reaching the end stages. He died at hospital.

77. I conclude that the standard of care afforded to him while at Woodhill was at least equitable, if not better, than what he might have received had he been living alone in the community. Generally, the clinical reviewer and I find that both prison healthcare and hospital staff treated him appropriately. However, I make seven recommendations. Several of my recommendations relate to the specific issues arising from prisoners with diagnosed long term, and probably terminal conditions. I do not think that any would have prevented his death, but they might help prison staff to look after prisoners in similar situations in the future.

RECOMMENDATIONS

The NOMS response is recorded in italics below each recommendation.

1. The Head of Healthcare should remind healthcare staff of the proper protocols for informing seriously and terminally ill patients about their condition and treatment and are reminded of the importance of full and accurate record keeping in such matters.

   Accepted. The Head of Healthcare, in conjunction with Prison and Foundation Trust colleagues, will ensure that all members of staff are aware of Protocols and Policies relating to terminal care provision and also ensure that staffs are competent to deliver such news to patients.

2. The Head of Healthcare should ensure that influenza and pneumococcal vaccines are made available to all patients with chronic illnesses and conditions and that this is recorded in the chronic disease register.

   Accepted. This directive will be included in the Immunisation and vaccination policy currently being written locally. All vaccinations offered/given will be recorded on the Electronic Records System.

3. The Governor should ensure that the prison's policy for liaison and contact with the families of seriously ill or hospitalised prisoners is reviewed to ensure that any visiting restrictions are appropriate and justified.

   Accepted. In cases where hospitalised prisoners are seriously ill, visiting restrictions will be regularly reviewed to ensure that these remain appropriate to the circumstances and in any cases of doubt staff should contact the duty governor for clarification.

4. The Governor should remind healthcare and other prison staff working with ill or elderly prisoners that it is essential to keep full and accurate records about the individual's wishes about notifying their next of kin or other family members about their health and personal circumstances.

   Accepted. This will be incorporated within the Older Prisoners' Policy. Prisoners' wishes regarding notifying next of kin or family members should be recorded on C-NOMIS.

5. The Governor and the head of healthcare should consider whether there is any scope for providing more disabled access cells in the inpatient unit.

   Accepted by the Head of Healthcare. It is recognised, through analysis of Healthcare provision of disabled / chronically ill patients within a custodial environment, that there is a need for increased disabled facilities and that this should be located within the in-patients facility. Costing to be prepared and presented for this to considered and approved by the Governor.

6. The Governor should remind all staff undertaking risk assessments of the options available under the NSF. The level of restraints and escort or bed watch staff must be necessary and proportionate.

   Accepted. All managers to be reminded of the risk assessment procedures for escorts and bedwatches under the NSF; these should be regularly reviewed particularly in cases of seriously ill prisoners.

7. The Governor should amend the bed watch occurrence logs to include the contact details for the prison's care team and area employee support section.

   Partially accepted. In cases of seriously ill prisoners the care team and area employee support section contact details should be made available to those staff who have undertaken duties on bedwatches or escorts for those prisoners who are near to the end of their life.