Investigation into the death of a man in March 2011 at HMP & YOI Holme House

Report by the Prisons and Probation Ombudsman for England and Wales

November 2011

This is the report of an investigation into the death of a man, a prisoner at HMP Holme House. The man died in a cell in the healthcare centre. The cause of death was found to be liver disease caused by chronic alcoholism. I offer my sincere sympathy and condolences to his mother and to all who have been affected by his loss.

The investigation was carried out by one of my investigators. A review of the man's clinical care in custody was carried out by the clinical reviewer on behalf of North Tees Primary Care Trust. I am most grateful for her assistance.

I would like to thank the Governor and staff of Holme House for their co-operation during the course of the investigation.

This is a very sad case of a young man who chose to die in prison rather than accept the hospital admission and treatment that he required to prolong his life. Whilst staff made numerous attempts to help him to overcome his apparent fear of medical intervention, his wishes were respected and end of life care was planned accordingly. I conclude that he received a high standard of care at Holme House and highlight as good practice the time that his mother was able to spend with him in the prison in the last days of his life. I make two recommendations; firstly regarding blood tests for prisoners whose liver function is suspected to be poor, and, secondly, the recall of previous prison medical records on reception to prison custody.

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 **November 2011**

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SUMMARY

1. The man who died was a young man who had drunk alcohol in large quantities for a number of years. He was diagnosed with alcohol related liver disease and experienced several complications in relation to this condition, including internal bleeding in his stomach and gastrointestinal tract. The man had an apparent phobia of hospitals and medical treatment, particularly needles, and would often refuse investigations into his condition. However, he spent three weeks in hospital in November 2008 whilst a prisoner at HMP Haverigg. During this time he was very unwell. He was treated with blood transfusions and had a surgical procedure to reduce the future risk of internal bleeding.

2. On 19 January 2011, the man was recalled to custody. He was initially sent to HMP Durham, where he told healthcare staff that he was on the waiting list for a liver transplant. There is no evidence to suggest that this was the case. The man refused to have a blood test to check his liver function, on account of his phobia of needles. After almost two weeks at Durham, he moved to HMP Holme House on 31 January.

3. The man was admitted to hospital on 23 February, after collapsing on the floor of his cell. During an overnight stay, he received a blood transfusion on account of internal bleeding in his stomach. The man was admitted to hospital for a second time, for a period of around two weeks, on 28 February. He spent much of this time in the Intensive Treatment Unit and received several blood transfusions due to internal bleeding. The man discharged himself on 12 March, against medical advice. His condition was now very serious and he was warned by hospital doctors that he might die if he did not remain and complete his treatment. He later told prison healthcare staff that he was more scared of the procedures that he needed than he was of dying. The man was assessed at hospital where it was determined that he understood the seriousness of his condition and the potential consequences of refusing treatment.

4. Over the following week, the man agreed to return to hospital on four occasions. Each time he discharged himself without completing the recommended treatment, sometimes within just an hour or two of his arrival. During this time, staff at Holme House made numerous attempts to persuade him of the need to remain in hospital and accept treatment. However, he came to the decision that he would rather remain in prison. As a result of this decision and the seriousness of his condition, it was determined that end of life care should be planned. A consultant in palliative medicine subsequently visited him at Holme House and gave staff advice on how best to care for him in the last days of his life.

5. A family liaison officer was appointed, who had daily contact with the man's mother in the last 12 days of his life. The man's mother was able to visit him in Holme House and spent around ten hours a day with him in his room in the healthcare centre. The man continued to deteriorate and died.

6. It is apparent that staff at Holme House made great efforts to persuade the man to accept the treatment he required. His capacity to refuse treatment was

assessed both formally and informally and it was determined that he was fully aware of the consequences and likely outcome of his refusal. His wishes were therefore respected and plans were made for the end of his life. I conclude that staff at the prison did all they could for the man in very difficult circumstances. My report makes two recommendations, with regards to carrying out liver function tests and the recall of previous prison medical records. I also highlight as good practice the liaison with the man's mother and, in particular, the considerable amount of time she was able to spend with her son in healthcare in the last days of his life.

THE INVESTIGATION PROCESS

7. The investigation was opened on 1 April 2011, when one of my investigators issued notices announcing the investigation to staff and prisoners. These notices included an invitation to those who wished to submit information relating to the man's death to make themselves known to the investigator. No one came forward as a result.

8. The investigator visited Holme House on 4 April. During the visit he met the Governor and a representative of the local Independent Monitoring Board (IMB, a body of local people who independently monitor and report on the conditions within the prison). The investigator also met a prison doctor and a healthcare assistant who had spent a lot of time with the man. He also spoke to a prisoner who knew the man. My investigator visited the healthcare inpatient unit and saw the cell in which the man had lived. He was provided with copies of the man's prison records. The investigator contacted HMP Haverigg and obtained the man's medical record from his previous time in custody.

9. A clinical review of the man's clinical care in custody was undertaken by the clinical reviewer on behalf of North Tees Primary Care Trust. I am grateful for her assistance in this matter.

10. The Ombudsman's senior family liaison officer telephoned the man's mother on 20 April. She explained the purpose of the investigation and provided the opportunity for the man's mother to raise any concerns about her son's care whilst at Holme House. She explained she had been treated well by staff at Holme House and that she thought they had done the "best job they could". I hope this report clarifies any issues that might remain unclear for the man's family and provides an understanding of what happened in the time leading to his death.

11. My investigation assesses the following aspects of the man's care and treatment:

    - Whether his diagnosis was made in a timely fashion
    - Whether the man was told about his condition and the treatment which followed
    - Whether he was treated properly and attended hospital appointments as necessary
    - Whether the liaison with the man's family was appropriate
    - Whether the man was accommodated in the most appropriate part of the prison
    - Whether consideration was given to compassionate release from prison
    - Whether appropriate palliative care was provided

12. The man's mother received a copy of the draft report as part of the consultation process. I am grateful for the time she has taken to consider the report and for the feedback provided. The additional questions that the man's mother has asked have been addressed outside of this report in separate correspondence.

HMP & YOI HOLME HOUSE

13. Holme House is a category B prison which opened in May 1992. (Category B prisoners are those for whom the very highest conditions of security are not necessary, but for whom escape must be made very difficult.) It has a capacity of 1,211, most of whom are adult males (there is a small population of unsentenced young offenders).

14. Health services are commissioned by County Durham NHS Primary Care Trust and provided by North Tees and Hartlepool NHS Foundation Trust. There is an inpatient unit with room for 28 prisoners in a mix of single and double cells. In the last weeks of his life, the man lived in a cell known as the 'crisis suite' in the inpatient unit. This consists of two adjoining cells, with a gated door between them (which was usually left open). In one room was the man's bed, whilst the adjoining room contained a sofa and other facilities for his mother when she visited.

15. HM Chief Inspector of Prisons last inspected Holme House in July 2010. The Chief Inspector reported that the prison delivered reasonably good outcomes for prisoners in all areas. Primary care services were reported to be good, and prisoners in the inpatient unit were able to leave their cells for extended periods of time.

16. The Independent Monitoring Board (IMB, a group of local people who independently monitor and report on the prison, ensuring standards of decency and care are maintained) annual report for 2010 concluded that Holme House was well managed during the year. They reported improvements in healthcare over the year, but considered that the crisis suite was "very much in need of refurbishment".

17. Five other prisoners died at Holme House in the two years before the man's death. Of these, two were due to apparent natural causes. In the report into the first of these deaths, the Ombudsman recommended that visits to significantly ill prisoners should take place in the healthcare centre. I am pleased to record that the man's mother was allowed to spend a considerable amount of time with him in his room on the inpatient unit.

ISSUES

The diagnosis of the man's terminal illness

18. In 2003, the man was diagnosed with pancytopenia. The clinical reviewer describes this as a "deficiency of all types of blood cells". She goes on to explain that pancytopenia has "widespread effects on the entire body, leading to oxygen shortage as well as problems with immune function". The man seemingly refused all investigations into this condition that were offered to him at the time.

19. The man had drunk alcohol in large quantities from a young age. In 2006 he was diagnosed with alcohol related liver disease and was admitted to hospital with a bleeding gastro-intestinal tract (the system connecting the stomach to the intestine). He was also found to have varices in his stomach (varices are enlarged veins that are prone to bleeding and are often caused by liver disease).

20. The man was convicted of various offences as a teenager and young man. He served two short prison sentences, at Durham, in 2006, before being remanded into custody to Durham for a more serious offence in November 2006. The man was subsequently convicted and sentenced to four years and four months imprisonment in early 2007. He moved to HMP Haverigg in August 2007 and was released from custody on licence on 18 May 2009.

21. Following his imprisonment in late 2006, the man declined a number of requests to take blood tests and monitor his condition. However, following his move to Haverigg in August 2007, he agreed to a referral to the haematology department (specialists in blood diseases) at Furness General Hospital. Tests at the hospital showed that the man had an enlarged spleen and portal hypertension (increased pressure, often on account of alcohol related liver disease, in the vein that carries blood to the liver. Portal hypertension can lead to the development of varices).

22. In November 2008, the man was admitted to Furness General Hospital, where he remained as an inpatient for three weeks. Investigations found that his varices were bleeding. During his admission, he underwent blood transfusions and a surgical procedure (known as banding) to stop the varices from bleeding. Towards the end of his admission, he was transferred to a Liverpool hospital for a procedure known as a TIPSS (transjugular intrahepatic portasystemic stent shunt). This is the insertion of an artificial tube (a stent) to reduce the pressure on the flow of blood to the liver and, in turn, reduce the pressure on the varices and the likelihood of future bleeding.

23. Following his discharge from hospital, the man refused follow up appointments to monitor the success of these procedures. In correspondence, a consultant hepatologist (liver specialist) commented that the man's long term prognosis would "depend upon his ability to remain abstinent from alcohol".

24. Having been released on licence in May 2009, the man continued to drink heavily. A year after his release, he attended hospital after vomiting a small amount of blood. Given his medical history, the man was advised that he would benefit from admission so that further investigations could be carried out.

However, the man reportedly became abusive to hospital staff and left the premises. He was arrested by the police following this incident and formally warned that a repeat would see him recalled to prison.

25. After committing a further offence in January 2011, the man was recalled to custody. He subsequently arrived at Durham on 19 January. A reception health screen (a routine health screen for all new arrivals into prison) was carried out shortly after his arrival at Durham. He told the reception nurse that he drank 300 units of alcohol per week (the recommended weekly maximum for men is 21 units) and had a liver problem. He was referred to the prison doctor and the prison's specialist alcohol treatment service.

26. The following morning, the man saw an alcohol detoxification nurse. He was prescribed a one week course of chlordiazepoxide (medication to treat symptoms of alcohol withdrawal). In the afternoon, he saw a prison doctor. The prison doctor requested that a blood test be taken to check the man's liver function. However, the man refused to have blood taken as he said he "dislikes needles". He did reveal some of his medical history to the prison doctor and said he had "collapsed and been seen in Liverpool Hospital". The prison doctor asked that the man's previous medical notes be requested. His doctor in the community was subsequently contacted, with the notes returned on 29 January.

27. The man's past medical notes showed that he had seen a doctor on 14 January 2011. This would appear to be the first time he had seen a medical professional since his self-referral to hospital in May 2010. The man told his doctor that he was on the waiting list for a liver transplant. On examining the notes, the prison doctor wrote that he was "vaguely sceptical" about this but that it would be explored further. The prison doctor also noted that a blood test would have to be taken "at some point" despite what he described as the man's "phobia" of needles. He also prescribed a course of omeprazole (medication for acid indigestion and stomach ulcers) as indicated by the notes.

28. The clinical reviewer notes that it was difficult for staff at Durham and Holme House to determine whether the man was indeed on the transplant list as he had suggested. She comments that he was vague in his description of events and there was a lack of clinical evidence in his past medical records. The clinical reviewer notes that most patients with chronic liver disease are followed up in specialist liver clinics, and that the doctors at such clinics would determine whether to assess a patient for transplant. However, it does not appear that thought was given by prison healthcare staff to contacting any such clinics in the man's home area.

29. Although the prison doctor explicitly asked for notes from Haverigg in his entry of 20 January (meaning the medical record from the man's previous time in prison), it does not appear as though they were actually requested at any time. It was from this source (once these records had been obtained by the investigator) that the investigator and clinical reviewer obtained the information summarised above. Prison Service Order (PSO) 3050, a national instruction regarding the continuity of healthcare for prisoners, states that records from previous periods in custody should be considered as a source of clinical information, where relevant.

Had they obtained the man's previous prison medical record, healthcare staff at both Durham and, subsequently, Holme House, would have had a much greater understanding of his medical condition and history.

The head of healthcare at HMP Durham should ensure that previous prison medical records are retrieved for all new arrivals into prison who report a chronic disease or other serious condition in their medical history.

30. After considering the information in his medical history, the clinical reviewer concludes that there is no evidence that the man had been placed on the liver transplant list. She notes that the man showed no indication of willingness to stop using alcohol and comments that an individual "must have been abstinent from alcohol for at least six months" before a liver transplant can be considered.

31. On 31 January, the man moved to Holme House. He saw Nurse A in reception and told her that he was awaiting a liver transplant. Nurse A noted that there was no evidence of this in his medical record. She opened Assessment, Care in Custody and Teamwork procedures (ACCT, a process to provide support as is necessary to ensure the safety of a prisoner identified as being at risk of suicide or self-harm) as the man was upset and said that he might self-harm as he was worried about his mother's health. A referral was also made to the prison's mental health team.

32. The following day, the man's ACCT was closed by Senior Officer (SO), his case manager. At a review meeting, the man told the SO that he had initially been apprehensive about moving to Holme House, but felt he had settled in already. He said he therefore had no intention of harming himself. The man later saw a mental health nurse for a review and, again, repeated his claim that he was awaiting a liver transplant. The man also said that he had no intention of stopping drinking on release from prison.

33. Following the man's move to Holme House, the prison doctor at Durham wrote to the prison to update them. The letter was received at Holme House on 8 February. He again noted that he was sceptical about the need for transplant, but that it needed exploring further. He suggested that they start by taking a blood test to check the man's liver function, although warned them of the man's needle phobia.

34. There is no indication that the man was approached to give a blood sample at any time over the following two weeks. This is somewhat surprising given the uncertain clinical history he provided and the potential seriousness of his condition. Whilst it is possible that he would have refused to provide a sample, healthcare staff at Holme House ought to have attempted to test his liver function at the earliest opportunity.

The head of healthcare should ensure that liver function tests are requested of all new receptions whose medical history might suggest poor liver function.

35. In their response to the draft report, the National Offender Management Service (NOMS) commented as follows:

> "As the majority of the receptions into Holme House have drug and alcohol history, it would be unrealistic for a GP to ensure liver function tests were requested unless clinically indications were present."

36. We thank NOMS for their response and appreciate their argument. Nevertheless, the man came to the prison with an uncertain and potentially serious liver diagnosis. We take the view that in such circumstances tests should be taken at the earliest opportunity.

37. On 23 February, the man was found collapsed on the floor of his cell. A nurse was called, who took a blood sample, and, after consultation with a prison doctor, an ambulance was called. The man remained in the University Hospital of North Tees overnight. A gastroscopy (examination of the stomach using a fibre optic camera) highlighted varices in his stomach. During his overnight stay, he received a blood transfusion and medication to treat gastrointestinal bleeding. He was advised by specialists at the hospital that he should never drink again. On discharge, he was prescribed additional medication including propranolol (for high blood pressure), lansoprazole (to stop the stomach producing gastric acid) and various vitamin supplements.

38. On 28 February, the man saw prison doctor A, for review. He said he felt light headed and had not been eating. The man also said his stomach was swollen and had been for around a week. The doctor determined that the man should be admitted to hospital for further investigation and an ambulance was subsequently called. The man was admitted to the University Hospital of North Tees later that morning.

39. The man remained in hospital until 12 March. During this time he was diagnosed with stomach varices, peritonitis (inflammation of the abdominal lining) and liver cirrhosis. The man was very ill during his stay in hospital and spent much of this time in the Intensive Treatment Unit. He experienced a number of gastrointestinal bleeds and therefore received several blood transfusions. The man was not happy in hospital and was reportedly abusive to hospital staff. On 11 March, he asked to be discharged from hospital but was persuaded not to do so by the consultant. The following day, he refused all treatment and insisted on returning to Holme House.

40. Prison doctor B, discussed the man's future treatment with the hospital consultant. She was told that when he returned to the prison there was little they could do other than continue with his prescribed medication. A prison nurse also visited the hospital to discuss the man's treatment. A note on his discharge letter explained the following:

> "The man understood that he needs to have an [endoscopy] and remain in hospital and that if he doesn't he may well die. The man retained this knowledge and told us he would rather self-discharge and run the risk of dying than stay in hospital."

41. As noted, the man gave vague details of his medical history and diagnosis on his arrival at both Durham and Holme House. This was not helped by a failure to obtain details of his medical history from all sources and the delay to requesting a blood sample to test the man's liver function. Nevertheless, he seemed reasonably well until his collapse on 23 February. He spent most of the next two and a half weeks in hospital until his self-discharge on 12 March. During this time, the man's condition deteriorated to the extent that he might die imminently if not treated.

42. We have highlighted some procedures that might have improved understanding of the man's diagnosis and medical history. However, we cannot say that these measures would have prevented his collapse and subsequent admission and deterioration.

The man's medical appointments and treatment

43. The man returned to Holme House on the afternoon of 12 March and was allocated the crisis suite in the inpatient unit. He saw Nurse A on his return and told her that he did not want any hospital intervention and was "scared of the camera" (meaning the fibre optic camera used to perform an endoscopy). The man added that he would not refuse any treatments or interventions that would be offered by the prison. Later that day, the man told Nurse B that he would go back to hospital for an endoscopy but would not stay in overnight. The hospital was contacted and they advised that they might be able to see the man on 14 March for this procedure. A care plan was written on the same day with various aims, including monitoring the man for signs of bleeding and keeping him pain free.

44. In the early morning of 13 March, the man told the night staff that he wished he had not discharged himself from hospital and wanted to return. An ambulance was called and the man was taken to hospital. However, he remained for only a short time before deciding again to discharge himself. The man returned to Holme House at around 4.30am.

45. Around 12 hours later, the man agreed to return to hospital for treatment. He told Nurse B that he understood the potential consequences should he choose not to do so. After only a few hours in hospital, however, the man said that he wanted to return to prison. He was persuaded to remain overnight by a doctor, who warned the man that he was "desperately ill and could die soon". During his stay, he had one unit of blood transfused but refused to comply with requests for additional transfusion. He returned to Holme House at around 8.00am on 14 March.

46. Over the following two days, the man was monitored at regular intervals and saw a prison doctor on both days. On the morning of 16 March, he was reviewed by prison doctor B. The doctor noted that the man was "compos mentis" (a Latin term meaning mentally sound) and aware of the risks of refusing treatment. That afternoon, he was found with a sweatshirt tied tightly around his neck. He told the nurses who attended him that he wanted to kill himself due to his condition.

It was noted that his health had deteriorated and he was told by prison doctor B that he needed to go to hospital as they were unable to provide the treatment he required at the prison. The man agreed to be admitted and an ambulance was called. In addition, ACCT procedures were started. These were closed the following day.

47. The man remained in hospital for just a few hours. He returned to Holme House on the evening of 16 March having refused all treatment. It was noted that he was now deteriorating. During the night Nurse C was on duty, was able to persuade the man to return to hospital. However, he said he would only go to hospital if Nurse C went with him. Nurse C agreed to this and contacted the healthcare manager for advice. As she was the only nurse on duty overnight, the healthcare manager advised that Nurse C should remain in the prison in case she was needed to attend an emergency involving another prisoner. (These are standard staffing levels at night at Holme House.) Nurse C told the man that she could not accompany him to hospital, and he subsequently refused to go. Later in the night, the man became upset and said he was frightened about dying at a young age. He asked to speak to a Listener (prisoners who have been selected and trained by the Samaritans to offer confidential emotional support) and was able to do so. In addition, Nurse C was permitted to enter his cell at any time during the night (staff normally only unlock a cell overnight in an emergency).

48. During the night, the man continued to decline hospital admission. He began to struggle for breath and was uncomfortable on account of swollen feet and legs. The man's mother was contacted by the night orderly officer (the individual in charge of the prison overnight) and updated about his condition.

49. In the morning, the man was assessed by Nurse B who described him as "burning up" (meaning a high temperature). Despite the attempts of Nurse B to persuade him of the benefits, the man again refused hospital admission. Nevertheless, an ambulance was called. Following the arrival of the paramedics, the man still refused to go to hospital.

50. As a result of the man's significant deterioration in health and refusal of admission to hospital to receive the appropriate treatment, it was determined that he should be referred to local specialists to plan his end of life care. Further discussion of the efforts of healthcare staff to encourage the man to engage in his treatment plan is considered in more detail in the following section. However, we consider the decision to plan end of life care to be appropriate at this stage.

Informing the man about his condition and treatment

51. It is apparent that the man refused numerous offers of medical intervention throughout his adult life. This continued through his earlier imprisonment, although he did agree to undergo a significant surgical procedure at hospital in Liverpool. In his first weeks in prison in 2011, he refused to provide blood samples having reportedly told staff that he was frightened of needles.

52. Despite his dislike of hospitals and the treatment he required, the man spent around two weeks in North Tees Hospital from 28 February. During this time he

had a number of blood transfusions and other interventions. The man eventually discharged himself on 12 March and said that he did not want any further hospital care. He said that he was more scared of the procedures that he required than he was of dying. The man was visited in hospital by Nurse D and the duty governor who explained to him that the prison was unable to provide the specialist care that he required. Specialists at the hospital also tried to persuade him that he was very unwell and needed to stay in hospital for further treatment. However, he insisted on returning to Holme House. He was assessed at hospital and it was determined that he had the capacity to fully understand the seriousness of his condition and potential consequences of refusing treatment. Following his return to the prison, other nurses spoke to him about the potential risks he faced, but were unable to persuade him to return to hospital at that time.

53. As noted in the previous section, the man did decide to return to hospital in the early morning of 13 March. However, he remained for just a few hours before discharging himself. That afternoon, Nurse B spoke at length to him about his treatment and the importance of going to hospital. She concluded that he fully understood the consequences of refusing treatment and was able to persuade him to return to hospital. However, he discharged himself the following morning, despite being advised that he required additional blood transfusions. The man was again assessed by a hospital specialist as having the capacity to understand the risks of discharging himself.

54. On the morning of 17 March, the man was very unwell. He was adamant that he would not be admitted to hospital, despite efforts by staff to persuade him of the benefits. Nurse B recorded her view that the man fully understood what would happen were he to refuse admission. It was also recorded that the man had made an informed choice and that admission could not be forced on him. That afternoon, he was visited by a consultant in palliative medicine (palliative medicine is concerned with the relief of pain and other symptoms of illness, rather than cure). After a joint assessment with prison doctor C and a prison nurse they judged that the man understood the likely consequences of his actions and had the capacity to make his own decisions. The man reiterated that he wished to be managed in the prison and did not want a blood transfusion. From here on, it was determined that end of life care should be planned, given the man's consistent wish not to receive the recommended treatment.

55. It is clear that the man was a challenging patient for staff at Holme House to manage. His fear of the treatment that he required led him to refuse almost all offers of help. The man's capacity to refuse medical intervention was assessed both formally and informally at hospital and in the prison. On each occasion it was determined that he understood the likely consequences of the choices he made. These tests are always important when someone is refusing treatment, and particularly so when they are reported to have learning difficulties. Nevertheless, it is apparent that staff at Holme House made great efforts to try to persuade him to engage in and comply with his treatment plan and to explain the potential outcomes. We are satisfied that they could have done nothing further.

Palliative care plans

56. When the man declined to go to hospital on the morning of 17 March, it was determined that the consultant in palliative medicine and the local Macmillan team should be contacted to start planning an end of life pathway. A Macmillan nurse was contacted later that morning, who gave advice about changes to the man's medication. In the afternoon, the consultant visited to assess the man. As I have previously noted, the consultant concluded that the man understood his decisions and had the capacity to refuse treatment. The consultant also considered that the man's poor health meant that it would not be appropriate to resuscitate him were he to stop breathing. It was noted that the man was clear about his wishes for his future treatment options. The appropriate 'Do Not Attempt to Resuscitate' forms were signed and completed. This was initially a temporary document, to be reviewed after 48 hours.

57. An end of life care pathway, based on the Liverpool Care Pathway, was commenced the same afternoon. The purpose of this is to provide appropriate care during the last phase of an individual's life. This means focusing on alleviating symptoms through pain relief and other measures, helping the individual to make decisions about their future (such as the 'Do Not Attempt to Resuscitate' order) and providing support to the family. The care pathway was used alongside the care plans that were already in place with the aim of improving the quality of care that could be provided in the last days of the man's life.

58. On the evening of 18 March, the man agreed to be admitted to hospital. He had changed his mind several times during the course of the evening, but finally agreed when he was told that the prison would pay for overnight accommodation for his mother so that she could visit. The following afternoon, however, the man said he wished to return to the prison. Following a discussion, which included the man's mother, it was agreed that he should return to Holme House and continue on the end of life pathway. It was noted that, in the light of the man's refusal of treatment, there were no further care options available other than keeping him comfortable. The permanent 'Do Not Attempt to Resuscitate' form was completed by hospital staff.

59. In the days after his return to Holme House, the man spoke about dying on several occasions. He said he was afraid to go to sleep in case he died and spoke about this with nursing staff. The man's medication was adjusted to provide him with appropriate pain relief. Following his return from hospital, the man lived in the crisis suite in the inpatient unit, where he received nursing care in line with that set out in his care plans and care pathway. The man was given sweets and soft drinks by staff as he would not eat anything else. His mother was allowed to spend several hours with him each day in his room in the last few days of his life.

60. On 29 March and 30 March, the man's health deteriorated rapidly. He died with his mother present.

61. The clinical reviewer highlights several areas in which healthcare staff at Holme House demonstrated good clinical practice when caring for the man. She concludes as follows:

> "The prison healthcare team who treated the man utilised the Liverpool Care Pathway and in doing so provided a very high standard of care … The prison healthcare team provided active, anticipatory management, co-ordination and care planning to improve the man's end of life care."

The man's pain relief and medication

62. Having started to complain of experiencing pain, the man was prescribed tramadol (an opiate based painkiller for moderate to severe pain) following his self-discharge from hospital on the evening of 16 March. The following morning a Macmillan nurse was consulted, who recommended that the medication oxycodone (for the relief of moderate to severe pain) be added to be taken as required for breakthrough pain (meaning pain that comes on suddenly for short periods of time and is not alleviated by the patient's normal medication).

63. However, the man did not like using tablet or liquid based medication (as his tramadol and oxycodone were respectively) and refused to take them. On 17 March these medications were cancelled and he was given a fentanyl patch as an alternative. (Fentanyl patches are used to relieve severe pain and are worn for three days at a time for continuous pain relief.)

64. After he experienced some breakthrough pain in the early morning of 20 March, the man was given a stronger fentanyl patch when it was changed later that day. He was also prescribed pethidine, a painkiller that is injected and was to be used as he required it for breakthrough pain. Given his fear of needles, it is unlikely that he would have agreed to take this medication had he required it. As it is, he reported no further breakthrough pain over the following three days.

65. From 23 March to 26 March, the man reported breakthrough pain on several occasions. He was given diazepam as a suppository in his rectum for this pain. Diazepam is a sedative and not specifically a drug for pain relief. However, as noted by prison doctor D on 26 March, the man's refusal to take injectable, tablet or liquid medication made prescribing for him very difficult. The doctor noted that diazepam had been effective for the man's pain and he was happy to use it. Nevertheless, the doctor also prescribed liquid oxycodone for breakthrough pain should the man wish to use it. He continued to use fentanyl patches.

66. Over the following three days the man was generally noted to be comfortable and pain free, although he did take rectal diazepam occasionally. Some discussion was held with regards to obtaining a syringe driver (used for the continuous administration of medication, usually pain relief, via a syringe). However, the man was adamant that he did not wish a syringe driver to be used. On the morning of his death, the man was in pain. He was given rectal diazepam but, on this occasion, the medication had no additional effect.

67. Prescribing effective pain relief for the man was a difficult task given his refusal to take tablet, oral or injectable medication. Nevertheless, the medication that he would take was usually adequate to control any breakthrough pain he experienced. The clinical reviewer highlights as good practice the communication between nursing staff of the plan to control the man's pain and ensure his comfort.

Liaison with the man's family

68. Following his admission to North Tees Hospital on 28 February, the man's condition deteriorated and became critical on 3 March. His mother was contacted by hospital staff that day and was able to visit him in hospital on 5 March.

69. When his condition worsened on the morning of 17 March, the man's mother was telephoned by the night orderly officer. She was able to visit the man that evening. During her visit the deputy head of offender health, spoke to the man's mother and updated her about his current condition and the move to end of life care. Hotel accommodation in the local area was provided for the man's mother by the prison overnight.

70. The following morning, the man's mother again visited him at Holme House. A family liaison officer was appointed and met the man's mother. As I have noted earlier, the man agreed to go to hospital that evening when he was told that the prison would provide overnight accommodation for his mother so that she could visit him.

71. The man's mother had to return home the following day and a taxi was arranged by the family liaison officer to take her to the station. On each of the following five days, the family liaison officer telephoned the man's mother to update her on her son's condition. The man's mother was able to visit again on the evening of 25 March. She stayed in the local area and visited her son in Holme House on the following five days. She was allowed to spend the whole day, from 9.30am until evening lock up at 7.30pm, with her son in the crisis suite in healthcare.

72. The man's mother was with him when he died. Over the following days, the family liaison officer contacted the man's mother regularly to speak about funeral arrangements and her son's property was returned. The man's funeral took place on 11 April and the prison contributed towards the funeral expenses.

73. The man's mother told the Ombudsman's senior family liaison officer that she was treated well by staff at Holme House. The support that she received at such a difficult time reflects well on the family liaison officer and the staff at Holme House.

74. We consider that the extensive time she was allowed to spend in healthcare with her son in the last days of his life constitutes an example of good practice.

Restraints, security and bedwatch

75. The Prison Service has a duty to protect the public and hence restraints and escort staff are routinely used when prisoners are taken out of the prison for any reason. An individual risk assessment is completed on each occasion and regular management checks are made. The assessment will consider the offences and the risk of further offending, as well as the prisoner's health and mobility.

76. Following his admission to hospital on 28 February, the man was accompanied by two prison officers and handcuffed to one of them by an escort chain (a chain of 1.8 metre length with a handcuff at each end). These are the standard arrangements when a prisoner stays overnight or longer in hospital (a period of time known as a bedwatch). The escort chain was removed on 3 March as the man's condition had deteriorated significantly and he was now being treated in the critical care unit. Given the man's ill health, I consider this the right and respectful course of action.

77. The escort chain was reapplied on 9 March, as the man was reported as being verbally abusive to nursing staff at the hospital and acting aggressively towards some equipment. The man's conduct reportedly improved in the immediate aftermath of the chain being applied, but declined again later in the day. I acknowledge that the man was unwell at this time but, as I have noted, the protection of the public is a primary concern of prison escort staff. On balance, I am satisfied that the use of restraints was appropriate at this time. I also note that the escort chain was removed to allow essential treatment over the following days.

78. On 13 March, the man agreed to return to hospital. He stayed for a very short time, around two hours, and refused all treatment before returning to Holme House. As previously, he was accompanied by two officers and an escort chain was used.

79. On the evening of 13 March, the man returned to hospital for a second time. On this occasion he remained in overnight before discharging himself the following morning. An escort chain was used throughout the man's time in hospital. As was the case in the latter days of his previous stay in hospital, the man's very ill health had to be balanced against his conduct in hospital. On this occasion he was again warned about his behaviour towards hospital staff. I am therefore satisfied that the use of restraints was again reasonable.

80. The man returned to hospital on 16 March. He stayed for a very short period and refused all treatment before asking to return to prison. As previously, the escort was made up of two staff and an escort chain.

81. In the late afternoon of 18 March, the man agreed to go to hospital for the final time. An escort chain was initially used, but this was removed on the morning of 19 March. Given that the man was now very ill and on an end of life pathway, we consider this to be the right course of action.

Compassionate release

82. Early release on compassionate grounds is a permanent release on licence, usually on medical grounds, and any decision to grant early release can only be made by the Minister responsible. The criteria for early release are set out in Prison Service Order (PSO) 6000:

    - the prisoner is suffering from a terminal illness and death is likely to occur soon; or the prisoner is bedridden or similarly incapacitated; and

    - the risk of re-offending is past; and

    - there are adequate arrangements for the prisoner's care and treatment outside prison; and

    - early release will bring some significant benefit to the prisoner or his/her family.

83. It is questionable whether adequate arrangements could have been made for the man's care outside prison. Nevertheless, PSO 6000 goes on to say that "conditions which are self-induced … would not normally qualify a prisoner for release". This would include examples where a prisoner refuses treatment. It is therefore apparent that the man did not meet the criteria for early release on compassionate grounds and his release was not therefore considered.

CONCLUSION

84. In the last month of his life, the man was very unwell. He was warned on numerous occasions of the risks of refusing the hospital treatment that he required. It is incredibly sad to see a young man choose to die in prison rather than accept treatment, particularly when it was fear of the form of treatment he needed that led to his refusal. As a result, caring for the man was especially challenging for staff at Holme House. I am pleased to commend them for providing a high standard of care for the man.

RECOMMENDATIONS

1. The head of healthcare at HMP Durham should ensure that previous prison medical records are retrieved for all new arrivals into prison who report a chronic disease or other serious condition in their medical history.

   Partially accepted – Systm1 Clinical IT is in use at HMP Durham. Where transferring prisons use this system we can access the continuous record on reception. Where prisoners have a long history of custodial sentences prior to electronic systems being in place, it may not be feasible to retrieve all paper records which could in some cases be archived in various establishments.

2. The head of healthcare should ensure that liver function tests are requested of all new receptions whose medical history might suggest poor liver function.

   Partially accepted – As the majority of receptions into Holme House have drug and alcohol history, it would be unrealistic for a GP to ensure liver function tests were requested unless clinically indications were present.

GOOD PRACTICE

1. The man's mother was allowed to spend around ten hours a day with him in his cell in healthcare in the last days of his life.