Investigation into the death of a man on 6 September 2006 at a nursing home whilst in the custody of HMP Moorland

Report by the Prisons and Probation Ombudsman for England and Wales

August 2007

This is an investigation into the circumstances surrounding the death of a man who died at a nursing home whilst a serving prisoner at HMP Moorland. The man had been diagnosed with Motor Neurone Disease whilst a prisoner at HMP Moorland. He spent the last month of his life in a nursing home and died as a result of his illness. The man was 59 years old when he died.

I extend my condolences to his family and to all those touched by his death.

The investigation was undertaken by one of my colleagues. Both my colleague and I would like to extend our thanks to the Governor of Moorland, and to her staff, for their cooperation during the investigation. Particular thanks go to the appointed prison liaison officer and to Healthcare Manager, for gathering all relevant documentation and ensuring it was made available in a timely way.

I would also like to extend my thanks to the clinical reviewer from the Doncaster Primary Care Trust for undertaking a review into the clinical care the man received.

The man's condition was undiagnosed when he was transferred to Moorland from HMP Lindholme. It is clear that the decision to transfer him to a prison with 24 hour inpatient facilities was a timely one, but I am in no doubt that providing round the clock care for him was a draining and stressful experience for staff. Motor Neurone Disease (MND) is a relatively rare condition that affects middle aged men slightly more than women. It is a devastating, fatal condition that causes muscle wastage in the limbs, face and throat and can lead to severe problems with speech, chewing and swallowing. MND is difficult to diagnose and the rate of progression of the disease varies from patient to patient. The provision of appropriate care and support for patients with MND is a challenge to any healthcare facility, let alone a prison healthcare environment.

Despite these challenges, my investigator found that healthcare staff provided excellent care for the man, and it is a pleasure to commend the doctors and nurses for their dedication in supporting him for a considerable length of time. I also commend the healthcare team for the speed with which they obtained and shared information about the disease and how to manage his condition effectively.

Careful consideration was given to releasing the man under Home Detention Curfew conditions and then on compassionate grounds but neither proved successful. He was eventually released on temporary licence and transferred to a nursing home where he died.

I make one recommendation and highlight three areas of good practice in a report that generally reflects very well upon HMP Moorland and the Prison Service.

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

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SUMMARY

The man was convicted of robbery at Leeds Crown Court in 2004. He was sentenced to three years and 11 months in prison.

He began his sentence at HMP Leeds before being transferred to HMP Lindholme where he began to experience difficulty walking unaided, and developed symptoms of slurred speech. The prison doctor felt that Lindholme could no longer provide a safe environment for him and referred him to Moorland. Lindholme is next door to Moorland and part of a 'cluster' of three prisons in the area. It transfers all prisoners with inpatient needs to Moorland.

When the man arrived in reception at Moorland in December 2005, he was weak. The prison doctor examined him and referred him straight to Doncaster Royal Infirmary (DRI) for further investigation**.** He stayed in two hospitals over Christmas and New Year, and was diagnosed with Motor Neurone Disease after he was seen by a specialist at the Royal Hallamshire Hospital in early January 2006. The man was returned to Moorland some time towards the end of January and went straight to the healthcare centre on reception.

He never saw the main prison and did not experience any standard regime throughout his stay at Moorland. Despite this separation from the general prison population, healthcare staff made every effort to enable the man to participate in some form of association and education. He was located in a gated cell, close to the staff office and his environment was made as homely as possible. The cell next to his was reserved as storage space for the equipment he needed. The man befriended another prisoner who was an inpatient at the same time, and they became chess partners when he was well enough to play.

Between February and August 2006, the man's health deteriorated on an almost daily basis. Healthcare staff supervised him around the clock and liaised with external agencies and organisations to bring in medical aids, mobility equipment and specialist knowledge. His independence was maintained until he could no longer care for himself in any capacity. Extra healthcare staff were brought in, and all staff caring for him attended an awareness raising presentation and further training in how to manage Motor Neurone Disease more effectively.

Moorland's healthcare manager and his team also endeavoured to release the man from custody and into the care of a nursing home in his local area as soon as possible. In March, a Senior Health Care Officer (SHCO), with support from her manager, first looked into the prospect of assessing him for release. This became a lengthy process and the prison experienced a number of difficulties over the coming months whilst a suitable placement was found.

The man spent approximately seven months at Moorland. His time was split between the healthcare centre and local hospitals. He deteriorated rapidly. In August 2006, he was released on temporary licence to his home area and a bed was secured at a nursing home that provided 24 hour care. He stayed at the nursing home for approximately one month.

On 6 September, he was due for release on conditional licence. His release papers were hand delivered to him for his signature later that same day by a SHCO. He signed his papers and was due for release at midnight that evening.

Sadly, the man died at 6.55pm that day.

THE INVESTIGATION PROCESS

1. The investigation was opened on 10 September 2006. My investigator began by requesting all relevant prison records relating to the man. These included his medical and core records covering the time he spent in prison.

2. Notices to staff and prisoners were supplied and displayed around the prison. These invited anybody with information to talk to my investigator. In this instance, nobody came forward. My investigator examined the records and recorded significant events before visiting the prison. Using the evidence gathered from the man's records, my investigator identified a number of key healthcare staff and interviewed them in November 2006.

3. A clinical reviewer from Doncaster Primary Care Trust (PCT) was invited to undertake a review of the clinical care the man received while in custody. The review is included as an annex to this report.

4. The Coroner was informed of the Ombudsman's investigation. The post mortem report concluded the cause of death as:

   1a Aspiration Pneumonia
   2b Motor Neurone Disease

   The Coroner will receive a copy of this report when it is completed to assist him with his enquiries.

5. The man's next of kin was contacted by one of my Family Liaison Officers to ask whether she or other members of the family had any comments or concerns about his death. His family raised no concerns and commended the prison for the way everything had been handled. The family will receive a copy of my report.

HMP MOORLAND

6. HMP Moorland, near Doncaster, is an adult and young offender (YO) category C training prison. The numbers held break down into approximately 314 YOs and 451 adults. It has an operational capacity of 791. Moorland is a complicated prison that sits on two sites, one establishment for prisoners in open conditions and one for closed. The closed prison accepts a potentially challenging population including escape list prisoners, serious offenders and some life sentence prisoners.

7. The closed site has five houseblocks and, as a training prison, operates a regime of programmes designed to address offending behaviour, to enhance thinking and to prepare prisoners for employment on release. Moorland forms part of a 'cluster' of three prisons and is the only establishment in the cluster with 24 hour inpatient care. Prisoners in need of an inpatient facility from nearby HMP Lindholme and Moorland (Open) can be transferred into the closed site's healthcare centre to receive the appropriate care.

8. Moorland (Closed) was last inspected by Her Majesty's Chief Inspector of Prisons (HMCIP), in December 2005. A report published in May 2006 recorded that Moorland was a relatively safe prison, purposeful and able to deliver a resettlement orientated regime. HMCIP found some areas of prison life in need of improvement, most notably healthcare provision.

9. The healthcare centre (HCC) is a two-storey building with the lower floor dedicated to inpatient care. The inpatient facility consists of 18 beds, two gated cells and one safer cell equipped with CCTV. It has a well placed staff office or 'bubble', large association rooms currently under refurbishment, shower facilities, and access to additional medical equipment through the local Primary Care Trust (PCT).

10. The inspection of the inpatient facility found a slight shortage in staffing levels. The healthcare manager, a Registered Mental Nurse (RMN), is also a Principal Officer (PO) and as such is detailed to carry out orderly officer duties across the prison. There are two other dual-qualified members of staff who carry out both nursing and senior officer (HCSO) duties. Inspectors commented that whilst prisoners with chronic conditions were well managed, the regime for patients was limited and staff struggled to cope with additional inpatients from the other two sites. Agency staff were often used in times of shortage, but were well inducted. The report recommended that the healthcare manager should be removed from orderly officer duties, but at the time of my investigation he still held dual responsibilities.

11. Her Majesty's Chief Inspector of Prisons emphasised the challenges Moorland's population presented to staff. In her summary, she wrote:

> "It is to the credit of the Governor and her team that this inspection found that the prison was, overall, performing satisfactorily".

KEY FINDINGS

12. On 25 October 2005, the man was transferred from HMP Lindholme to HMP Moorland. Whilst at Lindholme, he had presented with symptoms of slow speech and had begun to stumble. On arrival at Moorland, he bypassed the usual reception process and went straight to the healthcare centre (HCC). He was assessed on arrival and it was noted that he suffered from arthritis in his spine, hips, knees and ankles, and was reliant on crutches for mobility. He had certain food allergies and was allergic to penicillin. This was also recorded at his First Healthcare Screening.

13. The man stayed at Moorland for two weeks before being discharged back to Lindholme on 8 November. He was seen in reception on arrival and placed on the doctor's list to be seen for a prescription. An entry in his medical record noted that his speech was slurred and unclear at times, but that he was fit for education. The prison doctor did not see him. He was seen by healthcare again, prescribed aspirin and, escorted back to his wing and placed in a single cell.

14. On 8 December, a nurse was called to the wing to see the man and found him physically tired and "in tears" according to his medical record. The nurse assured him that she would push for a permanent transfer to Moorland. The doctor reviewed his suitability for a move and agreed that he needed to be in an establishment that provided 24-hour healthcare.

15. Moorland accepted the transfer, and on 14 December the man found himself back in reception at the prison. The doctor saw him in the afternoon and noticed a weakness on the left side of his body. The doctor also recorded history of a stroke, slurred speech and weaknesses in his facial muscles. Following the examination, he was immediately transferred from Moorland to Doncaster Royal Infirmary (DRI) for further investigation.

16. The man stayed in hospital over Christmas and the New Year. On 15 December, he underwent a computerised tomography (CT) scan of his brain, and was transferred to a ward the following day. The CT scan results were normal, and on 28 December he was transferred to the Royal Hallamshire Hospital (RHH) to undergo tests for Motor Neurone Disease (MND). His speech and mobility remained limited and on 30 December, he was placed under the care of an MND specialist at the hospital. After a second opinion confirmed his diagnosis, the man was moved to another ward and the hospital prepared for his discharge into the care of the prison. The specialist prescribed Rilutek and Clexane and arranged for them to be delivered to Moorland. As the man was still technically in the custody of Lindholme, he was released on temporary licence under the authorisation of their deputy governor. His licence extended until 27 January and clearly stated that no restraints should be used for the duration of his time in hospital.

17. The man left hospital and arrived at Moorland between 21 and 27 January 2006. (It is not clear from his medical records exactly when he was returned to Moorland.) A post dated Discharge Summary letter dated 19 April 2006 from

the consultant neurologist at Sheffield Hospital suggested that he was discharged from RHH on 23 January, having been diagnosed with an atypical form of MND. The Escort Risk Assessment form, dated 21 January, stated that he was returning to Moorland having been on temporary licence for a number of weeks. He was escorted by one officer shortly after, without the use of restraints.

18. A SHCO told my investigator that healthcare staff generally get one or two days' notice to prepare for the admission of a patient with substantial healthcare needs. The officer stressed, "we just have to do what we can to get ready for their admission."

19. On 27 January, a member of the healthcare team contacted the Sister on the hospital ward to chase up the man's medication. It is not clear from the medical records whom this member of staff was. The Sister explained that, due to restrictions on the availability of the drugs, delivery could take several weeks but the hospital would post them to the prison as soon as possible. The MND specialist would arrange a follow-up appointment to review the man's condition in six weeks time.

20. On 29 January, the man pressed his cell bell. When the nurse responded, he explained that he had fallen from his wheelchair whilst getting ready for bed. The nurse noticed that he had sustained small lacerations to his head, examined him for further injuries, and decided no further treatment was necessary. He was then helped into bed by two members of the healthcare team and was checked again at 2.00am on the morning of 30 January. An entry in his medical record stated that he was "ok" and had suffered no ill effects. The nurse completed the relevant documentation and an F213 form (which is used to record injuries to prisoners).

21. The following day, an MND specialist nurse at the RHH, contacted healthcare about the man's medication order. The SHCO took the telephone call and was told that the specific drugs prescribed by the MND specialist required funding. The MND nurse explained that this had caused a delay and she would contact healthcare as soon as it became available.

22. Approximately two weeks after the man was discharged from hospital, healthcare staff at Moorland began enquiries about his release from custody and into either his own home with community support or the care of a nursing home.

23. On 9 February, another SHCO contacted the man's physiotherapist to discuss discharge arrangements. The officer explained that, in order for the man to be released, he would need the right circumstances: namely, a wheelchair adapted three bedroom house with support from his local social services department. The officer asked whether the physiotherapist could contact Manchester Social Services. The physiotherapist agreed and said he would ring healthcare back the following day.

24. On 10 February, the same SHCO contacted the MND nurse who confirmed that she would visit healthcare on 24 February to deliver a presentation on MND, its progression and management of the condition. The nurse also confirmed that she would liaise with her equivalent in Manchester to prepare the area for the man's release.

25. The man fell again on 16 February. He told a nurse that he had stumbled in the shower and that it was an accident. The nurse recorded his fall in the medical record. No F213 injury form was found in his records.

26. Over the next week, healthcare staff contacted the Red Cross to arrange for the loan of hoist equipment to assist with the man's mobility. A SHCO also liaised with the Occupational Therapy department at DRI and arranged for a wheelchair, cushion and bed assessment. The department also confirmed that they would arrange delivery of specially adapted cutlery to help him maintain his independence at mealtimes. The MND nurse delivered a short awareness training session for the healthcare team.

27. The man's speech therapist reviewed his condition on 28 February. The speech therapist noticed a decline in his ability to swallow and, following a discussion with him, referred him to the hospital for an endoscopy to fit a 'PEG' feed. The speech therapist told healthcare staff that the man would have to be placed on a 'Stage II' diet. This meant that all food would have to be mashed and thickened before he could consume it safely. Healthcare staff were also told to be vigilant at mealtimes as the deterioration in his swallowing had increased his risk of choking. An entry in his medical record suggested an open door policy at mealtimes.

28. On 1 March, the occupational therapist (OT) visited the HCC and delivered hoist training to staff. A SHCO told my investigator that she had previous experience of PEG feeds, the use of hoist equipment and moving and handling training. The officer shared her knowledge with staff less experienced than her and delivered on the job training until the OT arrived.

29. The same SHCO contacted Doncaster Social Services to chase up plans for the man's release into community care. A Social Worker at Doncaster, returned her call and explained that the man's Probation Officer would be contacted in due course to discuss what needed to be done to ensure continuity of care for him on his release back to his home area of Manchester. The social worker added that he was concerned about the lack of MND awareness among healthcare staff at Moorland, and the care required to ensure the man's safety in a prison environment. The SHCO reassured him that staff were fully aware of the risk of choking and took every precaution necessary to ensure the man's safety. The social worker was also reassured that, whilst knowledge of the condition was limited, staff knew their responsibilities and were being trained to use the hoist equipment to move the man safely.

30. Moorland's Head of Healthcare was informed by nursing staff that the man's needs had increased and that they were unable to cope, particularly at night,

with a skeleton staff of one qualified nurse. The Head of Healthcare was also aware that the man's condition had increased his risk of choking and he would need medical intervention day and night. He told my investigator that he explored the possibility of securing extra nursing cover and introducing a 24 hour open door policy with the head of operations and the deputy governor.

31. The Head of Healthcare then held a series of meetings with his management team to look at how they could best manage the situation. He secured authorisation and funding for an extra healthcare assistant and was given permission to operate an open door policy. A SHCO completed a full risk assessment and safer system of work assessment, and circulated this throughout the whole prison.

32. The Head of Healthcare confirmed that the man's open door policy would commence on 1 March. An entry in his healthcare log stated that, in order to comply with the risk and security assessments, staff were to remove his wheelchair from the cell at 8.00pm and carry out roll checks during the week and at weekends.

33. A letter dated 1 March from the speech therapist to healthcare confirmed that the man would need to be referred to DRI's Endoscopy Deptarment as soon as possible. The letter also told staff that his Stage II diet could be continued for a short time after the PEG feed procedure to aid the transition from oral to non-oral feeding. The speech therapist also provided staff with guidelines to safeguard against the man choking on his food and asked for him to be supervised at mealtimes. In addition to his change in diet, the therapist arranged for a Light writer, a specifically designed typewriter, to be issued to on a trial basis with a view to long term loan. This would enable the man to clearly communicate with staff and prisoners in the healthcare centre.

34. The following day, the healthcare centre received confirmation that his medication would be delivered on a four weekly basis. A SHCO took responsibility for delivery and signing for the prescription on his behalf. This was approximately five weeks after he was discharged from hospital.

35. On 6 March, the same SHCO received a telephone call from DRI's wheelchair suppliers asking if the man remained in custody and where he was likely to go on release. The officer told the suppliers that he would probably return to the Manchester area. The officer then updated his Probation Officer and confirmed that the man had agreed to nursing home care. The Probation Officer told her that the house he originally wanted to go to, owned by his named next of kin, had been assessed and was unsuitable for his healthcare needs. His next of kin had also stressed that she would not be able to care fully for him.

36. A SHCO noted in the man's medical record that the feasibility of applying for early release on compassionate grounds was also discussed, and a meeting between healthcare staff and one of Moorland's governors would be scheduled in order to reach a decision.

37. On 15 March, the man was taken to the RHH. He arrived by ambulance in his wheelchair, escorted by two uniformed officers. The escort risk assessment stated that without a wheelchair he was unable to walk, but that "Cuffs can still be applied." The assessment also said that he was not an escape risk or a risk to the public, and that the strength of escort required was due to him being held in closed conditions. The deputy governor authorised the use of restraint and gave the following reason for the decision:

"Given [his] lack of mobility, the restraint to be used should be an escort chain. To be used at all times, excepting Duty Governor's permission."

38. The Prisoner Escort Record (PER) form for this journey does not mention the use of restraints, and it is not clear what type of restraint, if any, was used. The man saw the MND specialist who took blood samples and confirmed that she would send a letter to include the results. His PER form said that he arrived back at Moorland at 5.00pm.

39. The man continued to deteriorate throughout March and a SHCO made several attempts to check the progress made in releasing him from prison and finding a suitable community placement. On the morning of 22 March, the officer contacted Doncaster Social Services Department with the following questions:

How long before [he] is assessed?
Will he be assessed for a placement in the Doncaster or Manchester area?
When is he likely to be given a nursing home place?

40. Later that afternoon, a member of staff from Doncaster Social Services returned the SHCO's telephone call to arrange an assessment. The Speech Therapist then entered a new plan into his records. The therapist noted that the Motor Neurone Disease Association (MNDA) would loan the man a keyboard and he would be able to take it home with him. The therapist further recorded that he would arrange for a shower chair, a leg splint and a different wheelchair with wider wheels to be delivered to help maintain his independence. The therapist arranged to review him again once his PEG feed had been fitted.

41. On 30 March, the man was sedated and fitted with his PEG feed during a surgical procedure. He was released on temporary licence, arrived at DRI at 10.00am, and was returned to Moorland at 11.15am. His escort risk assessment indicated that he was accompanied by two escort officers and restrained using an escort chain. The decision to use restraints was authorised by the head of operations. My investigator could not read the signature on the documentation and it is not clear whether restraints were used.

42. Throughout April, the man's condition was monitored, his mealtimes supervised and equipment ordered to make him as comfortable as possible. A dietician from DRI visited healthcare to deliver PEG feed training and the speech therapist carried out a review of his diet. A SHCO contacted Social

Services again to chase up his assessment for a nursing home place. The SHCO also contacted Greater Manchester Probation Area and was informed that the man was not eligible for Home Detention Curfew, as he was technically of no fixed abode.

43. On 11 April, the same SHCO explored the possibility of transferring the man to HMP Manchester as an interim measure, whilst he waited for assessment and a suitable placement in the area. The officer sought agreement from the prison doctor at Moorland, and Greater Manchester Probation Area. The doctor liaised with the healthcare manager at HMP Manchester, but was told that it would not be possible to transfer him because he was a Category C prisoner and Manchester was part of the high security estate.

44. On the same day, the Head of Healthcare sent a memo to security, the prison gate and the orderly officer informing staff that extra nursing cover for the man was in place. The memo clearly stated the names of the agency nurses to commence night duty and that cover would continue for the foreseeable future.

45. On 2 May, an MND nurse, contacted one of the SHCO's and discussed the man's release. The SHCO explained that the man had not yet been assessed and had no address to go to. The MND nurse said that she was happy with the care he was receiving at Moorland, but remained frustrated that he was still in custody. She and the MND specialist were happy to write in support of his release application.

46. On 6 June, the deputy governor authorised an escort risk assessment and agreed to release the man on temporary licence (ROTL) to attend a hospital appointment at the RHH. The risk assessment stated that he would be escorted by one officer, but that restraints would not be used. The ROTL allowed him temporary release from 7.00am until 6.00pm on 7 June.

47. On 7 June, healthcare staff prepared him for his appointment at the RHH with the specialist. However, the ambulance, booked on 5 June, failed to arrive at the prison gate and the man missed his appointment. The escort officer due to accompany him recorded this on his PER form. The following day, a SHCO spoke to the specialist's secretary who explained that the ambulance had gone to the man's old home address by mistake. The officer made further enquiries and discovered that the ambulance service had used an old file for information, despite being told by healthcare staff that he was in custody when the ambulance was booked. Attempts were then made to bring a new appointment forward, and two days later, the specialist's secretary confirmed a new appointment had been made for 5 July. On of the nurses in healthcare booked an ambulance and escort, and recorded the information.

48. The man saw the prison doctor as part of his morning rounds on 14 June. The doctor noted a further deterioration in his condition and referred him to DRI for admission. The man presented as anxious and lethargic. He was reassured by a nurse before being placed in his wheelchair and transferred by ambulance to DRI. The doctor wrote a referral letter for the man to take to the

hospital. His escort risk assessment indicated that he was to be accompanied by one officer, without the use of restraints. He was to be released on temporary licence until 21 June.

49. Whilst in hospital, the man was given a 'Continuous Care and Nursing Home Assessment' by members of Doncaster PCT and DRI's Outreach Team. A SHCO made an entry in his medical record following the assessment. It said that the care team would organise a placement in the Manchester area, but that funding would need to be secured before he could be transferred. The transfer would take between four to six weeks.

50. The man remained in hospital for approximately six days. It is not clear from his medical record when he was discharged back to Moorland.

51. On 30 June, the Neurological Outreach Team sent a letter updating staff on how to care for him following another review of his condition. The letter was thorough and provided healthcare staff with new information about his diet, mobility, and safe movement and handling of him using the hoist and sling. The letter confirmed that he was no longer able to use the wheelchair on his own and found it increasingly uncomfortable to sit in. The Outreach Team scheduled a reassessment of his wheelchair needs for 18 July.

52. The man was released on temporary licence three times throughout July. On 5 July, a SHCO noticed that his chest was 'rattly' and asked the prison doctor to see him. The doctor noted that the man was very tired. Later that day, he was released on temporary licence for 24 hours to DRI. He was accompanied by a letter from the doctor, a medication list and a member of the healthcare team. He went back to DRI and was fitted with a new PEG feed on 8 July.

53. On 11 July, the man attended his rescheduled appointment with the MND specialist and returned to Moorland at 5.30pm the same day. On 24 July, he was seen by the doctor because he had been vomiting. The doctor noted that he had presented as very unwell over the past few days and again referred him to DRI. The man was seen by the hospital doctor at 6.00pm and was told he would remain in hospital overnight. In fact, he stayed in hospital until 26 July on a temporary licence.

54. On 28 July, a member of the healthcare staff received a telephone call from Manchester Social Services confirming that a suitable placement had been found him at a nursing home.

55. On 31 July, a SHCO arranged for an ambulance to take him from Moorland to the nursing home on Saturday 5 August. The man's release on temporary licence was arranged. The ambulance was booked for 3.00pm and the cost of the journey was authorised by the Governing Governor. The officer made an extensive entry in his medical record. It said:

"Healthcare staff will escort him for a full handover. [He] will be ROTL'ed until his release date in September. Healthcare staff at Moorland are to make weekly contact with the nursing home. Compassionate release may be

discussed soon but due to the short length of time until release on licence, this may not be necessary."

56. On 5 August, the man was told he would be leaving Moorland for the nursing home. His care plan noted that he was tearful when told the news. A SHCO told my investigator that she knew he would be upset and took the decision to delay informing him of the move for as long as possible. Healthcare staff prepared him for the long journey and contacted Occupational Therapy to find out what equipment he could take with him and what had to be returned. The SHCO came in on her rest day and travelled to Manchester with him. He settled into his room, and the officer handed the man's medication and care plan over before returning home.

57. Between 5 August and 6 September, healthcare staff made regular contact with the nursing home manager and recorded updates on his condition in his medical record. A SHCO told my investigator that communication with the nursing home was difficult at times and that they had a responsibility for keeping a record of the man's condition as he was still technically in custody.

58. On 21 August, he was sent to Manchester Royal Infirmary where he was admitted for treatment. The same SHCO visited him there to renew his temporary licence. This took him up to the date of his conditional release.

59. At 12.15pm on 6 September, the SHCO and a health care assistant went to the nursing home with the man's conditional release papers. He signed the relevant parts which would release him from custody at midnight. The two members of staff said goodbye to him and returned to Moorland.

60. At 6.55pm, the manager of the nursing home telephoned Moorland's HCC and told a member of staff that the man had passed away. The SHCO was told of his death when she returned.

61. The SHCO informed the orderly officer of the man's death and contingency plans were activated. The duty governor notified the relevant agencies and Moorland personnel, but had difficulty contacting his next of kin at an early stage. The governor telephoned both the nursing home and the police before obtaining contact details. He rang the man's wife late that evening to break the sad news.

62. The family liaison officer for Moorland remained in touch with the man's next of kin and liaised with Manchester Social Services with regard to funeral costs. The Social Services Department offered both to arrange and fund Ian's funeral with the permission of his family. The nursing home ensured that his belongings were returned.

63. The man's funeral took place in Manchester on 26 September. Floral tributes were sent from Moorland.

ISSUES

64. The man was a prisoner with significant physical healthcare needs. It is comparatively rare for prison staff to encounter this level of chronic illness or be asked to offer the level of care he needed. He was already displaying mild symptoms of muscle wastage when he arrived at Moorland. He went from experiencing slight stumbling and slurred speech to almost total immobility in a relatively short space of time. For healthcare staff, this was the first time they had nursed a patient with Motor Neurone Disease in a prison environment.

65. I have no doubt that healthcare staff who came into contact with him did everything they could, within their means, to make his life more comfortable. Nursing staff took steps to maintain his independence for as long as possible. The open door policy, secured early in his illness, enabled him to spend time out of his cell, engage with staff easily and participate in a limited regime as his health allowed.

66. It is also clear that the difficulties encountered were not just focused on providing the high level of care the man needed whilst in a custodial environment. Healthcare staff evidently felt frustrated at the length of time it took external agencies to assess him for a suitable placement, and showed determination and patience in securing his release back to his home area.

67. That said, although there would have been no effect on the ultimate outcome for the man, the investigation has highlighted a number of areas where practice could be improved.

Healthcare Records

68. Healthcare staff at Moorland showed great determination and commitment in caring for the man during the last months of his life. It is clear from his medical record that nurses overcame difficulties quickly to ensure he was made as comfortable as possible, and followed the neurological care plan meticulously. What is not always clear from the record is who his primary carers were for the duration of his stay in the healthcare centre, and exactly when he was transferred to outside hospitals and returned. The man's medical records were generally well maintained but occasionally difficult to read, incorrectly initialled and signed, and below the expected professional standards.

The Healthcare Manager should remind staff that, in accordance with the Nursing and Midwifery Council's guidelines for records and record keeping, all medical records should be legible, up to date and in chronological order. In addition, audits of the quality and consistency of records should be undertaken in partnership with the PCT.

Housekeeping points

69. As the only inpatient facility for the cluster of three prisons, healthcare staff at Moorland are obliged to receive chronically ill patients, often at short notice. The healthcare team are then required to adapt to change quickly, and in this case they did so efficiently. The man was a patient at Moorland for longer than he should have been, and healthcare staff coped admirably with a demanding and terminally ill man, in addition to their daily nursing duties. Staff knew how to access the support offered by the prison's care team, but stressed to my investigator that, on reflection, they would have benefited from receiving acknowledgement that they were under strain and recognition that they were managing the circumstances well. Staff made it clear that it would also have been useful to have had more time set apart for reflecting on the care they provided for him. Again, I make no recommendation, but draw the attention of the Governor and PCT to this issue.

Use of Restraints

70. The man experienced short and long term stays in hospital on numerous occasions and was also a regular out-patient. He was released on temporary licence for every outside hospital admission and appointment whilst in both Lindholme and Moorland's care. Whilst it is clear that senior staff implemented the relevant Prison Service Order (PSO 2300), Release on Temporary Licence, effectively and efficiently, I have not been able to ascertain whether restraints were used to escort him to hospital on 15 and 30 March 2006. His PER form makes no mention that an escort chain was utilised on these dates. It is apparent that, for every journey both before and after these dates, the relevant documentation said that no restraints were required. This includes the lengthy stay he had in hospital whilst in the custody of Lindholme between December 2005 and January 2006. The man was increasingly dependent on his wheelchair for mobility and, by March 2006, his medical record documents the deterioration in his condition and his ability to walk. It would be surprising to learn that Ian was, in fact, restrained for these two journeys, and I must assume that the documents reveal an inconsistency in record keeping and risk assessment. I draw this point to the Governor's attention, but make no formal recommendation.

CLINICAL REVIEW

71. Doncaster PCT carried out the clinical review of the care afforded to the man. The clinical reviewer concluded:

> "It is clear that the care and management of the man posed prison health staff enormous challenges. Diagnosis of MND is difficult as presenting symptoms are often vague and uncertain. The fact that he was in custody does not seem to have delayed either his diagnosis nor commencement of treatment.
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> "His problems before diagnosis would seem to have been appropriately managed although there did seem to have been some initial confusion when he was transferred between HMP Lindholme and HMP Moorland. As his emerging problems required more active treatment and monitoring by the prison healthcare team, and he started to struggle to cope in normal prison accommodation, possibly more decisive action could have been taken and would have resulted in greater continuity and less uncertainty for him.
>
> "As the man's mobility and speech problems deteriorated it would appear he was referred and investigated entirely appropriately … although it may now seem that his initial problems were indicative of the onset of MND it is unreasonable to suggest any criticism at the speed with which it was diagnosed. Indeed the Medical Director at Doncaster Royal Infirmary commented having reviewed the man's medical record that his MND was untypical, therefore was not surprised that his symptoms may have made diagnosis difficult however he wasn't concerned that there had in fact been any delay.
>
> "From the point at which he was diagnosed as having MND, all members of the immediate prison healthcare team are to be congratulated at the professionalism with which they cared for him. This must have presented a very steep learning curve and from interviews with the members of the Neuro Outreach Team and MND Specialist Nurse they were extremely pleased with the manner in which the prison health team responded and were satisfied that he was cared for correctly.
>
> "A decision had been taken at an early stage in 2005 to explore the possibility of releasing the man under licence for him to be nursed in a more appropriate environment. Determining responsibility for assessment and funding however created great difficulty. Between March and July it would seem there was an unacceptable delay in undertaking an assessment and facilitating his placement. Accepting the fact that the circumstances were most unusual the ensuing delay in taking responsibility was inadequate, the frustration of those involved is clear from interviews and entries in his IMR".
>
> "The role of the local Social Services Department in Doncaster, the Probation Services in Manchester, Social Services in Manchester and

Manchester Central Primary Care Trust were at times blurred, poor communication compounding problems. In the final analysis responsibility for undertaking and funding the placement of a prisoner requiring placement and continuing care is shared between the Primary Care Trust and Social Services where the prisoner lives. This was however further complicated by the fact that the Primary Care Trust in which his General Practitioner was located is different to the one in whose geographical patch he lived. It was decided therefore by the Continuing Care manager at Manchester Central PCT to fund the man's placement and the issue of co-funding with Social Services could be negotiated when he had been released. The issue of which agency takes the lead and who facilitates placement and negotiation of funding needs to be expedited so as to reduce any possible delay.

"Motor Neurone Disease is a devastating illness, in any circumstances. It is difficult to imagine how awful it must be trying to come to terms with and cope with the distressing and debilitating features of this disease. Caring for and supporting a patient with MND would be extremely challenging for any Primary Care team, for a Prison Healthcare team this must have seemed especially daunting. Once again I believe all those involved both within and outside prison are to be commended for the way in which they attempted to care for the man. It is striking from interviews with prison health staff the close bond that developed with him and is corroborated with outreach teams working in the prison.

"Collaborative working with all the relevant agencies was absolutely vital to the outcome of the quality of care for him. I am satisfied that the various agencies involved with the man worked in a spirit of partnership and cooperation. The Medical Director at Doncaster Royal Infirmary specifically commented that the hospital have a good relationship with all the prisons in Doncaster including HMP Moorland and as such was satisfied with the way in which the prison interfaced with the hospital.

"It may be helpful for all concerned to have the opportunity to reflect on the events around the man's care and undertake an analysis of how his care was managed. There is an expectation that Primary Care teams will routinely undertake Significant Event Analysis of the care of patients dying at home to highlight good practice and explore any lessons to be learned. Given the challenges faced in caring for him, this would seem to offer a useful opportunity to review and reflect, enabling staff to explore in a non-judgemental way what happened and provide some closure.

72. The clinical reviewer has identified six areas for learning and I urge the prison health partnership to consider his findings and develop an action plan to address these in a timely manner.

The prison health partnership should develop a SMART action plan to address the identified learning from the clinical review.

GOOD PRACTICE

73. Throughout the man's stay in healthcare, his day to day management was overseen by one of two SHCO's. The SHCO who became his primary carer, managed his transfer to the nursing home, and forfeited one of her rest days to escort him and settle him into his new home. The SHCO demonstrated an acute awareness of the importance of providing continuity of care and should be commended for her actions.

The SHCO should be commended for her personal commitment and compassion in caring for the man.

74. The Head of Healthcare and his staff, should be commended for securing both a 24 hour open door policy and additional night duty cover to increase the levels of care for the man. This was achieved efficiently and effectively and struck the right balance between security for the prison and quality of life for Ian.

The Head of Healthcare and the healthcare team should be commended for their sensitive and compassionate management of the man and his clinical needs.

75. The senior management team's use of PSO 2300 Release on Temporary Licence (ROTL) was implemented efficiently and effectively for each of the man's stays in an outside hospital. Licences took into account the rare and debilitating nature of his condition and were always renewed in a timely way. I congratulate the Governor and her management team for the speed in which ROTL was considered and authorised.

RECOMMENDATIONS

1. The Healthcare Manager should remind staff that, in accordance with the Nursing and Midwifery Council's guidelines for records and record keeping, all medical records should be legible, up to date and in chronological order. In addition, audits of the quality and consistency of records should be undertaken in partnership with the PCT.

   The Prison Service accepted the recommendation and said the following:

   "An instruction to all Healthcare staff will be issued. A check sheet system will be implemented for Healthcare managers to regularly check quality and content of all medical records. The PCT Clinical Governance team will be consulted to identify ways in which they can assist in improving and maintaining standards in record keeping".

2. The prison health partnership should develop a SMART action plan to address the identified learning from the clinical review.

   The Prison Service accepted the recommendation and said the following:

   " An action plan will be implemented which has been developed with input from the commissioning PCT".

3. The SHCO should be commended for her personal commitment and compassion in caring for the man.

   The Prison Service accepted the recommendation and said the following:

   "A Commendation will be given by the Prison Service Area Manager. The PCT will also issue a letter of thanks".

4. The Head of Healthcare and the healthcare team should be commended for their sensitive and compassionate management of the man and his clinical needs.

   "A Commendation will be given by the Governing Governor of HMP Moorland. The PCT will also issue a letter of thanks".