PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the circumstances surrounding the death of a man in hospital in February 2012, while he was in the custody of HMP The Verne.

Report by the Prisons and Probation Ombudsman for England and Wales

August 2012

This is the report of an investigation into the death of a man. He died at Portland Hospital in February 2012 of chronic obstructive lung disease and heart failure. He was 65, and at the time of his death he was a serving prisoner at HMP The Verne. I extend my condolences to his next of kin and others affected by his loss.

The investigation was carried out by an investigator. The local PCT appointed a clinical reviewer to review the standard of clinical care the man received at The Verne. Staff at The Verne cooperated fully with the investigation.

The man had been unwell for a number of years. He suffered from severe breathing difficulties, a failing heart and several other conditions. As his health worsened, staff expressed concerns about the suitability of HMP The Verne, which does not have 24 hour healthcare cover, to meet his increasing needs. Prison officers regularly had to consult the out of hours service at night about him and he was admitted to hospital several times with breathing difficulties. In late January 2012, his health deteriorated rapidly and staff urgently tried to arrange for him to transfer to another prison with more extensive healthcare facilities. He moved to hospital for assessment, but died the next morning before a transfer to another prison could take place.

The investigation raises concerns about the operation of the prisoner carer scheme at The Verne and whether The Verne is an appropriate place for elderly and infirm prisoners like him. Too much of his care was left to a prisoner carer without sufficient staff involvement, oversight and safeguards to protect him and also his carer.

It appears that he regarded the prison as home, and wanted to stay there. Well-intentioned staff went along with his wishes without sufficient attention to the consequences. When it was finally acknowledged that the prison did not have the resources to support him further, attempts to transfer him to a suitable prison with 24 hour healthcare were either directly rebuffed by other prisons, or unnecessary obstacles were put in the way of a move.

It is a sad reflection on the Prison Service that it was unable to find a suitable place for the man to live for the last days of his life. The prison population is ageing and this case illustrates a number of the consequences that we are increasingly identifying and which require the Service's attention nationally.

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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **August 2012**

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SUMMARY

1. The man received a life sentence in 1980 for an offence of murder. Broadly speaking, his time in prison consisted of two distinct periods. For the first two decades, there were serious concerns about his mental health. He spent time in Broadmoor Secure Hospital but soon returned to prison. Concerns about his mental health became less pronounced as he got older, and during the latter part of his sentence his declining physical health became a problem.

2. He suffered from chronic obstructive pulmonary disease (COPD) and heart failure. Both of these conditions were degenerative and his health deteriorated year by year. He transferred to HMP The Verne in 2008 and subsequently refused to attend any further outpatient appointments or to undergo any more tests. He also signed a 'Do not resuscitate' form. He showed no further interest in trying to secure parole.

3. During 2011, the man's health began to deteriorate more rapidly. He frequently struggled to breathe, often during the night. The Verne has no nursing staff on duty overnight, so officers regularly consulted an out-of-hours telephone advice hotline. He was admitted to hospital on more than one occasion. After he was discharged from hospital in May, staff considered whether he should be transferred to a prison with 24 hour healthcare. They also contemplated moving him to a wing more suited to his frail condition. However, neither change was implemented.

4. He had an appointed carer, another prisoner. More than once, he or a member of staff expressed concerns about the prisoner's suitability for the role. It was suspected that he had too much influence over him and was isolating him from the other prisoners. Although a number of meetings were held to discuss the arrangement, the man continued to care for him until shortly before his death.

5. In January 2012, the man became even more unwell. The Head of Healthcare decided that he needed to transfer to another prison with an inpatient healthcare centre. The prison GP supported her decision and prison managers began trying to organise the transfer. They contacted four prisons in all, but the other establishments raised objections and no final decision had been made by the time he died.

6. At the end of January, he had to be admitted to hospital. However, he discharged himself and on 2 February returned to The Verne to his old cell for four nights, although it was unsuitable for his needs. He moved to a new cell on 6 February, before being taken to hospital on 8 February for an assessment. It was intended that the assessment would help to secure a suitable place in another prison, but, he died soon after.

7. The investigation found that The Verne was not a suitable establishment for the man to be held during the last weeks of his life. He required a 24 hour nursing facility. The role of his carer also caused concern, and lessons need

to be learnt for the benefit of other elderly prisoners. We make nine recommendations as a result of the investigation.

THE INVESTIGATION PROCESS

8. The investigator was notified of the man's death on 9 February 2012. Notices were subsequently issued to both staff and prisoners at HMP The Verne, informing them of the investigation process and giving them the opportunity to contact the investigator with any relevant information.

9. The investigator visited The Verne on 15 February to examine all the documents relating to the man's time in custody. He spoke to the Head of Healthcare, the Governor, the prisoner carer, a member of the Prison Officers' Association and a member of the Independent Monitoring Board (IMB). He visited the healthcare centre and D wing, where the man had stayed immediately before being taken to hospital.

10. He notified the local Coroner's office of the investigation. HM Coroner will be provided with a copy of this report.

11. The local PCT commissioned a clinical reviewer to carry out a review of the clinical care the man received at The Verne. The purpose of this review was to establish whether the care that he was offered in prison was comparable with that he could have expected in the community.

12. The investigator visited The Verne to conduct interviews with six prison and healthcare staff on 21 and 22 March 2012.

13. One of our family liaison officers contacted the man's next of kin, who did not initially raise any issues for the investigation but asked for a copy of the draft report. After another prisoner had telephoned and written to voice his concerns to them, the man's next of kin, a husband and wife who were friends of his, later got in touch to ask for more information about the care he received at the end of his life.

14. The next of kin were provided with a copy of our draft report. Our family liaison officer then contacted them to discuss the findings.

15. Having read the report, they did not think that prisoners should be cared for by other prisoners, particularly since they are not trained carers. They also believe that no prisoner should be given access to another prisoner's medication at any time. Finally, they thought that he should have been moved to receive appropriate care, regardless of his wishes. His next of kin commented that although most people do not like going to hospital, sometimes it is the best place for the person's own good.

HMP THE VERNE

16. HMP The Verne is a Category C (medium security) prison on the Isle of Portland in Dorset holding up to 607 men. Primary care and mental healthcare services are commissioned by NHS Dorset Primary Care Trust and provided by Dorset Healthcare University NHS Foundation Trust (DHUFT).

17. Prisoners have 'privacy' keys to their own cells. This means that they can lock their own cell during the day and no other prisoner has access. They can also leave their cell during the night to use the lavatory because there is no in-cell sanitation. A member of staff stays on the wing overnight in a secure room.

18. Prisoners are able to move around more freely at The Verne than they would in most category C prisons, and only prisoners who meet strict reception criteria are accepted.

Healthcare

19. Healthcare services are provided by Dorset Healthcare University NHS Foundation Trust (DHUFT). The Verne does not have 24 hour nursing cover, nor does it have inpatient facilities. Seven nursing staff make up the healthcare team. They work between 8.00am and 5.00pm seven days a week. Outside these hours, staff use the Dorset out of hours service for advice if a prisoner falls ill. The prison has a visiting GP who also works in the local community. He holds surgeries in the prison every weekday morning.

Her Majesty's Inspectorate of Prisons

20. The Inspectorate of Prisons completed an unannounced short follow up inspection of The Verne in August 2010. The Chief Inspector wrote:

> 'The prison's historic location limits its role and regime and has meant that only lower risk prisoners can be held there, many of whom might otherwise be in open conditions; as a consequence it holds many foreign nationals. When we last inspected, we commended The Verne as a well run and safe prison. On our return for this unannounced follow-up inspection, we found that this remained the case and The Verne continued to achieve a great deal despite limitations of its environment.'

21. Inspectors reported that the healthcare centre was in a poor state of decoration, but prisoners had access to a comprehensive range of health services. A variety of clinics were provided by nurses and visiting specialists. Palliative care and end of life procedures were judged to be good. Approximately 15% of the population was over 50 and the need to develop provision for older prisoners was recognised. It was noted that carer support had been provided but there was no formalised carer scheme.

Independent Monitoring Board (IMB)

22. The IMB consists of unpaid volunteers from the local community who monitor all aspects of prison life to ensure that proper standards of care and decency are maintained. In their latest annual report covering May 2010 to April 2011 the Board commented on problems with communication and care for elderly prisoners, both issues we discuss in this report:

> 'The whole layout of the Verne, with offices in at least 8 separate buildings, means that staff who should talk with one another often do not do so. The daily morning inter-departmental meeting, which an IMB member often attends, assists communication but does not fully make up for the physical layout of the prison. It is not a simple problem to overcome.
>
> 'In August 2009, representatives from the King's Fund visited the prison with the view to funding the establishment of an Elderly Prisoners' Unit. £30,000 was available for the project. The site was visited and deemed to be excellent, with minimal construction work needed. An expected completion date of August 2010 was set. Half of the money was passed on to the prison. However in February 2010 concerns were raised about the lack of support from the prison and a completion date of October 2010 anticipated by the Fund seemed highly unlikely. Since then nothing has happened and the Board feels strongly that all the hard work put in by Health Care staff is going to be wasted as the money is in danger of being lost as a result of the inactivity and apparent lack of interest shown by the prison.'

Previous deaths

23. We last investigated the death of a prisoner from natural causes at The Verne in 2009. He died after suffering a massive heart attack. We found that the healthcare the man had received was comparable to that he would have received in the community. More recently, we have investigated the self-inflicted death of another prisoner and the death of a man who fell from a stairwell. There were no similarities with this case.

KEY EVENTS

24. Before he was imprisoned, the man had a long history of mental health problems, offending behaviour and drug and alcohol misuse. He committed an offence of murder in February 1979 and received a life sentence at Crown Court in July 1980.

25. Soon after he was sentenced, he transferred from prison to Broadmoor high security psychiatric hospital. However, he was found not to be mentally ill but suffering from a very serious personality disorder. He returned to prison in late 1982.

26. In 1987, while at HMP Parkhurst, a consultant psychiatrist diagnosed him with paranoid schizophrenia and recommended that he should be transferred again to a secure psychiatric hospital. A doctor at Broadmoor did not agree that a transfer was necessary and he remained in prison.

27. The man was imprisoned for half of his life and spent time in a number of different prisons. He reached pensionable age in custody. As the years passed during his life sentence, his mental health seemed to stabilise. However, his physical health deteriorated gradually but inexorably. He had a heart attack in the early 2000s. He had developed severe vascular disease in his iliac arteries (which carry blood from the abdomen to the legs). He underwent an aortobifemoral bypass (surgery used to bypass diseased large blood vessels in the abdomen and groin to keep the blood flowing around his body). His heart was failing and he suffered severe breathing problems resulting from chronic obstructive pulmonary disease (COPD).

HMP The Verne

2008

28. The man transferred to HMP The Verne on 30 May 2008. He was assessed by a consultant psychiatrist who works with the mental health in-reach team based in nearby Dorchester. He was reluctant to treat him with psychotropic medication (drugs used to treat mental disorders) because he thought that these might impact on his long standing heart problems.

29. In August, the man complained that he was not receiving appropriate treatment from the healthcare department. He was placed in the segregation unit for throwing a television through his window. However, staff did not think that he actually had the strength to do this and they suspected that his cellmate had thrown the television. Staff considered transferring him but he remained at The Verne.

2009

30. At the start of 2009, a doctor referred the man for tests after he suddenly lost weight. In February, he underwent a scan at hospital which raised the possibility of a tumour in his bowel. He was due to undergo a colonoscopy in April, but this was cancelled because he contracted pneumonia. The hospital did not offer him another appointment because they had recorded that he 'failed to attend'.

31. The doctor pursued the matter and the man underwent the procedure in May. However, it took the hospital until August to inform him that the results of the colonoscopy were inconclusive. Both he and the doctor were frustrated with the wait for results, the lack of communication from the hospital and lack of explanation for his weight loss. The doctor recorded that the man had become fixated on the possibility of having cancer.

32. In September, the doctor made another referral to obtain a second opinion because there was still no explanation for the man's weight loss. He recorded that he was 'extremely anxious and feels forgotten'. At the end of the month, the doctor wrote in the clinical record that he had been told by the 'clinic' that he did not have cancer but was still under investigation for problems with his stomach and liver, because he did not have a clear diagnosis. In November he declined an investigative procedure (endoscopy).

2010

33. Because of his chronic COPD, the man kept a nebuliser in his cell to help him breath. This was briefly taken away for a service in December and he was not given a temporary replacement. While he was without the nebuliser, he experienced one of his periodic episodes during which he struggled for breath.

2011

34. The man's health deteriorated throughout 2011. He was provided with supplements to counteract his weight loss. In February, he attended the older patient review clinic. He was assessed by a consultant physician from the hospital. He was worried about his weight loss and pain relief. He continued to suffer from a number of ongoing health problems:

    - Chronic pain
    - Asthma
    - COPD (it was noted that no more could be done to improve this condition because he would not stop smoking)
    - His aortofemoral bypass
    - Schizophrenia
    - Heart disease
    - Gastric ulcer

35. On 9 March, a mental health nurse discussed a possible reduction in the man's medication with the psychiatrist, who decided that it should not be changed. The same evening, after the nurses had gone home, he had difficulty breathing, so the night staff asked an out-of-hours doctor to visit the prison to check him. This happened again a week later, on 16 March.

36. During this period, he experienced panic attacks which were linked to his breathing difficulties. He still had his nebuliser but was confused and anxious about his medication. The wing staff thought that he was 'in a bad way'. He continued to smoke. He told healthcare staff that he was 'fed up' of being so ill. He was still losing weight and was not eating. He had mobility difficulties and was often short of breath. An officer recorded that his health had declined, he shook uncontrollably, and he had difficulty with stairs. He was told that he no longer needed to stand by the door of his cell during roll checks because this was such an effort for him.

37. On 30 March, the man completed a disclaimer indicating that he no longer wished to undergo any further investigative treatment at hospital, or attend any more outpatient appointments. At about this time, he also told the staff that he was not interested in completing the targets in his sentence plan. He did not want to be released from prison and was content to die at The Verne. He said he did not wish to participate in the parole process.

38. On 18 April, an officer (a qualified first responder) administered oxygen to him during the out of hours period (when there were no healthcare staff in the prison) because he was having difficulty breathing. On 21 April, healthcare staff were unable to provide him with all of his medication because supplies had not been reordered by the pharmaceutical provider.

39. On 27 April, paramedics were called to The Verne because the man was struggling for breath and shaking. His COPD had worsened and he went blue in the face. He was taken in an emergency ambulance to hospital, where he stayed until he was discharged on 5 May.

40. The same day, the Head of Healthcare made the following entry in his clinical record:

> 'History: message from prison that he is being discharged from hospital today, healthcare has received no communication from the hospital about his condition and requirements on discharge. Contacted the ward and spoke to a Staff Nurse, who informed me that yes, he was being discharged today, expressed my concerns that healthcare had not been informed or verbal handover given to see if the prison could accommodate his needs. Apparently yesterday he was on 24 hour oxygen, when I mentioned this to the nurse and explained The Verne cannot accommodate this due to environment / risk and explained we do not have a hospital here it is an 8.00 – 17.00hrs healthcare centre, he said he would find out some up to date info and contact me.

'Phone call received from officer who was on escort with the man to inform me that the nurse had spoken to a consultant and he does not require oxygen on discharge and he was being released from the hospital today. Spoke to Disabilities, who expressed concerns as to him being in this environment with his medical condition being so unstable, explained that I can't stop the discharge from hospital and when he returns to the prison urgent discussions need to be made about the prison being able to accommodate his needs. Also discussed with a Gov and I will discuss with the manager tomorrow to see if a transfer to an environment with 24hrs care may be a possibility, although I know he will object to this as he won't even move wings where there is a stair lift.'

41. The same day, the Governor responsible for diversity and safer custody emailed relevant staff:

'I have expressed some concerns today as the man is about to be discharged back to us from hospital. Initially it was an oxygen assisted discharge which changed to without oxygen once Head of Healthcare confirmed we were unable to manage him.

'The only oxygen available is in the 'resus' equipment bag that healthcare make available to us during their time on shift (e.g. during the working day). Anything out of these hours requires a blue light to [outside] hospital. We cannot permit him to have oxygen here in possession due to the risk [associated with him smoking] but also they cost £300 per item and one tank would last for a minimal amount of time when he is most at risk of struggling for breath. We do not have the luxury of sending him to Dorch[ester] now and I understand from the Head of Healthcare the nearest healthcare prison is possibly Exeter.

'He will not locate flat which would be ideal in view of the stairs he has to use which exasperate his breathing. Although a wheelchair is on order for him he has stated that his neighbour is the only person he will allow to push him around!

'We also need to bear in mind if there was a fire on the wing he would struggle to evacuate.

'I have provided this information directly to staff who is liaising with the Head of Healthcare who will speak to her P[rimary] C[are] T[rust] lead tomorrow when she is at Forston Clinic.

'Staff is gaining clear instruction for us to care / manage him on his return to us in the meantime. We will have to manage him as best we can but naturally there is concern he will immediately smoke on his return which no doubt will cause stress to his lungs.

> ‘Something documented for day / night staff would be beneficial in the event of another emergency would be advantageous and to reduce staff anxiety – can I leave that with you?
>
> ‘Regards’

42. Later that same day, the Disability Liaison Officer replied to the governor:

> ‘I have contacted the policy lead for disabled and older prisoners at [National Offender Management Service] headquarters. She has said that we should really be looking at a medical move due to health needs and the closest prison with a 24hrs healthcare is Exeter. I don’t know if it would be best to take this to the Governor to see if we can organise a medical transfer.’

43. The man returned to The Verne from hospital on 5 May. When he returned, an officer asked a prisoner who had been informally caring for him and the night patrol staff to monitor him.

44. The Head of Healthcare told the investigator that hospital staff had originally indicated that he would require oxygen. This was why she had recorded her concerns that he should not return to The Verne. She explained that healthcare staff had considered a transfer to HMP Kingston during this period. However, the hospital then informed her that he would not require oxygen. As a result, she and the GP decided that he was not sufficiently unwell to justify a transfer from The Verne. She did not approach prison managers at the time to suggest a transfer.

45. A multi-disciplinary team meeting about the man’s health and circumstances was held on 6 May. A nurse spoke to him the next day about the outcome of the meeting. They discussed the possibility of a move to C2 wing, which is equipped with a stair lift.

46. On 9 May, the Head of Healthcare and the Disability Liaison Officer both spoke to him about his future care needs. The Head told the investigator that he was adamant that he would not move. She described the meeting as ‘pre-emptive’, a chance to plan for his eventual decline. They talked about the suitability of B2 wing and his mobility in the event of a fire. He said that he could still negotiate the stairs, but agreed to a move to a different wing with a stair lift in the longer term as his condition deteriorated.

47. During the meeting, the man agreed to transfer to a prison with 24 hour healthcare if The Verne could no longer accommodate his needs. The Head and Disability Liaison Officer spoke to him about the best course of action if he stopped breathing and he indicated that he wanted to sign a ‘Do not resuscitate’ form. He was so unwell that he did not wish to receive cardiopulmonary resuscitation if he stopped breathing.

48. The same day, the Disability Liaison Officer arranged for a prisoner to begin work as the man’s paid prisoner carer. He had already been helping him on

an informal basis. His appointment was checked by a number of different professionals in the prison and he signed a prisoner carer agreement:

- To act as a companion for the man to prevent isolation
- To collect all of the man's meals and deliver them to his room
- To assist his movement around the wing
- To set up his shower equipment and return it to his room when finished
- To help him get to healthcare / Offender Management Unit / doctor's appointments
- To keep his room and bed space clean and hygienic
- To keep a log of his daily health in a diary
- To assist him with his wheelchair when required
- To keep wing staff informed of any concerns
- To bring any concerns to the attention of the disability liaison officer

49. On 12 May, the psychiatrist reviewed the man. He asked for an increase in his medication. However, the doctor maintained him on the same dose because he was worried that too much codeine (a pain killer) would affect his breathing. The psychiatrist planned to review him again three months later.

50. The following day, 13 May, the man signed a 'Do not resuscitate' form citing his severe COPD and lack of quality of life as reasons why he did not want to be resuscitated. A copy of the form was placed in his wing file so that officers on his landing were aware of his wishes if an emergency occurred overnight. The same day, he also gave permission for the prisoner to collect some of his medication. The healthcare team consented to this arrangement.

51. Later that month, he was given a wheelchair for the prisoner to push. At the end of May, he declined another outpatient appointment at the hospital. On 15 June, the Head of Healthcare spoke to him about his refusal to attend outpatient appointments. He made it very clear to her that he definitely did not wish to attend any further appointments. He said that he would sign a disclaimer.

52. In July, staff issued the man with some equipment to make it easier for him to shower. The same month, an officer submitted a security information report (SIR). He was concerned that the prisoner had some sort of influence or hold over him.

53. On 20 July, the man told staff that he no longer wanted the prisoner to be his carer. The Disability Liaison Officer met both men, discussed the situation, and all agreed that the prisoner would continue in the role. She told the investigator that the man had temporarily 'sacked' him, but then later claimed that they had had a 'silly falling out'.

54. On 6 August, the prisoner wrote a letter to the kitchen manager about the man's diet. He asked to meet the kitchen manager to discuss his meals. Healthcare staff intervened because they thought it was inappropriate for him to interfere in the matter and that he had overstepped the boundaries of his

role as a prisoner carer. It is not clear from the records if his diet was then altered.

55. On 4 October, the Disability Liaison Officer questioned whether the prisoner should be a prisoner carer because he did not have enhanced IEP (Incentives and Earned Privileges) status. (The IEP scheme is designed to encourage good behaviour. Prisoners are on either a basic, standard or enhanced regime. They can be move between regimes depending on their conduct.) She wrote:

> 'I feel that the only person who will suffer from this position being withdrawn from the prisoner is the man as he has made it quite clear that he would not have any other prisoner care for him. I know we cannot let prisoners dictate to staff but George is quite poorly…'

56. A governor replied to her and decided that the prisoner should keep his job as a carer. She thought that his removal would have a detrimental effect on the man. She wrote that it was not necessary to be an enhanced status prisoner to be a carer.

57. On 10 October, the man fell out of bed. The Head of Healthcare checked him but he had not sustained any injuries. On 17 October, he was taken to the accident and emergency (A&E) department at hospital again after his COPD worsened. The next morning, healthcare staff made the following entry in the clinical record:

> 'Received a call from [the hospital] requesting a printout of patient's record as he was taken to hospital in an ambulance yesterday evening. Healthcare had not been informed of this by the prison. We contacted comms to find out the details. They rang [the out of hours service] at 18.20 but the urgent care service said they were not commissioned to start until 18.30 so refused to send the duty doctor to see him. The prison rang for a paramedic and they call and ambulance [sic]. He went to hospital in a blue light at 19.20…'

58. The next day, 18 October, a seconded probation officer and the man's offender supervisor raised her concerns about the prisoner's role as his carer with the Disability Liaison Officer. She had spoken with the prisoner's offender supervisor and in their assessment he was unsuitable for the role because he tended to manipulate situations.

59. It is not clear from the clinical record when exactly the man returned to The Verne, but on 21 October a doctor assessed him and recorded that he was 'getting visibly worse'. Towards the end of the month, his weight was continuing to decrease and his appetite was very poor.

60. On 31 October, the offender supervisor, the Disability Liaison Officer and a governor met the prisoner and the man separately to discuss the prisoner's role as a prisoner carer. The man insisted that he wanted the arrangement to continue. Staff were concerned that the prisoner was starting to cross

boundaries, but planned to monitor the situation. The governor told the investigator that there was no clear evidence that the prisoner was doing anything inappropriate at this stage. She explained that she thought that it would have been detrimental to the man's health to remove him from his role.

61. On the evening of 12 November, officers called paramedics to assess the man because his breathing had become worse. The paramedics decided he did not need to be taken to hospital.

62. By 24 November, staff thought that he had become faecally incontinent, but he denied this. They provided him with incontinence pads. The next day, 25 November, the prisoner carer was given gloves to help him rub cream into his skin.

63. On 27 November, officers again contacted the out-of-hours service asking for advice about him. On 28 November, a doctor diagnosed an oedema in his legs (a swelling caused by water retention because his failing heart and lungs could not circulate the water around his body so it stayed at the extremities). He also had leg ulcers.

64. On 2 December, wing staff asked the healthcare team for another copy of the man's 'DNR' form in case he collapsed overnight and they needed to communicate his wishes to paramedics. The wing staff could not locate the original copy dating back to May. The healthcare team compiled a new folder in the event of him being taken to hospital. Copies of the folder were placed on the wing and in the gate. It included details of his current health problems, current medication and his 'Do not resuscitate' form. His medication was recorded as follows:

    - Clopidogrel (to reduce the risk of a heart attack)
    - Isosorbide mononitrate (to prevent angina attacks)
    - Perindopril erbumine (to treat high blood pressure)
    - Codeine (pain killer)
    - Gabapentin (to treat seizures and nerve pain)
    - Paracetamol (pain killer that also thins the blood)
    - Quinine sulphate (to treat nocturnal leg cramps in the elderly)
    - Carbocisteine (to treat COPD)
    - Ibratropium bromide inhaler (to treat COPD)
    - Salbutamol inhaler (to treat asthma)
    - Mirtazapine (antidepressant mental health medication)
    - Procyclidine (to help coordination and mobility)
    - Sulpiride (antipsychotic mental health medication)
    - Ranitidine (to treat ulcers)
    - Omeprazole (to treat acid reflux and stomach ulcers)

65. On 19 December, a nurse spoke to the man about a possible move to a prison which was properly equipped to care for elderly prisoners. He appeared keen and they agreed that he might move within the next six months.

66. On 21 December, a governor completed an SIR. The prisoner carer had been applying ointment to the man and using medical scissors to change his dressings. He had also been looking after and dispensing his medication. She thought that he was exceeding his role and responsibilities. The governor wrote to him the same day, instructing him that he would be given medical gloves to apply ointment, but could not use the medical scissors and was not allowed to dispense medication. She recorded that he socialised only with the man.

2012

67. On 4 January 2012, an SIR recorded that the man had tried to buy gabapentin from another prisoner. On 10 January, a doctor prescribed furosemide (a drug used to treat excessive fluid and swelling) for the slight oedema in his leg. He remained very short of breath.

68. The psychiatrist reviewed him on 12 January. The doctor thought that he looked very poorly. He was brought to the appointment in his wheelchair. He was struggling with his breathing and getting panicky. The psychiatrist thought that he really needed to be in a prison with a wing dedicated to older prisoners. While the psychiatrist did not think he was being bullied, he did think that he was vulnerable. The Head of Healthcare told the investigator that she was not made aware of the psychiatrist's assessment at the time.

69. The offender supervisor submitted another SIR on 17 January. She wrote that the man was feeling vulnerable to his prisoner carer. Another prisoner had told her that he no longer wanted that prisoner to be his carer but was frightened of how he would react. One of the mental health nurses had also told her that he had informed her that he no longer wished that prisoner to be his carer. She recorded that the prisoner was sleeping during the day, effectively leaving him 'housebound', and neglecting his duties, such as washing, shaving and feeding him. (It should be noted that none of these were among the agreed duties listed in the prisoner carer agreement.) She recommended that healthcare staff review his care plan.

70. The following day, 18 January, a governor advised staff that secondary dispensing of medication was inappropriate. The same day, the Disability Liaison Officer spoke to the man to discuss the concerns that his offender supervisor had raised and submitted an SIR. She wrote that he was denying previous allegations and told her that the prisoner was a very good carer. However, he seemed very nervous and agitated. She recorded her concern that the prisoner was collecting medication for him from the dispensary.

71. She questioned whether secondary dispensing (by which she appears to have meant the prisoner collecting the man's medication and giving it to him) was appropriate. She told the investigator that she had not been aware of this arrangement until then, even though it had been in place with the agreement of healthcare staff since the previous May. She told the investigator that she became concerned whether he was actually receiving his medication. She

recorded that she, the governor and healthcare staff would hold a meeting to discuss the prisoner's suitability as a prisoner carer. She wrote in an email to the governor:

> 'I got the impression that the man was a bit worried that someone will tell the prisoner that I have been to see him and will ask him why! I explained that we have a duty of care and need to check on him every few months to see if everything is okay… I assured him that if he felt anyway unhappy with the prisoner at anytime he is to ask the wing staff to call me…'

72. The governor recorded that the man's health was declining. She noted that the staff were all concerned about the prisoner's role as his prisoner carer, and that they were gathering evidence.

73. On 23 January, the Head of Healthcare spoke to the man and he acknowledged that he was dying. He agreed to move to a prison with 24 hour healthcare. She was concerned about the suitability of The Verne and emailed the governor to say that she supported a transfer. She also arranged for a doctor to assess his healthcare requirements.

74. The following day, 24 January, a doctor saw him and confirmed that there was a clinical need for him to move to a prison with 24 hour healthcare with access to a built-in oxygen supply, because of his COPD and heart failure. The doctor thought that such a move would improve his quality of life and added his support for the proposed transfer.

75. The next day, 25 January, the governor chaired a multi-disciplinary meeting about the man's circumstances. The Head of Healthcare, a doctor, the Disability Liaison Officer and a number of other colleagues attended. All present favoured a move to a prison with 24 hour healthcare. The following entry was made in the clinical record:

> 'Meeting to discuss the growing concerns about the man's health and his management. This meeting was discussed and arranged last week, however since then there have been further concerns about his deteriorating health…
>
> 'The gov called a meeting to discuss the way we go forward in getting him a 24 hour bed, and transfer him out as soon as possible to prevent further deterioration.
>
> 'The doctor is happy to contact the doctor at HMP Winchester to see if a transfer would be possible to their 24 hour healthcare. A phone call will be made today to see if this is possible and to ascertain if this can be done within the week.
>
> 'The gov is going to speak with the number one Gov regarding this situation to see if it is possible to speed up the transfer and to gauge a response from HMP Winchester…'

76. The doctor told the meeting that the man might have about three months left to live. After the meeting, he telephoned staff at Winchester. A transfer was agreed in principle for the following Monday or Tuesday. The deputy lead nurse, the governor and a mental healthcare support worker then visited him and told him that he would be moving to a prison with 24 hour healthcare because the facilities available at The Verne were no longer adequate, especially at night. During this meeting, he became distressed and told the governor to leave his cell. She did not want to upset him further so she left. Once she had done so, the other two staff heard him say to his prisoner carer, 'I told her what you wanted me to say.' He also asked whether the prisoner could transfer with him.

77. On the evening of 29 January, the man's health rapidly deteriorated. He had trouble breathing and officers consulted the out-of-hours telephone service. He was taken by ambulance to the A&E department at hospital. He was diagnosed with pneumonia and worsening COPD.

78. On 31 January, Winchester withdrew their offer of a transfer. The number one Governor spoke to the management team at Winchester. Although a bed was available for him and 24 hour nursing cover was in place, Winchester decided that an additional prisoner with end of life needs would place too much pressure on their nursing staff, so they refused to accept him.

79. The Head of Healthcare visited him in hospital on 31 January. He wanted to discharge himself and return to the prison, and was refusing treatment. She tried to persuade him that hospital was the best place for him and he should not discharge himself as he was not well enough to be looked after at The Verne anymore.

80. On 1 February, the chaplain at The Verne informed the man's named next of kin by telephone that he was very ill in hospital.

81. The man refused further treatment, discharged himself from hospital and returned to The Verne on 2 February. The chaplain updated his next of kin by telephone. He was now weak, immobile and incontinent but initially returned to his old cell on B2, an upstairs landing.

82. Between 2 and 8 February, the nursing staff focussed their efforts on keeping him comfortable. They washed and dressed him and settled him in bed for the night before finishing their shifts. As a result of this extra focus on him, some regular clinics had to be cancelled. There were still no nursing staff on the premises overnight. Nonetheless, the Head of Healthcare organised increased nursing care during the day, additional carers to help him during the night and a special pressure mattress. He required a great deal of nursing but was still not so ill as to justify a move back to hospital.

83. After Winchester refused to accept the man, staff at The Verne continued to seek a transfer for him. The number one Governor made a number of telephone calls to other prisons to try to expedite a move. By 6 February, the

Head of Healthcare and the Governor were in touch with staff at HMP Bristol. However, Bristol would not accept him unless he underwent a social care needs assessment. They did not think that he had a medical need which justified a transfer. They also questioned who would commission and pay for his care. Ultimately, Bristol refused to accept him.

84. Staff at The Verne considered releasing him on temporary licence to a hospice. They began this process, but no decision had been made before he died. He had repeatedly indicated that he did not want to be released from prison. He did not have a release address or any family who could care for him. He acknowledged that he would die in prison and had previously abandoned the parole process. As he had not been diagnosed with a terminal illness, hospice provision at that stage would have been unlikely.

85. On 6 February, a governor visited him on B wing and became seriously concerned about the decline in his health and the influence which the prisoner carer now had over him. She fully realised for the first time the extent of his immobility. She found a notice that the prisoner had pinned to the door indicating that only he was allowed to enter the cell. The governor told the investigator that she could not understand why wing staff had allowed him to put up the notice. By now, she wanted to move the man to D wing, as a matter of urgency for his own protection and safety. He asked for the prisoner to move with him to D wing, but his request was refused.

86. The governor arranged for him to move to a ground floor room on D wing the same day. The room on D wing had been out of use, but staff prepared it for him. The rest of D wing consists of shared dormitories, but he had a room to himself.

87. The same day, the prison cluster lead manager at DHUFT and the Head of Healthcare's manager discussed a possible transfer with the deputy governor to nearby HMP Dorchester. Although the healthcare team at Dorchester had an available bed in their constant supervision cell and were able to accept the man on a temporary basis, the deputy governor refused on the grounds that it was not a medical transfer and he did not require a healthcare bed because he only had social care needs. The deputy governor told her that staff at The Verne would have to resolve the problem.

88. Although the number one Governor also telephoned Dorchester, they refused to accept the man because of the level of extra care being delivered by nursing staff at The Verne. They did not feel that they could offer the same amount of clinical care. The lead manager accepted that Dorchester could not offer a noticeably better standard of care.

89. On 7 February, the man's new carer on D wing withdrew his help. He also woke up the other prisoners by repeatedly pressing his cell bell, which sounded down the corridor in the shared dormitories. After he moved to D wing, a governor told the investigator that the extent of his health problems became apparent. She realised that he was having to be taken to the toilet.

Up until then, to some extent she believed the prisoner carer had been able to conceal his deterioration from staff.

90. On 8 February, the lead manager, two governors and the number one Governor met to discuss the man. The lead manager and the number one Governor had both been in touch with HMP Exeter, who agreed to accept him in principle if he underwent a social care needs assessment. A governor told the investigator that she became exasperated during the meeting because the lead manager told her that he had social care needs rather than medical needs. The governor thought that he needed to move prisons on health grounds. She recalled that the lead manager stated that prison managers would need to organise a transfer, because she could not justify a move on medical grounds. Her manager (the other governor) recalled that the lead manager suggested that all concerned wait and see how he progressed in the next couple of weeks.

91. She told the investigator that she insisted that he could no longer remain at The Verne. Her manager supported her demand. She and her manager explained to the investigator that the lead manager then visited the man on D wing and witnessed the extent of his frailty and immobility. She then spoke to the doctor for advice, asking him what he would do for a similar patient in the community. The doctor suggested that he could admit him to the local hospital as an interim measure whilst other plans were made.

92. A nurse, the Head of Healthcare, the lead manager and the governor went to speak to the man on D wing. They explained that they were trying to secure a move to another prison with 24 hour healthcare. He was unhappy to be told again that he had to leave The Verne but he was informed that it was inappropriate for him to stay because of the lack of 24 hour nursing. The Disability Liaison Officer spoke to him and he begged her not to let him be moved from The Verne.

93. The lead manager and a doctor arranged for him to be taken to a nearby hospital. The doctor admitted him for the social care needs assessment that Exeter had asked for before his proposed prison transfer. The intention was for him to remain at the hospital for a week or two until a move to Exeter could be arranged. He would not be returning to The Verne. A social worker was due to complete an assessment to determine his future social care needs the following day.

94. The lead manager notified the Governors of The Verne, Exeter and Dorchester of his move to hospital. She spoke to staff at Exeter and thought that this prison was probably now the best option for him. She also contacted the commissioner at DHUFT to discuss the financial implications if he were to move to a prison outside the Dorset area.

95. The man transferred to hospital at 2.35pm on 8 February. It was a five minute journey from the prison. He was accompanied by one escort officer initially. To begin with, he was handcuffed to the officer using an escort chain. (An escort chain is a length of chain with handcuffs at both ends which allows the

prisoner to be treated without the officer obstructing treatment.) However, by 4.00pm the duty governor had given permission for the escort chain to be removed. At 5.45pm, on the instructions of the number one Governor, a second escort officer was sent to sit with him at the hospital. The chaplain visited him at 7.00pm.

96. The man died at hospital soon after. He had been laughing and chatting with the staff very shortly before and then seemed to suddenly fall asleep. Two officers and the Head of Healthcare were with him when he died peacefully. An officer from the care team visited the hospital to check on the welfare of her colleagues.

97. After staff at The Verne broke the news of the man's death to the other prisoners, a SO spoke individually to the prisoner carer and three other men who were particularly close to him, to check their welfare and offer support. The staff also reviewed prisoners subject to ACCT monitoring.

98. As the man's next of kin lived in south Wales, a chaplain from HMP Swansea broke the news of his death and the chaplain from The Verne spoke to them later by telephone. The Governor wrote to them and suggested a visit to The Verne to see where he had lived. The funeral, which the prison paid for, was held on 22 February in Weymouth.

ISSUES

Clinical care

99. The man had extreme chronic obstructive pulmonary disease (COPD) which caused his heart to fail. In his clinical review, the clinical reviewer comments:

> 'The man's health was poor from the day he arrived at The Verne and his history from then shows the chronic inexorable decline typical of those whose smoking damages their lungs. Exacerbations were promptly treated and he was sent to hospital when it became necessary.
>
> 'His schizophrenia was regularly and properly monitored and treatment adjusted.
>
> 'The quality of care and commitment to doing their best for him by the Health Care team at The Verne seems to have been of the highest order and their colleagues at the prison seem to have done their best to help him as well, often beyond the call of duty, carrying him upstairs, undressing him etc. The offer by the governor to take him herself to Winchester was not only practical but kind.
>
> 'Quite clearly The Verne is not an appropriate place for a chronically ill man to spend his last days. There is no Healthcare of any sort… between 1700 & 0800h i.e. most of the time. The care that is provided is equivalent to that of a GP surgery.
>
> 'Given the circumstances the care he was given was good but the environment and the facilities were inappropriate, putting unreasonable demands and responsibilities on custodial staff whose only source of medical help is the [out of hours] service. In all the [out of hours] service was asked to visit him 16 times.
>
> 'Why there was not more planning involved by very senior management - by which I mean at Area level and above - about this man's care is difficult to understand when governor grades were aware of his problems at least nine months before he died.
>
> 'And why the governor in Dorchester declined to accept him when his own healthcare department was ready to is disappointing: the issue appears to be whether someone who only needs oxygen intermittently has Health or Social problems, despite the fact there is no oxygen supply in The Verne. As I understand it a prisoner may be transferred on Health grounds but not on Social ones and despite being expected to die shortly his needs were deemed to be Social.
>
> 'So Dorset Social Services were contacted and asked to assess him, which seems a bizarre and inappropriate use of resources at this stage, particularly as they made it clear they could only assess, not be

in a position to offer Social care in prison. To what use was the assessment to be put? Whether or not they did visit him in Portland Hospital I do not know as I do not have the records after he left The Verne.

'Eventually it seems to have been decided that the local "cottage hospital" was a better place for him than a cell in The Verne. He was transferred there and died the next day.

'There seems to be a lack of clarity of thought here: if it was possible to use the hospital on 8 February why was it not considered and used earlier?

'The core issue is that The Verne was not an appropriate place for him to be but nowhere else was prepared to take him. When I first started writing these reports 5-6 years ago they were chiefly about young men who had killed themselves. More recently the emphasis has shifted to elderly men on true life sentences who are dying from natural causes often with complex medical problems, such as his. There are some specialised units nationally catering for their needs but clearly not enough in this area.

'When the PCT took on responsibility for Health Provision in the county's prisons I remember it being publicly stated that "we want prisoners to have the same level of care as everyone else, but they are not at home". That aspiration, in my opinion, was not achieved for him.

'Only at a very late stage in the scrabble to find a place for him was higher management in the PCT involved in the negotiations and there is an argument that says it should have been earlier: local efforts to find a way through the bureaucracy were failing.

'Senior managers should ensure they are available to shoulder the burden when such events arise and have fully apprised themselves of the situation. It appears it was only when she had met him did one realise how grave his situation was.'

100. We address some of the issues which the clinical reviewer raises in the sections which follow.

Pharmacy

101. In April 2011, healthcare staff were unable to dispense all of the man's medication on one occasion. We gather from the Head of Healthcare that the service offered at the time by the pharmacy provider was subsequently deemed unsatisfactory and that their contract was not renewed. We are satisfied that a new provider is in place and that there was no subsequent evidence of the man missing his medication.

Admission to and discharge from hospital

102. In October 2011, the man was admitted to hospital overnight after staff became concerned about him. The next morning, none of the healthcare staff who arrived for work were informed about his admission. The Head of Healthcare acknowledged during interview that this is an area of internal communication which requires improvement. We make the following recommendation:

The Governor should ensure that all out of hours admissions to hospital are promptly communicated to healthcare staff.

103. In May 2011 and February 2012, the man discharged himself from hospital despite the Head of Healthcare raising strong objections. All interviewees agreed that he should not have come back to The Verne on the latter occasion because he was too unwell. Nonetheless, the clinical reviewer and we think that the nursing staff made every effort to care for him during his last few days, in spite of the inadequate facilities available. They went beyond their usual duties and were clearly fond of him.

104. Staff at The Verne told the investigator that they were not consulted about whether they could cope with the man's needs before he was discharged from hospital on 2 February. We understand that Dorset Healthcare University NHS Foundation Trust (DHUFT, responsible for providing healthcare in the prison) and Dorset County Hospital NHS Foundation Trust are currently holding some discussions about the manner in which prisoners are discharged back to The Verne from hospital. We make the following recommendation:

The Governor and Head of Healthcare should agree a protocol with the Dorset Healthcare University NHS Foundation Trust and Dorset County Hospital NHS Foundation Trust, to improve discharge arrangements for prisoners returning to The Verne from hospital.

Out of hours medical response

105. In October 2011, the man became unwell after the nursing staff had gone home at 5.00pm. However, when officers telephoned the out of hours service at 6.20pm, they were told that the service did not assume responsibility until 6.30pm. This was clearly unsatisfactory. We understand from the Head of Healthcare that DHUFT investigated the incident and staff at the out-of-hours service were found to be at fault. She confirmed during interview that the out-of-hours service is contracted to begin at 5.00pm as soon as the nursing staff leave the premises. We are satisfied that this matter was investigated and that the transition to the out-of-hours service is intended to be seamless.

Do not resuscitate (DNR) form

106. As his health deteriorated in 2011, the man refused further outpatient appointments and disengaged from the parole process. He accepted that he would die in prison. In May 2011, he signed a DNR form, which was supposed to be kept on the wing in case paramedics attended overnight. However, by December this form had been lost. Although this was unfortunate, healthcare staff then prepared a folder containing a new copy of the DNR form and a list of his clinical diagnoses and medications. A copy was placed on the wing and in the gate. We and the clinical reviewer consider the placement of this document in accessible locations to be an example of good practice which sensibly anticipated the likelihood of overnight emergencies.

Prisoner carer scheme

107. A prisoner became the man's prisoner carer for about nine months. Before this, he had got to know him as his neighbour on the wing and had been caring for him on an informal basis. It was the man who suggested him as his carer. Healthcare staff, security staff, wing staff and the prisoner's offender supervisor then assessed his suitability to be a carer and approved his appointment.

108. Prisoner carers are paid £10.50 per week. The carer scheme is managed by prison rather than healthcare staff. Prisoner carers are supposed to escort the disabled prisoner to healthcare appointments, clean their cell, collect their meals and provide company. They are not supposed to perform tasks such as applying ointment, dressing wounds or administering medication. These tasks should be reserved for the trained nursing staff.

109. The prisoner began his work as a paid prisoner carer for the man on 9 May 2011. He was subject to the usual vetting process. Staff from the Offender Management Unit (OMU) approved his appointment but recommended that the situation be monitored. The Disability Liaison Officer oversees the vetting of prisoner carers with oversight from her manager and, in turn, her manager. The managing manager confirmed during interview that there is no formal procedure in place to monitor the scheme after a carer is appointed.

110. Different members of staff all raised concerns about the prisoner's suitability as a carer in July and October 2011 and January 2012. The offender supervisor told the investigator that she attended a public protection meeting in the prison at which she (as the man's offender supervisor) and the prisoner's offender supervisor agreed that it would be inappropriate for him to be a prisoner carer. She then contacted the Disability Liaison Officer and the governor in October. She had concerns because she considered him to be manipulative. At the same time, she had noticed that the man, formerly very demanding and vocal, was becoming meek and compliant.

111. It was decided in October that the prisoner would carry on in his role as a carer. The governor told the investigator that he was not removed from his

role because there was still no clear evidence that he had done anything inappropriate. The offender supervisor told the investigator that she accepted this decision on the basis that his role would be monitored. There is no evidence of any subsequent monitoring.

112. She raised her concerns again in January when she noticed the man's health declining rapidly. She thought that the combination of the prisoner's increasingly controlling behaviour and his advancing frailty was inadvisable. She observed that the prisoner seemed to enjoy his dependence on him. A number of staff commented that he would push him everywhere and seemed to encourage him to become dependent on his wheelchair. However, she also noted that the prisoner had been 'neglecting his duties' by not washing, shaving and feeding the man.

113. These intimate tasks are not listed among the responsibilities of carers, suggesting that the staff were themselves unaware of the boundaries of the carer role. We think that they abrogated some of their responsibilities to the prisoner, yet were blaming him for not fulfilling them. He had been expected to apply cream to the man's feet. He was also administering ointment to sores on his leg which healthcare staff accepted should not have happened. The governor told the investigator that she was shocked by the condition of the man's cell when she visited it in on 6 February, which does not suggest sufficient managerial oversight of the situation.

114. Staff told the investigator that the prisoner continued to cross boundaries in his role as a carer despite being warned. He seems to have been allowed to assume a level of (self-appointed) authority. For instance, he put an inappropriate notice on the man's door which the governor removed as soon as she saw it. She told the investigator that she became seriously concerned about the man's safety at this point and moved him away from the prisoner as a matter of urgency, but that was at a very late stage.

115. This matter provoked a lot of discussion during interviews with staff. The managing manager told the investigator that the man had spoken to him in the chapel a few weeks before he died. He had said that the prisoner was a good carer and that he wanted to stay at The Verne until he died. The manager thought that he was speaking honestly at the time.

116. Most interviewees agreed that the prisoner initially provided him with a good level of care. However, at some stage near the end of his life, all are agreed that this caring role crossed appropriate boundaries and that, in the end, he was vulnerable to abuse, and was intimidated by, and dependent on, the prisoner.

117. We accept that whenever doubts were raised about the prisoner's suitability, the man would deny any problems and insist that he did not want anybody else looking after him. But there appears to have been a lack of vigilance and if the staff's suspicions were true, there was a failure to protect a vulnerable adult. Although staff thought that the two men should have been separated at an earlier stage, no effective steps were taken to ensure this happened.

118. The governor commented that the carer scheme is a work in progress. She accepted that there is little formalised oversight of or training for prisoner carers. The managing manager expressed his hope during interview that the prisoner's eventual inappropriate behaviour would not detract from the earlier good work that he had done with the man. He thought that staff had allowed the prisoner to expand his role, and to assume too much control over him. He agreed that this had happened gradually because the prisoner was filling the vacuum left by the absence of nursing staff after 5.00pm.

119. There seems to have been a breakdown in communication between the disability and equalities team and the healthcare staff regarding the extent of the prisoner's responsibilities. Since May 2011, the healthcare team had allowed him to collect some of the man's medication for him, with his consent, if he was too unwell to collect it himself. The Disability Liaison Officer told the investigator that she did not find out about this arrangement until January 2012 when she spoke to the man. She suspected that the prisoner might have been keeping hold of the man's medication in his cell. The governor also identified this issue in December 2011, but no action appears to have been taken, as she recorded further concerns a month later, in the middle of January. The Head of Healthcare agreed during interview that her department and the disability and equalities team need to communicate more effectively in future about the extent of carers' responsibilities.

120. We consider that the prisoner carer scheme requires more precise boundaries and improved monitoring. Carers should be trained for their role and should not be expected to fulfil the responsibilities of healthcare or residential staff. We make the following recommendations:

The Governor and the Head of Healthcare should ensure that where prisoner carers are used, they are appropriately selected as part of a formal carers' scheme and trained, supervised and equipped for personal social care.

The Governor and the Head of Healthcare should ensure that staff do not rely on prisoners to manage another prisoner's needs identified as the responsibility of healthcare staff.

Chronic illness

121. Although the man was the most chronically unwell prisoner at The Verne, his care and location do not seem to have been regularly discussed at a forum for prison and healthcare staff. He had a care plan but there were no formalised reviews (multidisciplinary or otherwise) of his deteriorating health. Regular reviews might have sooner alerted healthcare staff to the need for a transfer and they in turn could have asked prison managers to engineer a move.

122. The Head of Healthcare confirmed that there are currently six other chronically ill men being held at The Verne, so the need for regular multi-disciplinary meetings remains. All of the staff the investigator spoke to agreed

that, in future, prison managers and healthcare staff need to regularly communicate about chronically ill prisoners who may require a transfer from The Verne. We make the following recommendation:

The Governor and the Head of Healthcare should hold a monthly meeting to review chronically ill prisoners and their care arrangements.

Location

123. The man made it clear to staff and other prisoners at The Verne that he did not want to move. One of the reasons he stayed on B2 landing for so long appears to have been because he simply refused to move and staff acceded to his wishes. It was understandable that he did not want to move to another prison. Nonetheless, the circumstances of his death suggest that managers need to achieve a better balance in future between the wishes of a chronically ill prisoner and the needs of other prisoners and staff. The desire to respect his wishes seems inadvertently to have overridden an objective assessment of his needs.

124. Night staff regularly had to call on the out-of-hours telephone service and in the end healthcare staff also took on a role well beyond their own remit. While the wishes of a prisoner coming towards the end of his or her life are important, in the end the prison had a duty to respond to his clinical needs and should have taken steps to move him to an appropriate facility sooner than they did. To a large extent, the problem appears to be something of a national one because of a lack of suitable facilities.

125. Facilities for prisoners at The Verne with mobility difficulties are poor. Until the last few days of his life, he continued to live in cell 10 on B2 landing. There are two flights of stairs to reach the cell. The accommodation he moved to on D wing on 6 February was the only available ground floor accommodation and far from ideal, consisting mostly of dormitories. An out of use area was found for him so that he could have some privacy, but this disturbed other prisoners. One landing, C2 landing, can be reached by a stair lift, but he resisted a move there.

126. Both B2 and D wing were not suitable for the man. An evacuation in an emergency from an upper landing would have been very difficult. None of the staff we interviewed were able to explain how he was allowed to return to B2 when he returned from hospital on 2 February, when it was evidently unsuitable. There were disagreements about who was responsible. It was not until the governor returned to work on 6 February that she found he had returned from hospital, and immediately moved him to D wing. She appeared to blame healthcare staff for this, but we think that the allocation of prisoners in The Verne must be the responsibility of prison managers.

127. The Verne lacks any suitable ground floor accommodation for prisoners like the man. Any substantial alterations to the buildings would be costly but not impossible. There are large, mostly empty, rooms on the ground floors currently used for prisoner recreation which might be converted into a suite for

disabled prisoners. Alternatively, we note from the most recent IMB report that the King's Fund recently offered to contribute towards an Elderly Prisoners' Unit but that this matter was never satisfactorily resolved. We make the following recommendation:

The Governor should ensure that prisoners with chronic illnesses and mobility difficulties at The Verne are housed in appropriate accommodation with facilities to meet their needs.

Proposed transfer to a prison with 24 hour healthcare

128. Almost everyone the investigator interviewed agreed that the man should have moved to another prison weeks before he died. Because the decision to move him was only taken in late January, time was against the staff when they encountered resistance from other prisons. Had they not swiftly organised the move to hospital on 8 February, he would have died on D wing.

129. The clinical reviewer and we agree that The Verne was an unsuitable environment for the man in the last weeks of his life because it lacks 24 hour healthcare. Although concerns about his chronic health problems and his location were noted in the clinical record, these do not seem to have been communicated well to prison managers at an earlier stage. He should have transferred before his needs became acute, something which could have been arranged with better advance planning. Prison mangers seem not to have grasped how ill and immobile he was

130. There is no national strategy in place or centralised help at NOMS headquarters to assist prison managers find a suitable place when a chronically ill prisoner needs to be moved. The number one Governor explained that such transfers were arranged by individual negotiation between healthcare staff and governors. Once it was finally accepted that The Verne was no longer suitable, the prison was faced with the intransigence of prisons in the vicinity with 24 hour health care. Winchester, Bristol, Dorchester and Exeter were all reluctant to accept such a sick man.

131. The governor thought that the prisons who declined to accept the man on the grounds that he only had social care needs were simply looking for a convenient excuse to refuse him. The clinical reviewer writes in his review that the insistence on a social care needs assessment was 'bizarre' and 'inappropriate'. We agree that this was an unnecessary requirement which would have served little purpose. Too many barriers were placed in the way of quickly obtaining a suitable place for him.

132. Just as there appeared to be a lack of clarity about responsibility for his location in the prison, prison managers and healthcare staff could not agree about who was ultimately responsible for the transfer of a sick prisoner. While healthcare staff said that it was appropriate that they should liaise with their counterparts at other prisons, they did not believe that it was their responsibility to find a place for him in another prison and arrange a transfer.

The Head of Healthcare said that she considered it was up to healthcare staff to propose a move and for prison managers to facilitate it.

133. Ultimately it is the responsibility of prison managers to arrange a move, because only they have the authority to arrange a transfer. However, they clearly depend on healthcare managers to advise them of the clinical need. We are surprised that prison managers at The Verne did not involve the deputy director of custody, responsible for oversight of the prisons in the area, to help arrange a suitable move. This case shows that responsibility for moving a sick prisoner needs to be more clearly defined. We make the following recommendation:

The Governor and the Head of Healthcare should, in conjunction with regional management, ensure there is a clearly defined procedure for arranging transfers of prisoners whose health care needs can no longer be met at The Verne.

134. We think it highly regrettable that a dying man was left in inappropriate circumstances at The Verne until the very last minute while those in a position to help him tried to avoid doing so. The clinical reviewer finds that the care the man received was not comparable to that which he would have received in the community. We think that he is right. We are very concerned that staff at other prisons in the south west did not offer adequate support to their colleagues at The Verne during a critical period.

135. However, we also think that this case provides evidence of a problem which needs tackling at a national level. There is no 24 hour healthcare provision in category C prisons like The Verne. The only available option which provides a chronically ill patient like the man with round the clock care is to move them to a more secure category B prison like Exeter, as only these prisons have the necessary inpatient facilities and nursing cover.

136. He was reluctant to move to the inpatient healthcare centre in a large local prison. This was understandable, as these units often hold a significant number of severely mentally ill patients waiting transfer to psychiatric care. The population is transient in local prisons and it seems unsatisfactory and inappropriate to penalise a dying man by moving him to a more secure environment. While the transfer was necessary to offer him the care he needed, we do not think that this kind of environment is an appropriate place for a dying man to end his life. We make the following recommendation:

The Chief Executive Officer of the National Offender Management Service should ensure that there are sufficient appropriate facilities in Category C prisons for chronically ill prisoners and those at the end of their lives.

Restraints

137. The man was restrained by an escort chain when he was taken to hospital on 8 February. The number one Governor explained to the investigator that he

discussed the need for restraints with his managers before he was taken to the hospital. He thought that the use of the escort chain was reasonable and appropriate until staff had had an opportunity to conduct a thorough risk assessment of the building. The Governor explained that prisoners are not normally taken to hospital, so his staff were unfamiliar with any potential risks. He told the investigator that he always planned to authorise the removal of the chain and, indeed, did so very shortly after staff had arrived with him.

138. A nurse completed the section of the escort risk assessment which asks if there are any medical objections to the use of restraints. She wrote: 'He is extremely frail and unable to mobilise'. In light of this information, the likelihood of him escaping or causing anybody harm seems negligible.

139. He was completely immobile by the time he was admitted to the hospital. Although he was a convicted murderer, his offence was committed over 30 years previously and it is hard to imagine what possible risk he presented to anybody by 8 February. We consider that the presence of an escort officer during the journey to hospital would have been sufficient to manage the risk. We make the following recommendation:

The Governor should ensure that escort risk assessments fully take into account the medical condition of the prisoner and are based on the actual risk he represents at that time.

CONCLUSION

140. The man had been in prison for over three decades. He was an institutionalised prisoner who had no interest in release. He signed a 'Do not resuscitate' form and decided that he did not want to attend any further outpatient appointments. He told staff and prisoners alike that he wanted to die in prison. His health declined gradually over a number of years, and deteriorated more rapidly in 2011. He resisted a transfer to a different prison, and also declined a move to a more suitable wing at The Verne.

141. The investigation has highlighted two particularly significant failings in his care. Firstly, the lack of oversight of the prisoner-carer scheme. Secondly, he should have been moved to a prison with 24 hour healthcare before his health problems became acute. This did not happen and staff encountered resistance from other prisons.

142. There were also breakdowns in communication. Our interviews demonstrated that healthcare and prison managers require clarification about their areas of responsibility. They could not agree about who should initiate or organise the relocation or transfer of a prisoner. As a result, decisions about his care were not taken quickly enough.

RECOMMENDATIONS

For the Governor of The Verne:

1. The Governor should ensure that all out of hours admissions to hospital are promptly communicated to healthcare staff.

   The Governor accepted the recommendation and provided the following response:

   'A Staff Information Notice has been issued reminding all staff (particularly Senior Officers, which includes the Night Orderly Officer) that the prison healthcare team must be informed of all out of hours hospital admissions at the earliest opportunity.'

2. The Governor should ensure that prisoners with chronic illnesses and mobility difficulties at The Verne are housed in appropriate accommodation with facilities to meet their needs.

   The Governor accepted the recommendation and provided the following response:

   'A regular meeting (at least monthly) is now being held between the Head of Custody, the Head of Residence and the Primary Care Trust Practice Manager to discuss the specific requirements of prisoners with chronic illnesses and / or mobility issues.

   'At this meeting, the suitability and extent of care provision and the resultant appropriateness of their current location is discussed.'

3. The Governor should ensure that escort risk assessments fully take into account the medical condition of the prisoner and are based on the actual risk he represents at that time.

   The Governor accepted the recommendation and provided the following response:

   'It is felt that this risk is appropriately assessed already, however, it is felt prudent to err on the side of caution in light of previous incidents. These decisions are always made by E grade managers and above.'

For the Governor and the Head of Healthcare at The Verne:

4. The Governor and Head of Healthcare should agree a protocol with the Dorset Healthcare University NHS Foundation Trust and Dorset County Hospital NHS Foundation Trust to improve discharge arrangements for prisoners returning to The Verne from hospital.

The Governor and the Head of Healthcare accepted the recommendation and provided the following response:

'The work is under way. Clinical treatment of these men is relatively straightforward, however, social care and particularly its funding is proving more complex.'

5. The Governor and the Head of Healthcare should ensure that where prisoner carers are used, they are appropriately selected as part of a formal carers' scheme and trained, supervised and equipped for personal social care.

The Governor and the Head of Healthcare accepted the recommendation and provided the following response:

'The Equalities Manager and Disability Liaison Officer will revise the policy on prisoner carers to ensure appropriate procedures regarding selection and training are in place. The use of prisoner carers will remain suspended until a satisfactory protocol is written and accepted by the Senior Management Team.'

6. The Governor and the Head of Healthcare should ensure that staff do not rely on prisoners to manage another prisoner's needs identified as the responsibility of healthcare staff.

The Governor and the Head of Healthcare accepted the recommendation and provided the following response:

'The prisoner carers scheme will only require prisoners to assist others with tasks such as pushing wheelchairs, escorting prisoners to and from healthcare and collecting meals. Prisoner carers will not be expected to carry out any personal procedures that would be identified as the responsibility of healthcare staff.'

7. The Governor and the Head of Healthcare should hold a monthly meeting to review chronically ill prisoners and their care arrangements.

The Governor and the Head of Healthcare accepted the recommendation and provided the following response:

'A regular meeting (at least monthly) is now being held between the Head of Custody, the Head of Residence and the PCT Practice Manager to discuss the specific requirements of prisoners with chronic illnesses and / or mobility issues.

'At this meeting, the suitability and extent of care provision and the resultant appropriateness of their current location is discussed.'

8. The Governor and the Head of Healthcare should, in conjunction with regional management, ensure there is a clearly defined procedure for arranging

transfers of prisoners whose health care needs can no longer be met at The Verne.

The Governor and the Head of Healthcare accepted the recommendation and provided the following response:

'This work is underway across Dorset, with a view to expand the model across the whole of the South West region.'

For the Chief Executive Officer of the National Offender Management Service:

9. The Chief Executive Officer of the National Offender Management Service should ensure that there are sufficient appropriate facilities in Category C prisons for chronically ill prisoners and those at the end of their lives.

The Offender Safety Rights and Responsibilities Group were unable to provide the Ombudsman with a response to this recommendation from the National Offender Management Service.

Good practice

We consider that the placement of a folder containing the man's 'Do not resuscitate' form and a list of his clinical diagnoses and medications on the wing and in the gate was an example of good practice. This ensured that wing staff and hospital staff were fully aware of his wishes about resuscitation.