Investigation into the death of a man who died in hospital whilst in the custody of HMP Lincoln in February 2006

Report by the Prisons and Probation Ombudsman for England and Wales

March 2008

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.

This is the report of an investigation into the death of a man in hospital in February 2006. The man was on remand at HMP Lincoln for the murder of his daughter. He had refused food on and off for over a year and eventually died as a result of starvation. The post mortem has given the cause of death as bronchial pneumonia and severe under-nutrition.

The man had written an advance directive refusing all food and most medical intervention. This was eventually upheld as a legally binding document by the High Court in August 2005. The advance directive meant that the man was deemed to have the "capacity" to decide to refuse food and medical intervention.

I would like offer my sympathy to his family and friends. They remained steadfastly supportive throughout the time he spent in prison. I must sincerely apologise for the delay in producing the report into this most complex case.

The investigation was undertaken on my behalf by one of my colleagues. An independent review of the man's medical care while in prison was undertaken by two medical practitioners of Bassetlaw Primary Care Trust (PCT) who were appointed by the then West Lincolnshire PCT. I am grateful to them both for their assistance and for a clinical review that tremendously assisted the investigation. Lincolnshire Teaching PCT provided an additional report and I must also thank their clinical reviewer for her commitment to the clinical review process.

It is rare but not unknown for prisoners to kill themselves by starvation. This report explores the circumstances of the man's death and the legal and moral issues raised by it. I believe important lessons can be learned at national level from what occurred in this case and have been very impressed by the professionalism and sensitivity demonstrated by staff and management at HMP Lincoln.

I formally recognise three issues of good practice. I must commend Lincoln's senior management team and the West Lincolnshire Primary Care Trust for their pioneering care of the man who is the subject of this report. I make four recommendations and I agree with the six recommendations made by the clinical reviewers.

Stephen Shaw CBE
Prisons and Probation Ombudsman **August 2007**

Contents

SUMMARY

The man was arrested by police after allegedly murdering his daughter with whom he had been living after his marriage broke down. The murder attracted significant media attention. The man was taken to Lincoln prison on 18 August 2004 and was immediately located in the healthcare centre and placed on an intermittent suicide and self harm prevention watch.

The man was reluctant to talk or engage with other staff or prisoners initially and spent most of his time in his cell watching television. He spent two days on a normal residential unit but quickly returned to the healthcare centre. He said he had been threatened by other prisoners. On 13 November, half a mug of pills was found in his cell and he admitted to staff that he intended to take an overdose. He was immediately placed on constant supervision and relocated into a gated observation cell within the healthcare centre. A few days later some shoelaces were also found in his cell. His tablets were replaced with liquid medication to reduce the opportunity of his storing it up. He was assessed as being at risk of suicide throughout November and December 2004 and the constant supervision continued.

On 24 December, the man declined to eat or take his medication. This continued over the next couple of weeks. At an ACCT case review on 12 January 2005 the prison doctor explained to the man that if he continued to refuse all food his physical condition would deteriorate and he could die. (ACCT stands for Assessment, Care in Custody and Teamwork and is the term used to describe the system for monitoring and supporting prisoners considered to be at risk of self-harm or suicide.) The man said that he understood this but wanted to die in this way. The doctor suggested that he should contact his legal team and ask them to draw up an advance directive to say that he did not want to be force fed, or treated in the event of becoming unconscious through food refusal. The doctor then contacted a consultant psychiatrist and asked him to assess the man's 'mental capacity' to make such a directive.

The psychiatrist assessed him on 14 January 2005. While he considered that the man was competent to refuse food and drink and enter into the advance directive, he could not rule out the possibility that he was suffering from a mental illness that required him to be assessed. In contrast, the doctor's opinion was that the man was not suffering from a mental illness. However, the two doctors agreed that he should be assessed under the Mental Health Act 1983 for a period of assessment. The signed advance directive was sent to the prison by the man's solicitor on 16 January 2005.

The doctor discussed the man's case with a forensic psychiatrist at a medium secure unit. He advised the prison that they might be required to treat the man within the terms of his advance directive and allow him to continue his food refusal. He also recommended an urgent independent assessment. On 20 January, the man moved to the high dependency unit within Lincoln's healthcare centre. That evening, two consultant forensic psychiatrists, assessed him to establish whether he was suffering from a mental illness and

whether he had the necessary mental capacity to refuse food, drink and medical treatment. They jointly concluded that the man should be detained under the Mental Health Act for the treatment of his depressive condition. They also concluded that his illness meant he could not "rationally weigh information in the balance regarding his healthcare and wish to die".

The man was extremely upset at being told that he was to be detained. He understood that this meant he would be treated in hospital if he continued to refuse food and fluids. The man therefore agreed to start eating and drinking again.

The man was transferred to the medium secure unit on 24 January 2005. Staff at the secure unit found it difficult to assess him because he refused to engage with their efforts. After several months it was decided that, although he suffered from personality disorders, he did not fulfil the Mental Health Act criteria for a detainable mental illness. He had been transferred to hospital as a result of a mental illness which had to be resolved with treatment. It was therefore decided that he should be recommended for transfer back to prison.

The man returned to Lincoln on 27 July 2005. The first entry in his clinical record reads, "on arrival the man expressed his intention to kill himself by starvation and clearly stated that there is nothing we can do to stop him." The man was put back in the healthcare centre, on constant supervision in a gated cell. No advance directive was in place. The doctor recorded that the man needed to be seen again by the two forensic psychiatrists so that they could reassess his capacity.

The two psychiatrists did not agree over whether the man had capacity to sign an advance directive. West Lincolnshire PCT sought a declaration of capacity from the family division of the High Court. Another psychiatrist was instructed by West Lincolnshire PCT to provide a third expert assessment of the man's capacity and did so on 8 August. Her opinion was that the man had capacity to refuse food and treatment and the High Court therefore judged that the man's advance directive, dated 10 August 2005, was a valid legal document. Staff at the prison were informed of the judgement and a note was made in the man's record, "The man stated that he is now at peace." The Healthcare Principal Officer (PO) encouraged him to reconsider his advance directive and said that he could change his mind at any time. The man stated his desire to carry out his advance directive in full.

Over the following months, the man remained under constant supervision in the gated cell in the healthcare centre. He spoke to staff regularly about his past and his desire to die through food refusal. In November 2005, his condition deteriorated and arrangements were made for him to be transferred to hospital. However, while he continued to refuse food, he began to consume fluids and as a result, his condition then improved and it was not until February 2006 that staff made arrangements for him to be transferred to the hospital. The man was transferred to a private room in the local hospital where he died.

THE INVESTIGATION PROCESS

1. One of my colleagues was appointed to lead this investigation on my behalf. She and I visited Lincoln on Friday 3 March 2006. We met with the Governor and her Deputy Governor. We were briefed about the man's condition while he was at Lincoln and the management decisions that were made about his care. We were given a tour of the healthcare centre and met the Head of Healthcare and the Head of Clinical Governance for West Lincolnshire PCT. We met with representatives of the Independent Monitoring Board (IMB) and with the prison's family liaison officer.

2. Notices were issued inviting prisoners and staff who had any matters relevant to the investigation to make themselves known to the lead investigator. One member of staff made himself known to the investigation team, through the Prison Officers' Association (POA). No prisoners responded to the notices.

3. One of my Family Liaison Officers contacted the man's identified next of kin. The next of kin was pleased to be told about the investigation process, but had no concerns about the man's care in the prison. He thought that the prison had done everything that they could for him. The family did request to see a copy of my report and I hope that it has answered any outstanding questions they might have.

4. The lead investigator attended Lincoln with another colleague from my investigation team in May 2006. They interviewed prison, healthcare and probation staff. The team examined the man's prison files, including the constant observation files and records relevant to the High Court proceedings. The investigator also liaised with Prison Service's Safer Custody Group, visiting their offices on two occasions. I would like to thank them for their co-operation and assistance in this investigation.

5. West Lincolnshire PCT was commissioned to undertake a clinical review of the man's care at Lincoln. To increase the independence of the clinical review, the PCT approached a neighbouring Trust, Bassetlaw PCT, to conduct the review on their behalf. Two representatives from Bassetlaw visited HMP Lincoln with my investigation team and conducted joint interviews. I received their final clinical review on 29 November 2006. I would like to thank them for their active participation in the investigation and the clinical review. Following receipt of the clinical review, the lead investigator wrote to Lincolnshire PCT (as West Lincolnshire PCT had merged into a larger county-wide PCT) with a number of issues on which she required further guidance. A solicitor wrote a comprehensive reply to the investigator's letter on behalf of Lincolnshire PCT. This was received in this office on 22 January 2007. I would like to reiterate what I have said in my foreword to this report and thank Lincolnshire PCT for their professional contribution to this investigation.

HMP LINCOLN

6. Fronted by an impressive Grade II listed gate building, HMP Lincoln is a Victorian category B adult male local prison that overlooks the city of Lincoln. The five narrow wing buildings can currently hold up to 490 prisoners. A-wing has been closed for refurbishment since it was devastated by a riot in October 2002.

7. The modern administration block situated at the front of the prison is abutted by the healthcare centre. This can hold up to 14 prisoners in normal cells over two floors. The healthcare centre has one gated cell with a transparent door and a recently refurbished high dependency unit. There are good links between the healthcare centre and the local hospital.

8. The Annual Report from the IMB in 2005 recognised Lincoln as a prison that had successfully resolved many of the problems it faced in the aftermath of the riot. The report concluded that while there remained some concerns, "the Board detected an air of change occurring within the establishment and a more positive sense of purpose in all areas of the prison."

9. HM Inspectorate of Prisons published a report in early 2006 of an inspection that they carried out in September 2005. This did not reflect such a positive view of Lincoln. While the Chief Inspector identified some "green shoots of recovery", following the jail's "troubled history", she concluded that it was not performing satisfactorily and that Lincoln was not a safe prison.

10. Significantly for the purpose of this investigation, the Chief Inspector found that 20 of 23 of her recommendations for Lincoln's healthcare centre had been addressed since the last inspection in 2002. The Inspectorate report concluded that the healthcare provision had considerably improved. Overall, work in healthcare was found to be of a high standard.

KEY EVENTS

The man's remand and initial period in custody

11. Following the murder of his daughter, the man went missing for a number of days until he was discovered by police. He was taken in for questioning, charged with his daughter's murder, and remanded to the custody of Lincoln prison on 18 August 2004.

12. A healthcare assessment noted that the man "does have a noticeable tremor of his head", due to Parkinson's disease. It indicated that he had seen a psychiatrist at the age of around 25. Following the healthcare assessment, he was prescribed chlorpromazine (a drug commonly used to treat psychotic disorders).

13. A letter was received by the prison from the man's solicitors on the day of his arrival to indicate that he was suicidal. The letter asked that consideration be given to placing him in a mental health hospital. Given the nature of the charge against him and the circumstances of his arrest, an application was made for him to be put in a safer cell in the healthcare centre on the day of his arrival. The man was appropriately identified as being at risk of self-harm and was made subject to ACCT procedures. (ACCT stands for Assessment, Care in Custody and Teamwork and is a system used for managing and assisting prisoners who are considered to be at an increased risk of suicide or self-harm.) He was placed on the second level of observations which meant that he was considered a medium risk and was checked intermittently, several times an hour.

14. By the next morning, the man's ACCT ongoing record noted that he was feeling overwhelmed by the number of visitors he had received and that he wanted some space. He told staff that he was worried about those whom he had hurt but that he did not have the courage to hurt himself. The man was located in a cell with a camera fitted for continuous observation on 20 August, but he was not subject to continuous supervision at that time. His monitoring was intermittent, at around 30 minute intervals. The prison received information from the police in their case summary to indicate that he had "suicidal intent".

15. The man's solicitor wrote to Lincoln on 3 September to express her concern that the man was suffering from clinical depression and perhaps the onset of Parkinson's Disease. She also questioned the appropriateness of his legal visits taking place in the visits area where their conversation might be overheard. The details of the murder and his family history had been the subject of significant media attention in the previous weeks. The letter was placed in his medical record and staff continued to monitor him closely.

16. From 9 September 2004, staff assessed that the man was to remain subject to intermittent observations. An officer wrote:

"The man is still very emotional and presents as being unsure of his future."

17. On 13 September, he told a member of staff that he "hates waking up in the morning and seeing the light – he wishes God would take him in his sleep so he could be with his daughter."

18. A note was made in his wing history record on 19 September that he was experiencing problems with another prisoner in the healthcare centre who was asking about his offence. The man requested that he be allowed to go back to his cell during association to avoid the prisoner. ("Association" is the opportunity for prisoners to spend time out of their cell, mixing with other prisoners and participating in recreational activities.)

19. A consultant psychiatrist assessed him on 24 September. He found that the man had a "strong wish to be dead. Intention to kill himself when opportunity presents itself. Does not believe efforts should be made to keep him alive." The psychiatrist concluded that the man was depressed and recommended that he should remain subject to continuous observation. He also prescribed him anti-depressants. According to his ACCT record, he was in fact still subject to intermittent observations at this time. This level of observations continued. The man complained that the anti-depressants caused him to feel dizzy and shortly afterwards he refused to take them.

20. The man walked out of a self-harm review meeting on the morning of 30 September after he was asked if he was going to self-harm. A further ACCT case review took place on 7 October. It was recorded that the man remained "resilient" to any questions about his index offence but was not posing any problem to staff. The man expressed his concern at being in healthcare where there was little activity in his daily regime and he was not being stimulated. This sentiment was echoed in a letter, dated 8 October, from his solicitors to the Governor of Lincoln. They were particularly anxious that the man was yet to receive his spectacles and more generally that he was located in healthcare with little to occupy him. They suggested that he should have a radio to pass the time.

21. The man had a "traumatic" legal visit on 11 October during which his solicitors made him aware that the full facts of the offence might emerge as a result of the ongoing criminal investigation. The man remained reluctant to discuss with prison staff the details of the charges against him. An ACCT case review took place following the visit and he was encouraged to associate with other prisoners.

22. The Governor replied to the man's solicitor saying that the man would receive his spectacles as soon as payment had been received for the optician's fees. The solicitors replied on 15 October stating that they would do so. The governing Governor also reassured the solicitors that

the man was not located in a strip cell and that he was getting the opportunity to live a “stimulating life” in the healthcare centre.

23. The man had a radio and television in his cell for most of his time in the healthcare centre. He particularly enjoyed watching television. Staff tried to get him to associate with other prisoners, saying that they would review whether he could have a television in his cell unless he agreed to come out of his cell during association periods. So important was the television to him, that later he spent a good deal of time planning his viewing schedule in great depth with the member of staff who was observing him. However, he preferred not to associate with other prisoners. The charge against him was high profile in his local area and nationally and he did not want to speak about the circumstances. The man would chat with the member of staff carrying out his observations and watch television for most of his days.

24. On 18 October 2004, the man was assessed as fit to be transferred out of the healthcare centre and was moved to a normal wing in the prison. Whilst on the wing, the man received a visit from the Lifer Manager and a bereavement counsellor. Just two days later he was returned to the healthcare wing. He was experiencing stress, sleep deprivation and headaches and his suicidal ideation continued. The doctor told my investigators during interview that the man experienced some threatening behaviour from other prisoners on the wing, probably as a result of his high profile.

25. At his ACCT case review on 21 October, he was recorded as “tearful” although it was felt that he had “no firm intention” to self-harm. During the review, he was initially reluctant to engage but went on to speak quite freely about his concerns. He alluded to childhood abuse and suggested that revelations at his upcoming trial might lead to the imprisonment of another family member. The man remained subject to intermittent observations.

26. The man’s third nursing care plan was drawn up on 27 October 2004 and related to his diagnosis of Parkinson’s Disease. Nursing staff were to encourage him to discuss any difficulties and monitor his physical condition. All changes were to be reported to a prison doctor.

27. Observations were continued intermittently, about every 15 minutes, following the next ACCT case review meeting on 28 October 2004. The review recorded that the man was increasingly anxious about the forthcoming court hearing. He was apparently confused about the amount of “fuss” being made about the hearing, considering his intention to plead guilty.

28. The Governor responded to concerns raised about his mental health by his solicitors on 18 August 2004 in a letter dated 3 November. In her letter, the Governor reassured his solicitors that he was subject to suicide prevention strategies, including intermittent observations, and

that his mental health would be subject to review by psychiatrists. Indeed, the consultant psychiatrist reviewed the man's condition two days later (5 November). The man reported hearing voices. The doctor thought that the voices were not a symptom of a psychotic process but, more likely, a result of his sleep deprivation and stress levels. Again, the doctor suggested that the man should remain subject to constant supervision. The man was actually subject to intermittent observations at that time and these continued. The man was taking medication for suspected Parkinson's Disease, as well as medication for his headaches and an anti-depressant.

29. The man continued to refuse to associate with other prisoners on the healthcare centre. On 10 November 2004, staff advised him to use his association times as an opportunity to get out of his cell.

30. Staff searched his cell on 13 November and discovered half a mug of "pills". When questioned by staff, the man admitted that he was going to take an overdose the following night and that he had written a letter absolving Prison Service staff of any responsibility for his suicide. The man was placed on a constant supervision immediately. This meant that he was relocated into a different cell in the healthcare centre (a gated cell). On the day of his cell move, a record of a telephone conversation between the man and a friend was noted in his wing history sheet. The man had said that he couldn't do "it" now that he was being watched.

31. The cell used for constant observations has a glass door which is transparent from floor to ceiling. There is a metal gate between the glass door and the rest of the healthcare centre. Staff observing him sat in the corridor just outside of the cell, continuously monitoring him and writing notes at least every 15 minutes. There is a normal (not gated) cell immediately opposite which directly overlooks the gated cell.

32. A further search of the man's cell was made on 14 November but nothing was discovered. Officers were informed two days later that there were shoelaces in the man's personal mail.

33. The doctor countersigned a psychiatric nursing assessment dated 14 November. The assessment described the man as suffering from a "Low mood, feelings of abject hopelless [hopelessness], sadness and apathy." His communication was assessed as poor unless prompted, although he said that he spoke to his daughter, his alleged victim, every night. The assessment suggested that he was "in denial concerning his relationship with family and in particular his daughter. Is unwilling to accept that he felt any anger towards his family." The man particularly complained that he "feels like he is in a goldfish bowl, everyone talking to him."

34. The doctor wrote to the Governor on 16 November 2004 for the Governor's information only. He passed on concerns from all of the staff, himself included, as follows:

> "He [the man] has expressed his intention to end his life on several occasions. Only this afternoon, shoelaces have been found in his cell. He is on constant watch and I see no imminent change to this, just so you are aware from a staffing viewpoint."

35. The man was found to be saving his medication again on 25 November. Three days later, he was observed storing medication in his mouth. The man became abusive to staff on 29 November 2004 when they informed him that he would not be coming off the constant supervision in the "foreseeable future". The man's frustration at being on constant supervision continued and, on 3 December, the Healthcare Senior Officer (HCSO) recorded that the man seemed "desperate to get off" the constant supervision. The HCSO went on to report that the man had asked a fellow prisoner, who was working as a cleaner on the healthcare wing, for a shoelace. Following his several attempts to store his medication, staff changed the man's medication to a liquid form. He remained in the gated cell and was subject to continued constant supervision.

36. The man expected to go to court on 9 December, but did not appear on the court list. A note was made in his Daily Record of Nursing Care that he was "unhappy about this situation". The following day, his solicitors informed him that his case would be heard in his absence in January, but the man was reportedly "concerned and confused" by this information. The man also told his solicitor that he was concerned about the lack of privacy, given his constant supervision.

37. On 16 December, a case conference was held to discuss his repeated attempts to store medication. Staff were concerned that he was attempting to store medication in order to take an overdose as an attempt at suicide. The case conference was attended by the Governor and healthcare staff, but the man refused to engage with the meeting. He would not discuss his reasons for storing medication and walked out.

38. The consultant psychiatrist reviewed him on 17 December. The man maintained that he wanted to die. The psychiatrist concluded that he was still at risk of suicide. According to his medical records, he had a "usual day" on 18 December. He had a legal visit in the morning. It was recorded in his Daily Record of Nursing Care by an officer that the man was trying to "obtain shoelaces" and might have been storing his medication again. The entry went on to state that the man "has made no secret that he wants to be with his daughter at Christmas". Another room search was conducted but nothing was found.

The man's food refusal and sectioning under the Mental Health Act

39. A nurse wrote a Nursing Care Plan in the man's clinical record on 28 December 2004. The trigger for this Care Plan was the following need, as identified by the nurse:

> "Declining to eat and accept medication since 24/12/04, possibly catalysed by a dispute with Aramark, but no explanation given. Also angry re:- current situation (constant watch, trial coming up)."

(Aramark is the private contractor that runs the prison's shop from which prisoners may purchase food and other goods.)

The nurse went on to describe nursing interventions aimed at preventing the decline in the man's physical health. He suggested that staff should give him a daily opportunity to vent his feelings. Staff were to offer food and medication to him and document whether he accepted the food or not. A urine test, carried out on 4 January, tested negative for ketones. (Ketones are often found in the urine when the body has not had enough carbohydrates to digest. This is turn might suggest that an individual has not been eating.) Despite the lack of ketones in his urine, clinical observations showed that he was rapidly losing weight at that time. The nursing care plan about his food refusal was reviewed on 5 January 2005. No change was made to his planned care. The man initially declined to see his solicitor on 5 January 2005. He was encouraged by staff and eventually agreed to meet with her. The Healthcare PO recalled that, after the visit, the man initially seemed agitated but soon settled down.

40. An ACCT case review took place on 12 January which the man and the doctor attended. During the review, the doctor explained to him that if he continued to refuse all food his physical condition would deteriorate and he could die. The man understood this, but expressed his wish to die in this way. The doctor suggested that the man contact his legal team to draw up an advance directive. (An advance directive is a document, in which a patient sets out how medical decisions affecting them are to be made.)

41. The doctor wanted to establish whether the man might be force fed were he to lose consciousness. If he did not want to be force fed or treated, he would have to set this down in an advance directive or staff would be obliged to treat him. In order to write a valid advance directive, it had to be established that the man had the mental capacity to enter into that directive at the time of writing it. To this end, following the care review, the doctor contacted the consultant psychiatrist to assess the man's capacity.

42. On 13 January 2005, the Nursing Care Plan was reviewed and a note was made by Health Care Senior Officer (HCSO) as follows, "Review. May decline to take fluids. Will review if and when." The same day the

man discussed signing “paper work for no medical intervention to save his life” with the nurse that was his key worker at that time. (A key worker is someone who acts as a support and the main point of contact for the prisoner-patient.) A care planning meeting was arranged to discuss the matter with the Governor. The nurse reported that the man was more “settled in himself now the decision is made”.

43. On 14 January, the consultant psychiatrist examined the man to determine if he had the mental capacity to make the decision to refuse food, fluids and treatment. The psychiatrist concluded that the man was competent to refuse food and drink and to enter into an advance directive. However, he was unable to rule out the possibility that he was suffering from a mental illness that might require detention. The doctor recorded his own view that the man was not in fact suffering from a mental illness. However, the two medical professionals came to the agreement that the man should be assessed under the Mental Health Act 1983. The reason given by the consultant psychiatrist to section him was:

> “Impossible to provide proper assessment and treatment with the facilities available at HMP Lincoln.”

44. On 16 January, the man apparently told staff that he had only a matter of days to live. The following day, the man expressed his intention to end his life through the refusal of food and fluids. His solicitor passed the first draft of the advance directive setting out this intention to healthcare staff.

45. The man was due to appear in court on 17 January. Staff in the healthcare centre encouraged him to attend court but he declined because he felt “vague and dizzy”. The Healthcare PO faxed the court to suggest that it was inappropriate to force him to attend court given his physical condition. The PO’s entry in the daily record of nursing care went on to say:

> “… he is now aware that he may be sectioned under the MHA [Mental Health Act] and possibly forced to be given diet. Not at all happy with this arrangement.”

46. The doctor went on to discuss the man’s case with a forensic psychiatrist based at the medium secure unit. The psychiatrist’s advice was to treat him within the terms of his advance directive should he be unable to make decisions for himself and to allow him to continue his food refusal. The doctor explained to the man the physical consequences of his continued food refusal, but agreed that he would not feed him artificially if he became unconscious. The doctor agreed that he would only treat him for pain and physical distress.

47. On 19 January, the man was seen by the mental health in-reach team. He said that he had felt a sense of peace since deciding to end his life. The man raised concerns about being transferred to a mental health

hospital. His key worker wrote a nursing care plan on 19 January 2005, aimed at preventing the decline in his physical condition. At this time, the man had not eaten for nearly a month and had stated that he would soon stop drinking. The care plan encouraged staff to talk to him about his "fears and anxieties", to continue to offer food and drink, and maintain the constant watch. In addition to the nursing intervention discussed in the previous nursing care plan, staff were to liaise with the doctor "as appropriate" and provide access to the chaplaincy if the man requested such support.

48. On the morning of 20 January, his key worker recorded in his Daily Record of Nursing Care that the man was "now officially refusing fluids". She also noted:

> "The man has signed the care plan relating [to] his care in the final stages of his life."

49. It was agreed that the man would be transferred to hospital if he lost consciousness. The Head of Healthcare told my investigation team that she did not think the prison healthcare centre would have adequate facilities to help him through the last moments of organ failure. In the meantime, he was transferred to the high dependency unit within Lincoln's healthcare centre.

50. The high dependency unit was a brighter room, with a fully adjustable bed and in-cell sanitation. Staff felt that the room better served his clinical needs, as his physical condition was deteriorating through the self-starvation. The man was given his last rites by a Roman Catholic minister in the chapel. The service was attended by staff.

51. That evening, following a request by healthcare staff at the prison, two forensic psychiatrists assessed him to establish whether he had the necessary capacity to refuse treatment and whether he should be detained under the Mental Health Act. Before his assessment, the lead psychiatrist liaised with the man's solicitor who had expressed her concern at her client's refusal to eat or drink. The assessment was carried out jointly and concluded that the man should be detained for the assessment and treatment of his depressive condition. The psychiatrists found that his illness was such that it meant he could not "rationally weigh information in the balance regarding his healthcare and wish to die". They felt that the man did not have sufficient capacity to refuse treatment, they strongly advised staff against following his wishes as laid out in the advance directive dated 14 January 2005.

52. The Healthcare PO made the following entry in the man's Daily Record of Nursing Care at 7:15pm on 20 January:

> "The man has been seen by two forensic psychiatrists and they have doubted his capacity to meet <u>all</u> the criteria due to his depression. He will, once a bed has been found, be transferred under s48 of MHA 83

[Mental Health Act 1983]. IF HE BECOMES UNCONCIOUS (although he has now agreed to take fluids only) THEN HE IS TO BE TRANSFERRED TO HOSPITAL IMMEDIATELY AS PER ANY EMERGENCY. The man is extremely upset at being sectioned, wants to be with his daughter."

53. The doctor met with the man and explained the outcome of the assessment and the decision to section him. He understood that he would be treated if he continued to refuse food or fluid and would not be left to die, so he agreed to start eating again. The doctor remembered him eating four meals in a short space of time. The doctor reflected that it was not good for a patient to eat so much so quickly after a prolonged period of starvation, but on balance it was to be expected from someone who had denied himself food for so long.

54. An observation made in his daily record of nursing care on 22 January noted that he recognised he could be aggressive but that he did not mean to be. The officer explained to him that his aggressiveness might be related to his urea level and caffeine withdrawal. Following this discussion, he decided to drink two cups of tea a day. That day the man started to eat and drink again.

55. On 22 January, he had a visit from his two sisters and his brother-in-law at around 2.00pm. It was reported to staff that he became angry during the visit and said "Right you've told me, now get out!"

56. That afternoon, his key worker made an entry in the Daily Record of Nursing Care. The man had told an Operational Support Grade (OSG) that he had been abused as a child:

"e.g. being made to drink his own urine and forage for food in bins."

57. The following day, his key worker explained to the man "what can be done under the Mental Health Act". She explained how long people can be detained for and "the right to enforce medication". She advised him to pay more attention because a lack of concentration "can appear to be indicative of a depressive condition". She recorded this conversation in the Daily Record of Nursing Care. During interview, she told my investigators that she felt the man was not clear about the sectioning process because staff were fearful that he would become angry once he had understood its implications. She said that the man was only angry because he felt he had been misled about the sectioning process until she had explained it to him.

58. The man was transferred to the medium secure mental health unit on Monday 24 January 2005. No care plan was in place at the time. The care that the man received at the medium secure unit falls outside of the remit of my terms of reference. Two Care Programme Approach (CPA) meetings were held whilst the man was at the Unit. Prison and PCT representatives attended those meetings to co-ordinate the care that the man received between the medium secure unit and the prison.

59. The first CPA meeting was held on 18 March 2005. It was attended by the Governor and the prison doctor, representing the prison. At the meeting, the doctor told the review team:

> "I said very clearly that he was not coming back to HMP Lincoln without a certificate of capacity."

60. A further CPA review took place on 22 July 2005, attended by the multi-disciplinary team from the medium secure unit, social services, medical advisors, as well as the Governor and the doctor. A clinical psychology report, nursing report, nursing risk profile and medical report were compiled in readiness for the review.

61. At the meeting it was noted that it had been difficult for staff at the medium secure unit to assess him, as he refused to engage with their efforts. The man was assessed as having a pre-morbid personality disorder, with borderline and dissocial personality disorders. Nonetheless, it was decided that he did not fulfil criteria set out by the Mental Health Act for mental impairment, although he did suffer from a psychopathic disorder. Legally, remand prisoners can only be transferred for treatment if they are suffering from a diagnosable mental illness as defined by the Mental Health Act or severe mental impairment. The man did not fall into either category and it was recommended to the Home Office that he be transferred back to prison. During this meeting, the clinical team discussed with prison staff the risks that the man posed to himself. The prison staff said they felt that they would be able to provide the necessary supervision and management. Finally, those present at the meeting concluded that he had capacity to refuse food and treatment and understood the effects of such a refusal.

The man's return to Lincoln prison

62. The doctor wrote to the Mental Health Unit at the Home Office on 22 July 2005 to inform them of the outcome of the CPA Review. No care plan was drawn up to determine how the man was to be treated when he returned to Lincoln. Between that meeting on 22 July and the man's discharge on 27 July, staff at the medium secure unit reported that he had been acting more threateningly towards them and, on one occasion, had struck a member of staff although no serious injuries were sustained. This information was not passed on to staff at Lincoln, either in a verbal or written handover at the time of discharge.

63. A warrant for the man's transfer back to prison was issued on 26 July. He was transferred back to HMP Lincoln on 27 July 2005. His Continuous Clinical Record was started again on 27 July. The first entry, made by his key worker, noted:

> "On arrival the man expressed his intention to kill himself by starvation and clearly stated that there is nothing we can do to stop him."

64. As part of the admission process for the Healthcare Centre, in line with West Lincolnshire Primary Care Trust policy, the key worker carried out a risk assessment. She concluded that, although he had no current mental health problems, he was a very high risk to himself and a moderate risk to others.

65. A number of nursing care plans were completed on 27 July looking at measures to care for his food refusal and his self-harming behaviour, as well as providing him with enough support to promote his independence. At 3.00pm that day, the Healthcare PO carried out an assessment of the man's intention to self-harm, and the linked decision to place him in the healthcare centre, despite recording that he asked to go on ordinary location. The second part of the assessment was completed by the doctor a couple of hours later. The doctor found him to be more frail than when he left Lincoln in January and agreed with the PO that the man should be located in the healthcare centre. The PO noted:

> "He remains at high risk of completed suicide. Level III obs (constant watch) is the only justifiable course of action."

66. The man was placed on constant supervision in the gated cell in the healthcare centre. It was the same cell that he had been in prior to his transfer to the secure unit. Overnight, he discussed with staff his intention to sign an advance directive. A note was made in the continuous clinical record that the Governor had been informed of his food refusal.

67. The Governor emailed the Home Office Legal Advisers Branch on 28 July 2005, requesting advice about what action the prison should take to ensure they discharged their duty of care to the man. In her email she referred to a case heard the previous week where a prisoner was found by the High Court not to have capacity to refuse food and was administered food intravenously despite his stated desire to die through food refusal. The doctor noted that the man needed to be seen again by the two forensic psychiatrists so they could reassess his capacity to continue to refuse food and drink and to write an advance directive. The PCT was notified.

68. On 29 July, the man's legal representatives faxed a letter for the attention of the Governor, covering a handwritten advance directive signed by the man and dated 28 July 2005. The same day, the Governor received a response from the Home Office Legal Advisers Branch to clarify what a prison's obligations are to a prisoner refusing food. She was advised that if two psychiatrists assess the prisoner as having the capacity to refuse food, if he is given the opportunity to revoke the advance directive at any time, and his mental capacity is kept under constant review, the prison has discharged its obligations.

69. The Healthcare PO described this time as particularly difficult for the man. It marked a year since his daughter's death and a time of great uncertainty as to his own fate. The PO told my investigators that he did not feel that there was any way to enhance the level of care that the man was receiving because staff were so attentive to his needs anyway, but he did remind staff to be sensitive to him over these few days. The actual anniversary of his daughter's death happened to fall over a weekend and the Healthcare PO was not scheduled to work. He made it clear to staff they were to contact him if the man was finding it hard to cope. The PCT gave healthcare staff a forensic psychiatrist's on-call contact details in case the man needed extra psychiatric support that weekend.

70. Staff suggested to the man that he ate and drank until his assessment by the two forensic psychiatrists, which had been arranged for 2 August, in order to appear mentally well during their assessment. The man agreed to drink until he was assessed, but made it clear that he would refuse food and fluid after 2 August. This decision was recorded in a nursing care plan, written by his key worker and added to by the Healthcare PO on 1 August 2005.

71. Following a clinical assessment on 2 August, the forensic psychiatrists disagreed about whether the man had capacity to enter into an advance directive. One psychiatrist felt that the man did have capacity to refuse food and drink and to enter into an advance directive. The other psychiatrist concluded that the man did not have the capacity to make treatment decisions. This was based on the fact that there was evidence to suggest that his ability to weigh things in the balance was impaired by factors relating to guilt and a sense of bereavement. During the assessment the man described how his daughter would have "double the justice" if he were to die in pain and said, "I deserve to die in pain, her mother will get justice." During interview, the psychiatrist described how the psychiatrist arrived at his conclusion:

> "It was my view that the man did not have the ability to weigh things in the balance. I took the view that factors related to guilt, bereavement, as evidenced by his attitudes towards death and the afterlife, a wish to punish himself by dying in as painful a way as he possibly could, could still be – could be argued to still be signs of an underlying residual depression. And then following discussions between, lengthy discussions really between ourselves, prison staff, the legal representatives, it was judged that this matter should be referred to the consideration to the High Court of Justice Family Division in London."

72. On 2 August**,** a multi-disciplinary meeting was held to discuss the man's care, which the PCT had scheduled to coincide with the clinical assessment. The purpose of the meeting was to ensure there was clear understanding between the prison and the PCT about the man's care. During the meeting, West Lincolnshire Primary Care Trust made known to Lincoln prison their intention to seek either a declaration of capacity

from the High Court or interim directions to allow time for a further independent psychiatric assessment of the man's mental capacity. Email correspondence on 3 August confirmed that the Secretary of State for the Home Department was to be a joint applicant in any such legal proceedings.

73. A consultant physician at the local hospital examined the man at the prison on 3 August. The prison doctor had requested that he come to the prison because the man was too ill to attend an appointment at the hospital. The physician found that the man was frail but otherwise well and alert. He anticipated that if the man refused fluid he would die within five to ten days. He went on to say that the man would die within six to seven weeks if he were to refuse food and nutritious intake but continued to take fluids.

74. An ACCT case review took place on 4 August. The man refused to attend the review and the meeting went ahead in his absence, a pattern which would recur throughout his time in healthcare. He was eating and drinking small amounts at that time and those who attended the case review described him as being in "reasonable spirits".

75. West Lincolnshire PCT and the Home Office jointly instructed a medical practitioner to assess the man's mental capacity to refuse food, drink and medical treatment and to enter into an advance directive to this effect on 8 August. The medical practitioner interviewed the man and wrote a report for the court. She was able to interview him in private but with a prisoner officer outside the gated cell. The doctor concluded that there was no evidence of mental illness or impairment during the interview. She advised the court of her opinion that the man did have the capacity to refuse food and treatment.

76. On Friday 12 August 2005, the High Court handed down a judgment that the man had capacity to refuse food and medical intervention and that his advance directive, dated 10 August 2005, was a valid document. Staff were informed of the judgment and offered the opportunity to approach the Healthcare Manager if they had any concerns.

77. The record of the man's weekly case review the following day (13 August) opens, "The man stated that he now is at peace." The PO who co-ordinated the case review, noted that he encouraged the man to reconsider carrying out his advance directive and reminded him that he could change his mind at any time. The man stated his desire to carry out his advance directive in full. He was offered the opportunity to see a Roman Catholic priest, but declined. The man was reportedly "in good spirits" at the review.

78. The Liverpool Care Pathway Plan is a clinical framework that provides a palliative care pathway for dying patients. It is opened only when a patient is dying and co-ordinates the different aspects of care, including comfort measures, anticipatory prescribing of medicines and

discontinuation of inappropriate interventions. Psychological and spiritual care and family support are also included in the framework. The prison doctor opened the Care Pathway to manage the man's care on 12 August 2005.

79. On 15 August, prison managers, the NHS trust and PCT met to agree the criteria that were to be reached before the man would be admitted to hospital. He was once more moved back to the high dependency unit after discussion with a governor. The governor on duty reminded the man of the option to take up treatment at any time. The man confirmed that he had not eaten for three days and his condition was notably worse. The prison doctor met with the man and again explained the physical impact that refusing food and fluid was having on his body.

80. The man was very anxious about his brother and his sister-in-law's visiting on 18 August. He repeatedly told staff that he was nervous that they would try to persuade him not to go through with the advance directive. That said, the family visit went ahead. Shortly after, the man told staff that he did not want to see his family any longer. The man felt that it was too distressing for them to see him.

81. Between 12 and 17 August, the man refused both food and fluids, although he did take some medication to assist his sleep. Staff observed that he was reflective and emotional during this time, talking about his childhood, his time as a miner and his family. At about 5:45am on 17 August, the man woke up after a good night's sleep complaining that he was suffering from dryness. He accepted a cup of tea. Later that morning at around 8:55am, the PO spoke to the man who said that he wished to revoke his advance directive. The Healthcare PO observed that the man felt as if he had let his daughter down because he promised he would be with her.

82. The man saw his solicitor over the lunch period and, on his return, told staff that he did now not want to formally revoke his advance directive. He had been informed by his solicitor that the advance directive did not preclude him from taking food and fluid if he chose to do so, but if he wanted to resume his food refusal the advance directive would still stand and he could, once again, still refuse clinical interventions. Clinical records were immediately amended to instruct staff that the man should be treated like any other prisoner. The man started to eat and drink again.

83. A weekly case review took place on 18 August. The record of this meeting mentions the man's "revival", referring to his decision to eat and drink again and that he looked much better following a haircut and a shave. However, he was to remain on constant supervision until after his court appearance the following month.

84. On 23 August, the man finally agreed to speak about the circumstances leading to the charge against him. The prison doctor arranged for a

Registrar of one of the Consultant Forensic Psychiatrists, to visit the man the following day. By then, the man had spoken with his solicitor and told the visiting doctor that he had been advised not to talk about the charge he faced.

85. On 24 August 2005, the solicitor produced another advance directive that was dated 22 August. The advance directive refused consent for resuscitation including Cardio Pulmonary Resuscitation (CPR), intravenous (IV) fluids and drugs. The prison doctor made it clear to the man that the advance directive only applied where his condition had deteriorated through food and fluid refusal. The man would be resuscitated following any other attempt at suicide or self-harm.

86. The man attended another weekly case review meeting on 25 August, a record of which was taken by a staff nurse , as follows:

> "Spoke quite openly about feelings, states categorically that he will not hunger strike again, and that were he going to use other methods he would have done so by now. Appeared quite convincing in this … keen to lose Level III status. All members of staff felt that this would be appropriate, although accept that this decision currently rests with other parties."

87. On 7 September 2005, the staff nurse wrote a nursing care plan, apparently triggered by that fact that the man was charged with the murder of his own daughter. The aim of the plan was to keep the man safe and monitor his mental health.

88. The next day, a case review made reference to the man's case being scheduled for Crown Court the following week. Despite this, the man was recorded as being in good humour. In fact, the case review recorded that the only reason that the man's observation level could not be reduced to "reflect his state of mind" is due to "senior management intervention".

89. On 13 September, the man appeared at the Crown Court via video link. It was noted in the record of his case review, dated 15 September, that he had been upset by his appearance on video link. The man retreated under his bedclothes and wanted to "go to sleep permanently". Mention was made that his case might be brought to the Crown Court on 17 October and that the man felt "that his family want to kill him". Staff reassured him that they would support him through the trial.

90. During a conversation with the prison doctor, the man said that he just wanted to be in the dark and on his own. He told the doctor that he would not end his life because so many staff had become so close to him. He repeated that he thought he would be reunited with his daughter when he died. The doctor's entry in the clinical record concluded that he had to be kept under constant watch until his court case.

91. Staff were concerned over the man's "buoyant" and "compliant" behaviour in the build up to his trial. Despite being keen to attend the case review where this matter was being discussed, the man walked out when he was asked about whether he was experiencing suicidal intent. A cell search carried out that day saw the marked change in mood continue. He was angry about the cell and personal search conducted by staff.

92. The man asked to make a call to his solicitor from the telephone in the staff office on 30 September. When his key worker advised him that this was not prison policy, and that he had to use the payphone and his PIN, The man claimed that the PO always allowed him to use the office phone for privacy. A note was made on his self-harm register that he had been told that only a governor grade could authorise use of the office phone.

93. Later that same day (30 September), the key worker made another entry in his continuous medical record. The man claimed to be stashing drugs, "in such a way the drug dog won't be able to find them" and hiding laces in order "to plait them to make a rope". He also claimed that staff in the healthcare centre were giving him privileges he was not entitled to. The man's cell was searched with dogs but nothing was recovered except a slither of concrete that the man had removed from another part of the centre and left on the window sill to be discovered by staff. The man complained that his slippers were damaged during this search.

94. A SO sent a message to all staff on the constant supervision on 2 October, reminding them not to watch television while they were observing him. The man's habit of turning the television around for staff while he slept was recognised as potential conditioning of staff not to pay close attention to what he was doing.

95. The man's room was searched again on 4 October, as he claimed that he was hiding drugs in his room. Nothing was found, but he remained on constant watch. He barely communicated with staff and spent much of the time under his blanket.

96. The man's agitation at his cell being searched was echoed in the record of a Case Review that took place on 6 October 2005 with the Healthcare SO, a member representing probation, and a representative from Lincoln's chaplaincy. The prison doctor contributed to the review. The man had told the doctor that he was having vivid dreams and intense visions. Although the man was not eating or drinking, it was not understood to be a formal food refusal at that stage. The doctor made a note in the man's clinical records that the man was showing some depressive symptoms:

> "Declined to attend review today. Has been quite agitated this week because of what he regards as excessive cell searches – a result of SIRs [Security Incident Reports] and an unexpected court appearance at which extracts from his daughter's diary were read out. He has

declined to eat again and refused his medication. He has also given all his personal bits and pieces to other prisoners, he states he doesn't want the Prison Service to give him anything.
"Constant watch continues."

97. The man was particularly distressed by a legal visit on the morning on 7 October. His legal team asked him to take his daughter's diary, which agitated him. Staff advised him that he was not obliged to take the diary. He continued to refuse to eat or drink and refused food and medication over the next few days.

Authenticity of the advance directive dated 10 October 2005

98. A final version of the man's advance directive was signed and dated by him and witnessed by his solicitor on 10 October 2005. It confirmed that the man refused all treatment, except the use of glycerine sponges for his mouth, pain relieving medication and measures required to avoid getting bed sores. The prison doctor made a note in his clinical record to the effect that, in his opinion, the man's capacity to refuse treatment had not changed since the High Court decision a few months before. The prison doctor asked one of the forensic psychiatrists to assess the man again as quickly as possible to establish whether or not the advance directive was valid.

99. Two days later, the psychiatrist attended the prison and assessed the man. The High Court had said that there would have to be a substantial deterioration in his mental state for the decision about his capacity to change. The psychiatrist found that the man's frame of mind had not deteriorated since the court judgment, in fact he seemed better within himself. The man said that he would drink fluids but not eat food. He thought that this would be less painful, although he realised that it would mean it would take longer for him to die. The psychiatrist advised him to start taking his anti-depressants again in case his mental state deteriorated. The psychiatrist concluded that there was no evidence to overturn the previous findings of the High Court, namely that the man had capacity to make an advance directive.

100. The Treasury Solicitors wrote to the governing Governor with a copy of the recently redrafted advance directive that same day. This instructed that the man did not want to be resuscitated in any event. This was an amendment from the previous version of the advance directive, in which he had said that he did not want to be resuscitated "in the event of a heart attack, stroke or any other ailment which results in a loss of competency and/or capacity".

101. A daily care checklist was started on 13 October, tailored to the man's personal needs. The checklist comprised 15 actions, for example, staff should offer food or supplements at mealtimes or spiritual support. A staff member entered their initials in a chart each time each of these actions was completed. The man was in a noticeably improved mood.

The prison doctor explained the consequences of his refusal to take food and the effect that it would have on his body.

102. On the morning of 13 October, the Healthcare SO and a member from Probation carried out a case review. The man refused to attend. A record of the case review taken by the Healthcare SO read as follows:

> "Has just signed a new 'Advance directive'. This time he will drink but not eat! However requesting 'build-up' drinks. Court case has been put back until Mar '06. No doubt this gamesmanship will continue until then."

103. An officer completed the man's weekly healthcare review on 19 October. She noted that he was suffering from mood swings and that, although he had previously refused medication as well as food, he had started taking his medication again. Later that day, he was seen by a psychiatrist for the prosecution team in the healthcare centre.

104. A further case review took place on 20 October with a senior healthcare officer, a probation worker and a representative of the chaplaincy. The man refused to attend because it was "pointless". It was recorded that he was refusing meals but drinking and taking medication.

105. West Lincolnshire PCT had maintained regular contact with the local hospital since the High Court decision on 15 August. On 25 October, the prison doctor formally wrote to the Medical Director at the hospital to alert him to the fact that the man had started to refuse food again. Although the doctor did not feel it was necessary to transfer him at that time, he wanted arrangements in place so that as soon as the man's condition deteriorated he could be transferred without complication. The doctor noted that the man had now lost about 10 kilograms in weight. This meant he was now 56 kilograms.

106. A nursing care plan dated 27 October was drawn up in response to the advance directive that the man signed on 10 October, with the aim of providing support and maintaining a safe and comfortable environment. As usual, the man refused to attend his weekly case review, but he agreed to see the Reverend from the chaplaincy who then passed on his thoughts to the case review meeting. The man had apparently pored over his daughter's diary in the early hours of the morning and become agitated.

107. During his meeting with the chaplain, the man reported having difficulty swallowing and the doctor undertook a medical assessment of him later that day. The man's Care Pathway communication log was recommenced on 27 October following the previous "few days" of food refusal and a noticeable deterioration in his physical condition. The man had been abusive to staff the previous night and continued to be aggressive towards the doctor and the PO. The man was described as very shaky and experiencing difficulties swallowing. The doctor noted

that the man was going through the “expected loss of mental clarity, calling into question his capacity for decision making. I consider his advance directive to be active now.” The doctor alerted the PCT and the Duty Governor of the change in the man’s condition.

108. The man was located in a constant watch cell with a clear door and lockable gate. His toilet and bed would have been clearly visible to a prisoner in the cell directly opposite. Members of staff were located outside the man’s cell 24 hours a day, in shifts, to carry out the constant observations. On 28 October, the Healthcare PO discussed a move to the high dependency unit with the man but he refused to go. The man also declined a mattress used to alleviate pressure sores, although he did accept some medication. The man refused to have his medical observations taken (blood pressure, weight and urinalysis). He also refused food and food supplements but did drink coffee, despite advice that coffee would dehydrate him.

109. A risk assessment was faxed from West Lincolnshire PCT to the Healthcare PO on 31 October. Clear reference is made to the PO contributing to the risk assessment and action plan. The assessment identified the following risks:

- the patient losing capacity to revoke his advance directive despite indicating that he wanted to;
- public/professional scrutiny;
- staff stress;
- efficiency of the healthcare centre;
- hospital might refuse admission when it is necessary;
- caring for distressed or unconscious patient in a healthcare setting.

110. The assessment rated the severity of the risks. It determined that the risk of public scrutiny and referral to a professional body was the greatest, shortly followed by the risk of staff stress. The risk assessment identified several actions to manage each risk, attributing a lead for each of the actions and recorded the action status. All of the relevant actions were in progress or completed, including advising staff that they could elect not to care for the patient in order to reduce stress.

111. On 31 October, an officer recorded that the man had become aggressive towards staff and that he was “fed up of being in a glass case”. Unusually, the man consented to giving a urine sample on the same day. The sample showed that he now had ketones in his urine. Healthcare Officers and the prison doctor held a case review which the man again refused to attend. They discussed his condition and noted that the food refusal was beginning to “take its toll in terms of physical appearance and mental clarity”. However, just the next day, the doctor noticed that the man was still “physically robust” when walking.

112. On 4 November, the man was recorded as swearing at staff because they were moving him from cell to cell. The member of staff who made

this entry suggested that this might have been a dream. A later entry, following a chat with him, suggested that this was either a dream or a hypnagogic episode brought on by toxicity from food refusal and that he once again appeared rational.

113. During the next few days, the man was asked on a regular basis whether he had changed his mind, as well as being reminded of the effects of not eating. It was noted on 10 November that he appeared very weak and that he was unable to stay awake when sitting in a chair.

114. At his ACCT case review meeting on 11 November, it was agreed that the man was getting as much care and attention that he would allow, but despite this was "looking quite haggard". He had apparently had a few outbursts towards staff, especially unfamiliar staff. He was also refusing all offers of help and support.

115. The situation was unchanged by the next weekly case review held on 17 November. The man was still refusing food, but drinking small amounts and taking medication.

116. A note was made in the man's nursing care plan on 18 November that he wished to work but that the work had to be minimal due to his physical condition. A brief note was made of his weekly case review that took place on 24 November, reporting that his condition remained the same. His weight was noted to have dropped to 50 kilograms.

117. The man was noted to be pleasant and continuing to refuse food but drinking lots of orange squash and coffee. The man was refusing pain relief at this time. During conversation with an officer on 29 November, The man said that he had no regrets, "… he knows his time is coming and he has sent out all letters etc to his family."

118. Following discussion between the prison doctor and the Governor, an instruction to healthcare staff was issued the same day. The instruction clarified actions that needed to be taken by staff if there was to be a sudden deterioration in the man's condition or if they were to discover that he had died in his cell. If he was to start eating again, he was to be transferred to the local hospital so that they could manage his care.

119. A Governor's Order was issued to Prison Service staff on 29 November 2005 notifying them of a "small risk of [the man's] sudden death". The Order suggested that if no signs of life have been detected for one hour, efforts should be made to check his vital signs. The Order clearly said that such efforts should not be intrusive or cause him to wake should he be trying to rest. The clinical record indicates that the doctor considered a transfer to hospital would be required in the near future for an enhanced level of nursing care.

120. One of the forensic psychiatrists came to review the man on 30 November. The man refused to be interviewed, so the doctor simply

observed him from outside his cell. The prison doctor said that the man's mental health had not suffered a serious deterioration and that there were no grounds to admit him to a mental health unit. He displayed no psychotic symptoms. The forensic psychiatrist did not make any recommendations about the man's future care.

121. The Governor's Order was discussed at the man's multi-disciplinary weekly case review on 1 December, and it was recorded that his physical condition was noticeably declining.

122. The man's solicitor met with him in a side room of the healthcare wing on 2 December 2005. An officer recorded that he "appeared to be ok" after this visit. The man was apparently shocked by a news broadcast on 5 December when his name was mentioned in connection with being found in a wooded area.

123. It was recorded in his weekly case review for 8 December that he was being visited daily by the doctor and the Governor. Both his mental and physical condition were noted as being under constant review. The man's calorific intake had increased because he chose to drink orange juice. He was still reminded daily about the physical impact that refusing food was having on his body. On 9 December, an oficer observed that the man "has become very talkative and funny'".

124. The Treasury Solicitors wrote a letter of response to a telephone conversation with governor on duty on 13 December. The letter contained the advice that as there was no formal policy about leaving food in the prisoner's cell when they are refusing food, food should not be left in his cell. The letter referred to the possibility that such a practice might amount to a breach of human rights as it could be interpreted as inhuman and degrading treatment. No opinion was given as to whether leaving food in a cell does constitute such a breach, but the possibility was recognised.

125. The brief note of the weekly case review meeting made by a duty nurse on 15 December said that the man "continues on course of action to refuse food to end his life". The doctor and the Healthcare PO visited him to ask him who he would like to visit him in hospital.

126. The man chatted to an officer on 16 December about the Roman Catholic Church. The man particularly remarked on how helpful the chaplaincy had been to him during his time at Lincoln. The Roman Catholic Chaplain told my investigators that it is part of the chaplaincy regime to visit healthcare every day. She said she spent quite a lot of time with the man and that he was "not difficult or reflective in behaviour".

127. The man "declined as usual" to attend his weekly case review on 29 December. It was recorded that he continued to refuse all meals but that mentally he was "very alert". It was agreed that the reviews should now

take place fortnightly unless his situation changed. The man continued to drink orange juice.

Events during 2006 leading to the man's death

128. On New Year's Day 2006, the man's principal concern was his dwindling stock of orange juice. Staff observations showed that he could talk of little else. He mentioned his worry to a governor who carried out the Duty Governor visit on that day and promptly arranged for 96 cartons of orange juice to be delivered to him. He was apparently "Elated!" at the delivery of his orange juice.

129. Somewhat at odds with his prolonged food refusal, the man was recorded by an officer as talking constantly about food on 3 January. Over the next few weeks, he was often observed watching the television programme 'Ready, Steady, Cook!' and chatting to staff about their evening meals or his favourite subject, orange juice. One member of staff even recommended that he write a book about orange juice.

130. When the man was advised that his solicitor had come to visit on 6 January 2006, he refused to see her because he would have to attend the legal visits area in a wheelchair. Staff later helped him to write a letter to his solicitor, apologising for refusing to see her and explaining the reasons for not wanting to go. That afternoon, he rang his solicitor to explain why he had refused to see her. According to observations in his constant supervision records, the man was concerned that prison staff might get into trouble because he refused to see his solicitor and he wanted to ensure that staff would not be blamed.

131. An SO remarked that on 7 January he noticed a real change in the man's attitude towards staff as he was "very concerned about staff welfare … there really does seem to be a change in his character since I last had dealings with him."

132. His key worker and a member of the prison's probation team met for his case review on 12 January and a brief record was made of the meeting which recorded that "no significant change" had occurred. The man continued to drink only orange juice.

133. On one of her several visits to see the man, the Governor made a note on 13 January that he was "quite bright" and "mentally alert". The man described his routine to her and told her how much he was enjoying drinking orange juice. He said that he was still waiting for his glasses, which should have been sent to Lincoln when he was transferred back to the prison from the medium secure unit in July 2005, six months previously.

134. After being quite depressed about an apparent shortage of orange juice, the man told an officer during the evening of 14 January that he did not think he had any longer than a month to live. The following day, he expressed his concern to an officer about the levels of hygiene of a prisoner a couple of cells away from him. The smell was affecting his

comfort and he was also worried about using the bath after that prisoner had used it.

135. Later that day, he also complained about the prisoner in the cell opposite his gated cell. The observation panel for the opposite cell directly overlooked the one that the man was in. He was concerned that the prisoner opposite always stared at him, even when he was using the toilet. Within an hour or two, the prisoner opposite him was relocated to another cell and the man was reported as being relieved and grateful.

136. An officer observed him as subdued and "very down" and made the following entry on 16 January in his constant watch record:

> "talking about his family wanting him to hurry up the process of his death. He said they aren't sending him any money and it has hurt him as he knew he was [dying], but he wanted to die with no pain."

137. The man's intake of orange juice steadily increased, and on 18 January the Healthcare PO arranged with kitchen staff for him to have three litres a day. The PO also discussed the matter with the Governor's secretary who agreed to purchase an additional one litre a day of tropical juice for him.

138. The same day, the man was given a new job to enable him to earn money and buy some more orange juice. The man was "a lot happier" because he had been given something to do. He was asked to make up new prisoner medical records, so that the blank files would be ready to be used by healthcare staff. He was able to carry out this work in his cell.

139. The man refused to attend the weekly case review on 26 January, as had become the norm. He was recorded as drinking three litres of orange juice a day, but not eating any food. The chaplain helped him to write to his sister on 27 January. The last daily care checklist on file took place on 29 January. On the same day, the man reached for his orange juice and slipped off his chair.

140. An officer recorded that the man's general condition had deteriorated between 30 January and 3 February. The officer noted that he continued to work despite the apparent deterioration in his condition. The officer also recorded that the chaplain was helping him to deal with his sadness because some members of his family had appeared to stop writing to him.

141. The man received his glasses on 31 January 2006. The occasion was marred because his canteen (order from the prison shop) had been miscalculated and, as a result, he was running low on orange juice.

142. The officer who was carrying out the constant watch on 1 February, noted:

"[t]alked at length about how much longer he has to live. He thinks about March perhaps April. Spoke about which type of coffin he will be buried in (cardboard) lot cheaper. Doesn't seem bothered about dying."

143. The contemplative mood continued into the afternoon shift when an officer made several poignant entries:

"Says he cannot remember when he stopped eating. Says he would prefer to go to sleep and not wake up that's why he does not want visits. Says he is happy that way … says he finds it easier now to open up and talk to staff. Talking about when he goes to the hospital that his family will be able to visit and that it would give them some comfort."

144. Later that afternoon (1 February), the man received Holy Communion "with great reverence" according to the entry made in his Daily Supervision and Support record.

145. On 4 February, the man was given his last box of medical records to make up, a task which he spent all day completing. His deteriorating concentration meant that the day ended in frustration and healthcare centre staff decided to withdraw the work. By this time, he could not dress himself without assistance. It was recorded in his Daily Supervision and Support record on 5 February that he was seeing double.

146. When the prison doctor reviewed the man on 6 February, he found such a significant deterioration in his condition that he wrote to his solicitors to inform them that he would no longer be fit to go to the visiting area. The doctor discussed the matter with the Governor and they were in agreement that any required legal visits should take place in the healthcare centre. In a letter to the Governor to confirm their discussion, the prison doctor suggested that, in his opinion, the man would soon be transferred to hospital to be nursed through the last stages of his life. The doctor tried to persuade the man to move to the high dependency unit, but to no avail. The officer who was carrying out constant supervision, was moved to make the following entry in the man's Daily Supervision and Support record:

"this is VERY UNDIGNIFIED FOR HIM HAVING SOMEONE WATCH WHILST HE STRUGGLES TO GET ON/OFF TOILET."

147. During interview, the officer said that he felt "uneasy" watching the man struggle with a basic function like going to the toilet. He said that the man did not complain to him about being observed so closely, preferring to chat about the television, cigarettes and juice.

148. When the Governor went to visit the man that day, they discussed his pressure sores and his swollen feet. The Governor spoke to the man

about moving into the more spacious and modern high dependency unit further down the corridor. According to the Governor's entry in his ACCT record, the man said that he would prefer to stay in his current cell because he did not like the bed in the high dependency unit. My investigators spoke to some staff who speculated that the man liked to be in a higher position than the member of staff observing him as a matter of control. The set up of the high dependency unit required that staff carrying out the constant watch would have to do so from a higher viewpoint than his bed, and some suggested this was at the root of his reluctance to move cells. Others thought that the man felt the room was too cold. Other staff members thought that he felt 'at home' in the cell he had spent so many months in.

149. Entries made in his observation record on 9 February suggest that the man had mixed feelings about being transferred to hospital. He expressed doubts about his pending transfer. Following his rounds, a governor wrote the following entry in the man's ACCT record:

> "Spoken to him at length about being admitted to hospital. He has a few concerns about visitors and his smoking in hospital. I have reassured him that procedures will be put in place for him to receive visits by his named visitors."

150. The man's reflective mood continued into the evening:

> "Said he is ready to die, he can't take the situation he is in anymore, said he is hoping to die soon and everything has been arranged but not til he has seen his family".

The man would repeat countless times over his last few weeks that he would like to see his family, his brother, sisters and nieces and nephews, before he died.

151. The deterioration in his medical condition was noted in his weekly case review on 10 February. In his record, the Healthcare SO mentioned that the healthcare centre was going to be closed for refurbishment on 17 February and staff were beginning to plan for his transfer to hospital before that date. According to his ACCT record, the man also had a legal visit on 10 February. On the same day, the man was chatting to staff about how he might go "any time now but hopes to get his visits from brothers and sisters first at the hospital]." He was chatting about what facilities he wanted and the arrangements for him to be able to smoke.

152. The man received Holy Communion on 11 February. Following his Holy Communion, he was in a chatty but gloomy mood. An officer recorded the following:

"Another long chat. The man telling me to enjoy my life as time goes so quick. He became a bit melancholy. Appeared to be thinking about his life."

153. Apparently adjusted to the fact that he would be transferring to hospital, an entry in the ACCT dated 12 February noted that the man "says he knows he won't be there for long may be two weeks at the most". Later that day the man commented that he felt "peaceful that his family will visit". However, he did suggest that some of his letters had gone missing.

154. An officer reported that, at 8:53pm on 13 February, the man was becoming "agitated" because of the "antics" of the prisoner in the cell opposite. By 9.10pm, the prisoner had been moved to another cell in the healthcare centre and the man was observed as being "more settled".

155. A number of nursing care plans were completed in respect of his care on 13 February. The identified needs were to prevent pressure sores, to maintain his dignity while offering him diet and maintaining his safety, to monitor his mental state and keep him company, to minimise pain, and to maintain his personal hygiene. Nursing interventions were identified to manage each of these needs.

156. In the early hours of 14 February, the man was using the toilet when he told an officer that he was "embarrassed" because he had wet himself in bed and he had not realised until he had woken up. The officer informed the nurse but he was unwilling to have the sheets changed until later in the day. A staff briefing took place during the afternoon of the 14 February between an officer and the key worker. The man seemed to be upset that he was being visited by a doctor and his solicitor the following day and would be asked the "same old" questions. He accepted that it was being done for his own good.

157. The following morning, the Governor visited the man and he told her about being visited later in the morning by the prosecution's psychiatrist. His appointment with the psychiatrist lasted just 25 minutes.

158. In the early hours of 16 February, the man used the toilet many times. According to the officer on duty, the man was "waffling" and "making no sense" for around three-quarters of an hour. The man was asked whether he would be willing to transfer to hospital. He said he did not want to transfer because he would not be able to smoke at the hospital. The hospital was contacted and told that the man's admission was to be delayed.

159. At 9.00am that day, after a visit by a Muslim minister, the officer made an unusual entry stating that the man thought he was going back onto a wing. By this time, the man's physical state had deteriorated so much that he could not possibly have been transferred to ordinary location.

This comment would appear to be due to his declining mental state at this time.

160. Around midday, an entry in his Daily Supervision and Support Record stated:

> "Started talking about being found in the forest, and sleeping in the ditch. Also about, D-Day coming, states if he wakes up he does, and if he doesn't no problem."

161. Despite experiencing difficulty passing urine and having a heavy fall in the early hours, on 17 February 2006 The man reported feeling "in good health". He estimated that he had "about 6 weeks left". He acknowledged that he was likely to lose his power of speech soon, but reported "being at peace with God". He told the officer who was carrying out the constant watch that "all is in order when [the] time comes".

162. When a Physical Education Officer (PEO) came on shift at midday, the man had moved onto discussing his refusal to transfer to hospital. The PEO entered into the man's ACCT record that it seemed the reason for this refusal was the smoking restrictions. The man discussed with the Deputy Governor who he would be able to receive for visits. The governor reassured him that the prison had a list of his approved visitors.

163. In the course of trying to go to the toilet in the early hours of 18 February, the man again fell heavily to the floor. He said that he was okay and managed to get to the toilet and use it. He smoked a cigarette and went back to the toilet for 40 minutes. An hour and a half after the fall, he was checked by the nurse who reported that he seemed alright.

164. There followed a morning of being his usual talkative self, discussing what he was going to watch on television and balancing the merits of certain types of fruit juices. In the afternoon, he reported that he was "feeling the cold more" and warmed himself up with a coffee and a change of tracksuit bottoms.

165. A governor chatted to him about visits on his rounds later that day. The Deputy Governor suggested that he might be too weak to have visits in the visitors centre and that he might need to talk to medical staff about allowing visits on the healthcare centre. An officer described a conversation that he had with the man:

> "… he knows that he's approaching his final weeks he can feel it in his body. That's why he wants to have his visits."

166. A further nursing care plan was completed on 19 February in response to the man's increasing incontinence. The aim of the plan was to maintain his dignity and to prevent a further deterioration of his pressure areas.

167. On 21 February, most of his afternoon was spent with the chaplaincy. He was also visited by the prison doctor and a governor on their respective rounds. The prison doctor again explained to him that he was dying and suggested that he should be transferred to hospital. Again, the man refused.

168. The man had a visit from his sister and other family members on the afternoon of 22 February. In his ACCT record, the officer described it as "very emotional for them all." The visit lasted one and a half hours and took place in the staff room in the healthcare centre. The man told staff he had had a good visit.

169. The same day, the man fell over twice: once in his room when trying to get to the toilet and once when he attempted to get out of the bath by himself. The Healthcare SO recorded in his multi-disciplinary progress notes that the man appeared increasingly frail, but continued refusing to be moved to the high dependency unit or the local hospital.

170. The chaplain made an hour long pastoral visit on the afternoon of 23 February. She helped him write a letter to his niece. She described him as being "relaxed" but "slower" during the course of writing the letter. The chaplain said the letter reflected the man's words but he was not physically strong enough to write it. The man was recorded as being very tired that day. He finally agreed 'in principle' to transferring to the hospital in two days time.

171. On 24 February, an officer wrote in the man's ACCT record that, "mentally he appeared to be aware of his surroundings and time and place."

172. The officer described him spending eight minutes being deeply focussed on opening a plastic bag in order to empty his ashtray into it. He told the officer that he kept the ends to give to people who needed them. The officer remarked upon the fact that every action was "slow and methodical". Uncharacteristically, the man did not chat with staff much that afternoon. In fact, he spent it in a state that the officer described as "almost catatonic", although the man did respond when spoken to. Again, he was feeling cold and was assisted with putting another jumper on.

173. Towards early evening, the man resumed his usual chat about television schedules and orange juice. He was visited by a governor that afternoon. The man needed a nurse's assistance to go to the toilet and to make coffee. Much later on, a PEO that had taken over the constant watch from another PEO and noted that the man seemed "very confused and disorientated".

174. The man then commenced rolling a cigarette, during which he fell asleep eight times. It took him well over two hours to roll a cigarette. Until this evening, his usual routine would be to go to bed at around 1.00am and

then wake up around 5.00am. The PEO noticed how remarkable it was that the man, while dozing off occasionally, did not stop talking all night. With the assistance of a nurse, the PEO finally got the man into bed at 4.10am.

175. The man then slept all the way through until 8.10am when the duty healthcare nurse checked him. An officer was on the constant supervision shift that morning. The officer noted in the observation record that the man said he was “not too bad”, although he noticed that his “speech was laboured and slurred”.

176. The man went back to sleep for an hour, until the duty nurse entered his cell at around 9.00am with a drink of orange juice. She rolled him a cigarette and sat him on the edge of the bed so that he could enjoy his drinking and smoking.

177. Around three-quarters of an hour later, the man had to be wheeled to the bathroom and lifted into the bath. His bath took half an hour, after which he returned to his room and sat smoking a cigarette. The prison doctor visited him with the chaplain, from whom he received Holy Communion.

178. The man offered to clean up his cell but was discouraged by the officer on duty who was concerned that he was not strong enough to do so and feared that he might fall. He spent the morning looking through a television magazine and dozing. Just after 2.00pm, the ambulance arrived to transfer him to hospital. Two officers accompanied him and they arrived at 2:25pm. The man was immediately admitted to the specialist ward. In the interests of privacy, he was located in a side room. No restraints were used for his transfer to the hospital because of his fragile physical state.

179. The man was asleep throughout his transfer to hospital. Pillows were used to make him comfortable throughout the afternoon in the hospital and he continued to sleep. A nurse visited him at 4:30pm to check if he was comfortable or whether he wanted his position to be adjusted. According to his observation record, he ”very slowly” said no.

180. A governor visited him at 5.15pm and confirmed that his solicitors had been told of the transfer to hospital. After this visit, nursing staff offered him orange juice but he “feebly” shook his head in response. At 6.00pm, nursing staff and HMP Lincoln were informed of a deterioration in the man’s condition. Staff called the nurse at 6.13pm because they thought he had “gone”. After the nurse attended, a priest arrived to perform last rites and the doctor was called. A doctor arrived at the man’s bedside and pronounced him dead at 6.31pm.

181. An escort officer contacted Lincoln to tell them that the man had died and his time of death. The bedwatch staff were told by nursing staff that the Coroner would be informed the following Monday (30 January). The

Duty Governor at the time contacted the man’s brother who had been due to visit him the following week.

ISSUES

Clinical Review

182. All of my deaths in custody investigations are informed by a clinical review. Ordinarily, in accordance with my terms of reference, I commission the clinical review from the PCT responsible for delivering healthcare in the prison in whose custody the prisoner was in at the time they died. However, West Lincolnshire PCT (now part of Lincolnshire PCT) was instrumental in the delivery of care that the man received at Lincoln. With this in mind, I approached the Head of Offender Health at the Department of Health, to see if a more independent arrangement might be reached.

183. After some negotiation, West Lincolnshire appointed two medical practitioners of Bassetlaw PCT to undertake an independent clinical review. The clinical reviewers reviewed the man's medical records and met with my investigator, with West Lincolnshire PCT and with prison healthcare staff to determine the parameters of their investigation. They joined my investigation team for many of the interviews and visited Lincoln's healthcare centre. They produced a clinical review that was sent to Lincolnshire PCT for their consideration in August 2006. After protracted negotiation, my investigator was sent the final agreed version of Bassetlaw's clinical review at the end of November 2006. The clinical reviewers have identified six areas of learning to improve clinical services.

184. The reviewers observed the healthcare facilities at HMP Lincoln. They found that the facilities to provide in-patient care were not of comparable standard to that of the mainstream NHS.

Clear accountability for ensuring working conditions [in Lincoln's healthcare centre] are safe and fit for purpose is required.

185. The clinical reviewers thought that a consensus should have been reached about the man's capacity before he was discharged from the medium secure unit. In their opinion, the High Court decision should have been sought before his discharge and then a care pathway could have been drawn up and begun straight away. In response to the draft report, Lincolnshire PCT wrote that all present at the CPA meeting before the man's transfer back to prison agreed that he had capacity to choose to refuse food, drink and medical treatment. The CPA meeting resulted in a plan and clarification that further psychiatric services could be accessed in the event of any deterioration following transfer back to prison.

When a prisoner is being returned from prison after a time in a mental heath secure unit under the Mental Health Act, a discharge process should be agreed by all relevant parties, to enable a care pathway plan to be drawn up as soon as possible.

186. Staff told the clinical reviewers that locating the man in a gated cell for such a long time did not allow him sufficient dignity. However, they recognised that, when he did express any discomfort about the prisoner located directly opposite his cell, the other prisoner would be promptly moved.

A patient under long-term constant supervision must not be held in a cell where he may be watched from a cell opposite.

187. The clinical reviewers thought that the high dependency unit was not set up for constant observation. It did not have a transparent door and the observing officer would have to sit on an elevated chair to carry out constant supervision.

Consideration should be given to making the high dependency unit suitable for constant supervision.

188. The clinical reviewers found that the man's transfer to hospital was appropriate. Nevertheless, they make the following recommendation:

There should be a clearly documented decision with the patient's preferences of where they want to die stated. Any reasons these cannot be complied with (eg security or ability to care) should be stated. This situation was appropriately dealt with in this case.

While I do not disagree with the principle behind this recommendation, I later commend the efforts made by staff to involve the man in choosing his place of death.

189. Constant supervision was carried out by prison officers. The clinical reviewers commented on discrepancies that emerged during interviews between some officers' understanding of their role as observer.

While not a key point, some clarity on the role of the observers in these situations [long-term constant supervision] is required. As the patient becomes frailer in the latter stages it may have been more appropriate to use a member of healthcare staff.

190. I am grateful to the clinical reviewer for their clinical review and concur with their recommendations. Overall they found that "the standard of care provided to the patient by Lincoln was excellent."

191. After submission of the clinical review, my investigator wrote to Lincolnshire PCT to request more detail on some outstanding matters. I would like to thank Lincolnshire Primary Care Trust for the full response that was received in this office at the end of January 2007. I have referred to this document in my subsequent consideration of issues.

Family contact

192. Lincoln enabled the man's family to visit him in the healthcare centre when he was too frail to get to the visitor's centre. The Deputy Governor reassured him that his approved visitors' details had been passed to the hospital ready for his transfer during the last stages of his life. These efforts with the man's next of kin continued when the man had died. The governing Governor and the Deputy Governor met the man's brother at the hospital on the night that the man died. Another senior officer continued with the family liaison and provided a single point of contact.

193. My family liaison officer was told by the man's brother that he was content that Lincoln did everything that they could for his brother. He said that the man was determined to die and so he did. He raised no particular concerns for consideration during the investigation. However, he was interested in seeing a copy of the investigation report and I hope it has addressed any outstanding concerns.

Advance directive

194. An advance directive is a statement of instruction about how a person wants to be treated in the future should they lose the capacity to make informed decisions about their own care. Around Christmas 2004, the man told the prison doctor that he was not eating because he had no appetite. By early January 2005, the man said he was not eating with the intention of ending his life by starvation. In line with Prison Service policy, the doctor suggested that the man contact his solicitor to formalise his refusal of food and treatment.

195. Adults with capacity have the right to refuse food, fluid and treatment, both at the time it is offered, and in the future using an advance directive. If treatment is forced, it is a breach of the patient's right to life, self-determination and liberty. It can also be considered a criminal offence to treat someone against their informed will.

196. The man had to have the capacity to make an advance directive, in order for it to be legally valid and implemented by staff. The presumption in law is that a patient who wants to make an advance directive has capacity unless it can be proven otherwise. A person lacks capacity if some mental health condition causes him or her to be unable to make a decision whether to consent to or refuse treatment. There are three stages to assess, if someone's capacity is called into question:

    - the patient must be able to understand information relevant to the decision
    - the patient must be able to retain that information
    - the patient must be able to weigh that information in the balance in order to make their decision.

197. The man had been treated for varying degrees of depression and had been diagnosed with a borderline personality disorder since arriving at Lincoln. The prison doctor and the consultant psychiatrist both felt that the man had capacity to refuse treatment. However, the consultant psychiatrist could not rule out that the man had a mental illness that would affect his judgement.

198. The prison doctor told my investigators:

> "There was a prison protocol from the management of food refusal and it's that document that recommends two psychiatrists to certify mental capacity and an advance directive to prevent artificial feeding."

199. The prison doctor contacted two consultant forensic psychiatrists from the medium secure unit, for their expert opinion. The two psychiatrists attended the prison together and jointly assessed the man. They found that he had a depression that warranted urgent treatment and made it difficult to assess whether he could effectively weigh information in the balance. The second forensic psychiatrist told my investigators:

> "I mean it was quite clear that my colleague and myself had the view that he had an agitated depression, he needed treatment. Obviously the issue of not eating and drinking was judged to be part and parcel of his depression and my colleague, again who you may well interview at some later stage, I think had a fairly robust view which was that treating him against his wishes if necessary by force feeding would be justified under common law and under the Mental Health Act if necessary but as it transpired that didn't prove to be necessary when he was transferred he did eat and drink, albeit to various degrees."

200. The Governor sought advice from the Prison Service and the Legal Adviser's Branch at the Home Office about what action she needed to take, given the man's circumstances. During interview, she could not remember who she spoke to at the Prison Service or at Treasury Solicitors. She expressed her extreme frustration at the lack of speedy advice and support. She told my investigators:

> "I was not supported and had to work extremely hard to get any kind of sensible advice from anybody that would listen to me."

201. When faced with such an extreme case as this one, Governors must have ready access to advice about how to effectively discharge their duty of care.

The Prison Service should review the role of the regional Safer Custody Advisers to ensure that they provide relevant and timely advice in sensitive cases.

The Prison Service and the Department of Health should prepare a briefing about the pathway of care for a prisoner who is determined to die through food refusal.

Procedure under the Mental Health Act 1983

202. The decision to detain the man was made after the consultant forensic psychiatrists assessed him as suffering from severe depression in January 2005. The man was detained in accordance with the Mental Health Act. The clinical review says:

> "… the decision to detain him for assessment under s47 and s 28 of the Mental Health Act was based upon the opinion of the consultant forensic psychiatrists that the man was suffering from severe depression of a nature and degree which made it appropriate for him to be detained in a hospital for medical treatment and that he was in urgent need of such treatment."

203. The key worker said that the man was not happy about being detained under the Mental Health Act. She felt that no one had fully explained the sectioning process to him and the reasons that he was being detained. She told my investigators that she explained to him why he was being detained and what would happen to him. She said that once he understood what was happening to him, he accepted the situation.

204. The clinical review team say of this decision:

> "It would not have been clinically appropriate or in the man's best interests for him to remain within the prison setting at this time and in light of his assessed need for treatment within a hospital setting."

205. The prison doctor said that the man was angry when he was told about being detained under the Mental Health Act:

> "Prison tends to disempower people anyway and really the only power that sometimes people are left with is the power to choose to eat, drink or take medication and we were basically removing even that power from him by placing him under the Mental Health Act and he understood that while he was under that Act, it would be possible to feed him against his will, so he was utterly disempowered, that would make me angry."

206. The prison doctor said he explained to him that the psychiatrists could not say that he had capacity at that time and that he needed to be treated for depression before his advance directive could be put into force. The doctor said that, once the man understood that his sectioning was necessary to bring about the validation of his advance directive, he was co-operative.

207. I am satisfied that it was appropriate for him to be detained under the Mental Health Act at this time. In the two days between the decision being made to detain him and his transfer to the medium secure unit, the matter was explained to him and he understood the process and the reason it was being done.

Did the man's case have to be referred to the High Court?

208. At a CPA meeting before the man's transfer back to Lincoln, it was agreed that at that time he had capacity. This was 22 July 2005. Upon his return, the Governor contacted the Prison Service for urgent advice and they confirmed that, for the advance directive to be valid, two psychiatrists had to agree that the man had capacity at the time of drafting. Two psychiatrists were asked to assess the man's mental capacity again to determine whether the advance directive was valid. On 2 August, the two psychiatrists assessed him. One psychiatrist felt that the man had the capacity to make a valid advance directive. The other psychiatrist assessed him as unable to weigh information in the balance. It was the West Lincolnshire PCT and their legal representatives that suggested his case be referred to the High Court. They and the Treasury Solicitors on behalf of the Home Office petitioned for a legal judgment as to whether the man had adequate capacity to make a valid advance directive.

209. Lincolnshire PCT said that, when the man was in the medium secure unit, he expressed no intention to die and ate and drank a little food. It was their view that the man's situation had changed upon his transfer back to Lincoln, whereupon he immediately stated his intention to kill himself through food refusal.

210. My investigators spoke with the second psychiatrist during the course of the investigation and he said that he did not feel the man had the ability to weigh information in the balance during his assessment on 2 August. He thought that his guilt and perpetual desire to 'be with his daughter' may have been signs of a residual depression. He said that there were lengthy discussions between himself, the prison and legal representatives, and the decision was made to refer the man to the High Court.

211. All staff reported that there was a sense of relief once the High Court had handed down its judgment. When asked whether staff found the situation easier once the High Court judgment had been made, the prison doctor said:

> "Absolutely, there was considerable anxiety in the time before because, as you alluded to earlier, it was unclear whether he should be resuscitated, it was unclear how he should be treated if he were to have an accident and there was a good deal of anxiety. After the court in turn decreed that he was capacitous, that eased very considerably."

212. Although it was unfortunate that the man's case had to be referred to the High Court, it provided staff and the man with the clarity they needed. The man was described as "euphoric" after the High Court decision. I think that, balancing the rarity of the situation and the lack of certainty about his capacity, there was no option but to refer his case to the High Court for confirmation of the legal status of the advance directive.

Facilities in the healthcare centre and the management of the man's food refusal

213. The man was located in the healthcare centre for the great majority of his time in Lincoln. During an interview with the Head of Healthcare, she was clear that the healthcare building at Lincoln was not fit for purpose. The clinical review team describe the facilities within the healthcare centre as "totally inadequate". She told my investigators that, since taking over the delivery of healthcare in April 2004, the PCT was responsible for providing necessary equipment while the Prison Service retained responsibility for the building or 'the estate'. The Head of Healthcare was clear that she had experienced no problems with obtaining equipment. She said that Prison Service staff have to electronically test the equipment and they were prompt and efficient in doing so. However, she said that she has made representations about the inadequacy of the healthcare building. She said she had discussed her concerns with the Chief Executive of the PCT and brought to her attention that she considered the building to be dangerous for health and safety reasons and because it had failed its infection control audit. Having said this, Lincolnshire PCT felt that the conditions in the healthcare did not affect the man's treatment.

214. Lincolnshire PCT had agreed to spend a substantial sum of money to improve the fabric of the healthcare centre at Lincoln. In order for the work to be completed, a similar sum had to be provided by the Prison Service. My investigators were told that, at the time of the investigation, the work had been postponed because the Prison Service was not able to offer the necessary funds for the refurbishment. While I appreciate the pressures placed on the Prison Service's resources, I am very disappointed that the refurbishment of an inadequate healthcare facility that can be described as "dangerous" was not prioritised.

215. The man was in a gated cell in the healthcare centre. He described it to staff as a "goldfish bowl". The cell had a Perspex door and was overlooked by another cell located directly opposite. On two occasions, he complained about the prisoner located opposite looking into his cell. It is recorded that, on both of these occasions, the prisoners were moved to a different cell within hours. The Healthcare SO said that he thought "more effort was made because of him [the man], because we knew it was going to be a long term thing."

216. The man elected not to move to the high dependency unit, which is situated at the far end of the healthcare centre and which would have

afforded him more privacy. His key worker described how the man was so desperate for privacy that he would often spend 20 minutes on the toilet in the morning because it was the only time he had by himself. The high dependency unit was the only alternative to the gated cell. However, the prison doctor said he did not want to move principally because he liked his room. He added:

> "He was a strange character and cared about the staff who were looking after him and he didn't want the constant watch officer to be sitting on a high chair looking in through a window, he much preferred them to be across a gate from him."

217. When I opened this investigation, staff kindly took me to see the cell where the man spent most of his time at Lincoln. I shared the view that the location of the gated cell gave him no privacy. However, given his refusal to move to the high dependency unit, I can see that staff had little option but to keep him safe in that cell.

218. It is very rare that prisoners die as a result of refusing food. In fact, only three other prisoners in the last 15 years have died in this way. Prison Service guidance says that prisoners refuse food either as a means of protest or as a result of a serious mental disorder. However, the man told staff from the outset that he wanted to die through food refusal. In January 2005, when he first mentioned his intention, the prison doctor explained to him what would happen to him as a result of such actions.

219. If a prisoner uses food refusal as a means of protest, or a bargaining tool, Prison Service guidance suggests that staff must try to find "constructive ways to meet the underlying need". The man expressed no ulterior motive. He told staff that he simply wanted to die in order to be with his daughter. The man did not fall within the 'usual' category of food refusal as protest.

220. Prison Service guidance on food refusal places the responsibility with individual prisons to decide whether to initiate suicide prevention procedures for prisoners refusing food. The ACCT procedures involve regular multi-disciplinary reviews of a prisoner's circumstances, to promote communication about the reason for the food refusal and to identify actions which may dissuade a prisoner from refusing food further.

221. However, the man repeatedly told staff that he intended to die. I think the ACCT process gave staff who came across him in different capacities the opportunity to share their views about how his care could best be managed. One example of this in practice was when staff who carried out constant supervision on him were concerned that he was anxious about money and bored. Healthcare staff suggested that he start a job constructing blank medical records. This is a good illustration of the ACCT process working to improve communication between different groups of staff and care planning. It is unfortunate that the man

declined to attend so many of the reviews. This meant that he did not have as much input into his care as he could have done.

222. The man wanted to die through his food refusal. I believe his food refusal was appropriately managed through ACCT suicide prevention procedures and improved the multi-disciplinary care planning and communication.

223. When it had been agreed that the man had capacity and therefore fell within the minority of cases of prisoners intending to die through food refusal, the rarity of his case meant that there was little guidance for staff on the day to day management of his care. For example, legal advice was sought as to whether staff should continue to place meals in his cell every mealtime. Legal advice was that this might constitute "inhuman and degrading treatment" and it was immediately stopped.

224. The prison doctor spoke to the man every day that he worked at Lincoln prison to ensure that he understood the consequences of his food refusal:

> "It's a question of explaining that food refusal would eventually lead to his death by organ failure, that he might be in considerable pain because of muscle wasting, explaining that his advance directive prevented us from treating him to prolong or save his life but his advance directive allowed us to treat him for comfort and dignity as best we could and I told him regularly in the last four weeks that in my opinion he was now doing irreversible damage so he was very well aware of that. He was seen every day by a doctor…"

I commend the sensitive management of the man's food refusal in the healthcare centre.

225. Although I think the ACCT process was the most effective way to manage the man's care, I am concerned that people who sat in on case reviews did not always know him. Case reviews are multi-disciplinary in order to ensure that staff have a full picture of the prisoner's risk factors. It is difficult to understand what contribution a member of staff who had not had contact with a prisoner could have made to the ACCT review. It is also important that those who attend case reviews are empowered to alter a prisoner's care plan. Staff interviewed by my investigators did not feel able to alter his observation status and said that the meetings became more of an update about his condition. I understand that healthcare staff did not feel able to override a senior management decision about whether his observation status could have been reduced. (I say more about this in the following section of this report.)

226. I commend the work of the Safer Custody Group (then part of the National Offender Management Service, now part of the Prison Service) who are about to pilot a training package in how to work with prisoners who are subject to constant supervision. The training package

encourages meaningful involvement rather than simply monitoring. It also requires staff to try to engage a prisoner in activities that reduce the amount of time they spend being observed in a gated cell. For example, staff might try to encourage the prisoner to attend education or receive tuition in their cell.

227. As well as the ACCT process, nursing staff ran a care planning process and there were also multi-disciplinary notes recording the man's time at Lincoln. While I cannot fault the committed approach to recording and planning his care at Lincoln, such a prolific amount of paperwork might lead to confusion or important observations being lost.

The Governor and PCT should consider streamlining the paperwork required for a prisoner determined to die through food refusal, so that all staff involved in an individual's care have an overview of the prisoner's condition and health and social needs.

Constant Supervision

228. Constant supervision is where a prisoner is supervised by a designated member of staff on a one-to-one basis, remaining within sight at all times. It is most commonly used when there is an immediate and imminent risk of suicide or serious self-harm. There are only two places within the healthcare centre at Lincoln where a prisoner can be constantly observed – a gated cell with a perspex door or the high dependency unit. The man was located in a gated cell in the healthcare centre on 13 November 2004. Excluding the six months that he spent in the medium secure unit, he was subject to constant supervision from September 2004 until his death in February 2006.

229. Prison Service Order (PSO) 2700 sets out instructions for prisons caring for prisoners at risk of suicide and self-harm. The section concerning prisoners on constant supervision describes constant supervision as "a temporary measure, intended to manage acute suicidal crisis". The Order stresses the importance of staff interacting with a prisoner, rather than merely observing their well-being.

230. At paragraph 4.2.2, the PSO says:

> "In those exceptional cases where this level of crisis lasts beyond 24 hours, further case reviews must be held at least three times during that establishment's core working day. Acute suicidal crisis is usually temporary and the aim of the case reviews should be to reduce the level of supervision progressively as the prisoner's condition improves. The temporary nature of this level of supervision must be reflected in the support plan."

231. In fact, the Healthcare SO told my investigators that constant supervision was "very rare" at Lincoln. He went on to say: "normally it's very short-term, sort of over emergency or some sort of crisis in somebody's life."

However, the Healthcare SO went on to reflect that the man was on an "artificial constant watch". He said that staff felt obliged to "cover their backs" by keeping him on constant supervision.

232. When a prisoner is on constant supervision, staff should hold reviews every four hours, or at least three times in a core working day. As stated above, the purpose of a case review for a prisoner subject to constant supervision is "to reduce the level supervision progressively as the prisoner's condition improves". Staff at Lincoln held case reviews weekly. A number of staff who took part in the man's case reviews told my investigators that the meetings were held but no active discussion took place about how to reduce his observation level. The staff attending the case reviews felt that the matter was out of their hands. The member from Probation described it as "a given" that the man should remain on constant supervision.

233. My investigators spoke to the Governor about the decision to keep the man on constant supervision for such a prolonged period. The Governor said that she did not have any direct involvement in the man's level of supervision. She said that she understood the decision would have been made by the case review team and reviewed by them on a weekly basis. She knew that the prison doctor was overseeing the man's care, and she passed on her concern that he had to be cared for as a "very, very high risk and we need to be careful because he's going to do it".

234. The prison doctor told my investigators that he felt the constant watch was "intrusive". During interview, he said:

> "The man gave his word to me on several occasions that he would not attempt to end his life by any other means than starvation."

235. The prison doctor said he felt "he had no other option" than to keep him on constant watch. He said that he was advised by governors at the prison that Safer Custody Group had told the prison "get him to court alive". The murder of his daughter had high profile media coverage and the doctor understood that, if the man were to die before his trial, the prison and the Prison Service might be open to some criticism.

236. My investigators met with representatives from the Safer Custody Group, in London. Safer Custody Group told my investigation team that they were kept informed of the man's case and were copied into a key submission in August 2005 that confirmed that he had the capacity to refuse treatment and therefore to elect to die by food refusal. They were not aware of the length of time that the man was subject to constant supervision. There is no record that advice was given to anyone at Lincoln prison by Safer Custody Group or by the regional Safer Custody Adviser for the East Midlands.

237. Bassetlaw PCT's clinical review found:

"As long as the patient did not have the right to refuse food, he appeared to be a high suicide risk. It was therefore entirely appropriate that he was under constant observation until the judgment. As this was a prolonged period, we felt it would have taken a brave decision following establishing capacity, given the profile of the case, to reduce the watch status. This was despite the fact that the patient appeared to be at a reduced risk. We cannot say for certain, but if capacity had been established earlier it may have been made easier to reduce the status. Either way, it would have helped his management in this case."

238. Lincolnshire Primary Care Trust responded that at no time did the man not have the right to refuse food. However, because of his severe depression he was assessed as not having the 'capacity' to make that decision with a view to ending his life.

239. As discussed above, Prison Service guidance on food refusal suggests that an ACCT Plan "may allow for a better continuity of care". I think that the man was appropriately managed through the ACCT system which encourages a multi-disciplinary approach to the support of an at-risk prisoner. I understand that the man expressed his determination to die and therefore could be assessed as an ongoing acute risk of suicide.

240. Although the man had stated that he would not take his own life by means other than food refusal, it would have been unwise to rule this out from an operational management perspective. It would have been impossible to exclude the possibility that he might have awoken one night in severe pain and decided to take his life by much quicker means. The man clearly wanted to die and was extremely determined to do so. This determination did not seem to waiver the closer he got to the end of his life. He was a high profile prisoner because of the nature of his alleged offence. Whether senior managers at the prison had been explicitly told by Safer Custody Group to "get him to court alive" or not, I can fully understand the feeling that the prison had no option other than to keep him under constant supervision. As the clinical review has highlighted, he had already been under constant supervision for a prolonged period before it would have ever been appropriate to consider reducing that level of monitoring. It would have been a brave decision to have done so and one which, in my view, would have to have been supported by the prison doctor, the PCT, the governing Governor, Safer Custody Group and the Area Manager.

241. A review of PSO 2700 is underway led by Safer Custody Group. As part of the review, the PSO section on constant supervision is being strengthened to provide clearer guidance to prisons on the management of acutely suicidal prisoners. The guidance has been drafted because concern has been raised by Governors and PCTs that a large number of people are being placed under constant supervision. It encourages staff to think of other alternatives to constant supervision, for example location in a care suite.

242. The revised Order also has a tiered approach to caring for a suicidal prisoner. Constant supervision should only be used as a crisis management tool. Safer Custody Group have introduced a secondary system that is triggered after a prisoner has been under constant supervision for eight or more days, when the prisoner is considered to be "particularly challenging" for the purpose of the Order. At that stage, an 'enhanced' case review team should meet, with multi-disciplinary representatives at a higher level of operational manager than a typical case review team. The case review team should then identify a single member of staff who becomes that prisoner's key worker. Between them, the case review team and the key worker must devise a plan that encourages the prisoner to break his behaviour pattern and reduce the level of observation.

243. I am pleased to learn of the Prison Service's plan to reinforce that constant supervision should only be used as a short-term, crisis management measure.

In cases of prolonged constant supervision, a high level care planning meeting should be convened involving, where necessary, the Governor, Area Manager, Safer Custody Group, Primary Care Trust, and senior healthcare staff, including mental health professionals.

244. In the man's case, I am satisfied that senior managers within the prison and the PCT were made aware of his condition and played a role in the care planning process.

Role of the Observer in Constant Supervision

245. Bassetlaw's clinical review team considered the role of the observer in constant supervision as part of their review. Almost all of the prison officers who carried out the constant supervision told my investigation team that they had volunteered to do so. One officer said that she began to feel uncomfortable with the supervision towards the end of the man's life when he became frail and looked to be in pain. She said that she easily removed herself from the constant supervision list. It is clear from the ACCT records that there were a select few officers who did repeated shifts with the man. My investigators spoke to several of these officers. While some described him as a private man who did not openly share his thoughts with them, others said that they often chatted with him about his personal history and his decision to end his life.

246. Department of Health guidance, 'Mental Health Observation, including constant observation – Good working practice for healthcare staff working in prisons', refers to the management of prisoners who have an assessed mental health problem or who are awaiting assessment and require formal observation. This guidance would have only applied to the man in the brief time he was at Lincoln before he was detained under the Mental Health Act. However, this document contains some useful

guiding principles for staff managing a prisoner with a prolonged acute risk of attempted suicide. It suggests that prisoners can either be monitored from arm's length or within eyesight. The least intrusive level of observation should always be adopted to preserve a prisoner's dignity and privacy. The man was observed within eyesight at all times that he was under constant supervision. Staff sat outside of his cell with the Perspex door between them and the man. Staff engaged him in conversation and there are many insightful notes of conversations between the observing officer and the man in his ACCT record.

247. The clinical review team concluded:

> "We discussed the benefits of having constant observation, in terms of building relationships with the staff looking after him and have made brief reference to these. We did not feel it was an appropriate function of the constant watch to perform specific therapeutic actions and did not therefore include this in the review. Our recollection is we did feel the benefits of building a relationship were similar, whether there was a healthcare officer or a discipline officer. We also felt there were other ways to build these relationships and surely a patient who was based on the healthcare wing for many months with frequent contact would gain this, without the need for constant observation. In short, we thought this would be gained either way."

248. Lincolnshire PCT go further to suggest that, although a member of discipline staff may not be qualified to deliver therapeutic interventions, they could request the assistance of healthcare staff at any time.

249. Although the prison doctor told my investigators that he felt the constant supervision was intrusive for the man, he acknowledged that the man began to enjoy their company:

> "… it must have been unpleasant although he enjoyed talking to the constant watch and they became his companions really."

250. The Department of Health's guidance says that staff who perform constant supervision should "be appropriately briefed about the prisoner, including their history, background, specific risk factors and particular needs. Prison officers undertaking observation duty should be considered to be a part of the care team…"

251. On balance, I agree with the clinical reviewers that constant supervision can be used as a positive way to engage and support a prisoner, whether by healthcare staff or discipline staff. I have seen sufficient evidence to conclude that staff performing the observations were appropriately skilled in engaging with the man and encouraging him to talk about his worries with them. All staff received a handover from the preceding shift and all felt well briefed about his condition. Staff felt able to ask healthcare for support. This is illustrated by one of the Physical Education Officers (PEO) on the morning that the man died who

acknowledged the great assistance that he received from a nurse after the man had fallen from the toilet. I think that the man's care is a good example of how prison officers and healthcare staff can work together to care for at risk prisoners.

Transfer between Lincoln prison and the Hospital

252. Once the High Court decision had been made, Lincoln chose to adopt the Liverpool Care Pathway, intended for patients who are at the end stage of their lives. This palliative care model focuses on the psychological and spiritual needs of the patient. It is meant to care for patients who are in the last 48 to 72 hours of their life. The man was not at that stage when the pathway was implemented, but healthcare staff adapted the documentation to meet his needs. As part of the Liverpool Care Pathway, practitioners are encouraged to discuss with the patient their preferred place of care and death.

253. The High Court handed down its judgment on Friday 12 August 2005. The man's advance directive was valid and he had the capacity to choose to refuse food and medication. On Monday 15 August, a third strategic case review was held, attended by members of the prison's senior management team, the PCT Medical Director and the Head of Clinical Governance, healthcare staff from the prison, including the prison doctor and the PO, and staff from Lincolnshire Hospitals Trust. The man did not attend that meeting. Security measures were discussed and agreed for the Hospital to put in place so that the man would be protected from press intrusion. The prison doctor pointed out that, although it was "technically possible" to care for him within the healthcare centre, "the prison and healthcare staff did not want this". At that meeting, it was agreed that the man should be transferred from Lincoln to the local hospital "when staff saw evidence of confusion". However, this agreement was made a long time before the man met the criteria and was transferred. No further meeting was held to review this arrangement, although there is evidence of continuous liaison between the healthcare centre and the hospital about his condition.

254. The man initially expressed a desire to die in hospital. When asked to go to the local hospital on 16 February, he did not want to go because he would not be able to smoke as much as he would like. The hospital was notified that the man wished to delay his admission. He refused again on 21 February. On 23 February, he agreed in principle to transferring to the hospital in two days' time.

255. This arrangement stayed in place until the man was eventually transferred on 25 February 2006. Staff at Lincoln liaised with the hospital to plan a side room for him when he went there. Hospital staff were briefed and updated about his condition as the months passed and all staff were made aware of the advance directive.

I commend the proactive approach to planning the man's transfer to hospital, which avoided delay and possible security breaches and ensured dignified continuity of care.

256. The man died at the local hospital. He was transferred around three hours before he died. The man seemed to have mixed feelings about being transferred to hospital towards the end of his life. An officer told my investigators that the man "was very worried about" transferring to hospital. She said that his main concern was that he would not be allowed to smoke. Originally, he had agreed to go to hospital when his condition deteriorated because he understood he would be allowed to smoke there. The officer said:

> "The next time I came [to do constant supervision shift] he said that the smoking had been overruled, he wouldn't be allowed to sit and smoke, 'cos he was a smoker wasn't he, heavy smoker and that to him was like, 'oh I am not going then'."

257. Other officers said that the man did not seem to mind being transferred to hospital. The prison doctor said he spoke to him on numerous occasions about his preferred place of death. The doctor told my investigators that he was happy for the man to die in prison if that was what he wanted. The doctor and the governing Governor discussed the matter "at length". The Governor told my investigator that if the man had said that he did not want to go, then she would not have insisted on him transferring to hospital. However, she said that ultimately she did not want him to die in prison for two reasons. First, she said that she was concerned "just in case there was something else that the services available could do". Secondly, she was worried about the effect that watching a prisoner die in prison would have on her staff. The doctor said that members of the management team at the prison felt that the man should be transferred for "perhaps political reasons which I find entirely understandable".

258. The man was transferred to hospital hours before he died. He agreed with the doctor that he would be transferred to hospital and the doctor said that "he was quite happy to be transferred on the day that I transferred him". An officer said that he "did not think that [the man] was in the frame of mind because of his condition to realise what was going on." The officer said that the man did not react at all when the ambulance arrived and described him as being "half asleep".

259. Whatever their own preference, the Governor and the prison doctor agreed that the man would not be transferred against his own wishes. In fact, it is clear from his advance directive that he wanted to die in hospital not in prison.

I commend the involvement of the patient in determining his own place of care and death.

Staff support

260. During the man's life, staff in general felt well supported by the management team at HMP Lincoln. Healthcare briefings were held regularly and there is evidence of communication at every significant change of the man's condition or care. Nearly all of the staff who carried out constant supervision shifts were volunteers. An officer told my investigators that, as soon as she felt uncomfortable doing the shifts because of the man's deteriorating condition, she was able to opt out.

261. One prison officer reported that he felt he was put in a difficult position towards the end of the man's life when his frailty meant that he needed more support to perform his daily functions. The clinical reviewers suggested that, when his physical condition deteriorated and he was prone to falling, constant supervision might have been more appropriately carried out by healthcare staff. I agree that this might well have been more appropriate.

262. The key worker felt that she was not well supported by the healthcare management team. She felt that the PCT was "intrusive" and said that she had raised the matter for the attention of her line manager.

263. The prison doctor and the Head of Healthcare said they felt well-represented in Lincoln's management team. The doctor reported that he felt he could speak with the Governor any time that he had a concern.

264. It seems to me that, overall, staff felt well supported and clear about their role in the man's care. In this respect as in others, there is much to commend.

RECOMMENDATIONS

I agree with the recommendations made in Bassetlaw's clinical review.

Clear accountability for ensuring working conditions [in Lincoln's healthcare centre] are safe and fit for purpose are required.

The recommendation was accepted. Refurbishment plans are agreed, awaiting funding and start date.

When a prisoner is being returned from prison after a time in a mental heath secure unit under the Mental Health Act, a discharge process should be agreed by all relevant parties, to enable a care pathway plan to be drawn up as soon as possible.

The recommendation was partially accepted locally. The Prison Service responded as follows:

> *"This recommendation is directed largely at the discharging mental health secure unit and outside the jurisdiction of the Prison. However, please note the comments of one of Consultant Forensic Psychiatrists who felt that the discharge process was effectively handled in this case."*

While I appreciate that the role of the discharging mental health unit is crucial, the recommendation was directed at the Prison Service because community health services are outside of my terms of reference. The investigation team did not have access to clinical records or consider the care that the man received at the medium secure unit. I am pleased that the Prison Service has accepted the recommendation.

A patient who under long-term constant supervision must not be held in a cell where he may be watched from a cell opposite.

This recommendation was partially accepted. The Prison Service said:

> *"Wherever possible, locally, this would be complied with however it would be dependent on prisoner numbers in the healthcare centre. Across the prison estate this would not always be possible due to resource and security issues. The revised PSO 2700 which is now available on the Prison Service Intranet provided guidance on preserving prisoner dignity during constant supervision."*

Consideration should be given to making the high dependency unit suitable for constant supervision.

This recommendation was not accepted. The Prison Service responded, "there are privacy issues for those prisoners requiring palliative care which would be compromised by these alterations."

There should be a clearly documented decision with the patient's preferences of where they want to die stated. Any reasons these cannot be complied with (eg security or ability to care) should be stated. This situation was appropriately dealt with in this case.

The recommendation was accepted. The Prison Service responded:

> *"Locally already complaint. The practice in this case was commended under good practice. Nationally, draft food refusal guidelines being drawn up by Offender Health, state that the wishes of patients should be under constant review. End of life care should occur in line with NICE guidelines."*

While not a key point, some clarity on the role of the observers in these situations [long-term constant supervision] is required. As the patient becomes frailer in the latter stages it may have been more appropriate to use a member of healthcare staff.

This recommendation was accepted. Response as follows:

> *"The revised PSO 2700 offers guidance for <u>all</u> staff about how to undertake a constant supervision. A period of constant supervision can only be authorised by a doctor or nurse or by a Duty Governor (in consultation with a doctor or nurse). A requirement of ACCT, which would be opened for every prisoner under constant supervision, is that regular multi-disciplinary case reviews are undertaken and PSO 2700 recommends that a doctor or senior nurse be included. The care of the prisoner would be discussed at these reviews including the need for observations to be undertaken by residential or medical staff according to the individual need."*

I make the following four additional recommendations to improve prisoner care:

The Prison Service should review the role of the regional Safer Custody Advisers to ensure that they provide relevant and timely advice in sensitive cases.

This recommendation was accepted. The Prison Service responded:

> *"The role of the Area Safer Custody Adviser (ASCA) is regularly looked at by Area Managers and Safer Custody Group, and this recommendation has been discussed at the SCG/ASCAs meeting in September 2007. ASCAs provide timely advice and guidance to Area Managers, Governors (Directors of private prisons) and staff on a range of safer custody matters. Prisons lead on the management of individual cases but the ASCAs' advice is sometimes sought and given."*

The Prison Service and the Department of Health should prepare a briefing about the pathway of care for a prisoner who is determined to die through food refusal.

This recommendation was accepted. Draft food refusal guidelines are being drawn up by Offender Health at the Department of Health.

The Governor and PCT should consider streamlining the paperwork required for a prisoner determined to die through food refusal, so that all staff involved in an individual's care have an overview of the prisoner's condition and health and social needs.

This recommendation was not accepted by the Prison Service, who responded: "There is no delegated authority to deviate from national policies on the management of prisoners subject to ACCT documentation.

The PCT wrote the following, in their response to the draft report:

> *"The PCT acknowledges that documentation for the ACCT process and documentation held by healthcare pertaining to a patient's risk of self harm can duplicate each other in some respects. However, the multi-disciplinary notes which form the patient's medical records are held in medical confidence. It would therefore be inappropriate to include the level of detail which may be reflected within them regarding mental health status, within the ACCT documentation which is more freely available to a range of staff. For this reason, the PCT does not feel that this recommendation is appropriate."*

In cases of prolonged constant supervision, a high level care planning meeting should be convened involving, where necessary, the Governor, Area Manager, Safer Custody Group, Primary Care Trust, and senior healthcare staff, including mental health professionals.

This recommendation was partially accepted. In response, the Prison Service wrote the following:

> *"Constant supervision is normally used as a temporary measure in order to assist a prisoner during a period of suicidal crisis (usually no more than 72 hours). The man' case is extremely unusual and presents many previously unconsidered issues. Safer Custody Group is always willing to give advice to prison staff about the management of at risk prisoners, as happened in this case."*

GOOD PRACTICE

Overall, the management of the man's care presented a considerable challenge to senior managers, healthcare staff and officers at Lincoln. The prison worked hard to protect his rights and preserve his dignity until the end of his life. I have identified the following areas of good practice:

I commend the sensitive management of the man's food refusal in the healthcare centre.

I commend the proactive approach to planning the man's transfer to hospital, which avoided delay and possible security breaches and ensured dignified continuity of care.

I commend the involvement of the patient in determining his own place of care and death.