Investigation into the circumstances surrounding the death of a man in March 2010 at hospital whilst in the custody of HMP Long Lartin

Report by the Prisons and Probation Ombudsman for England and Wales

January 2011

This is the report of an investigation into the circumstances of the death of a man, a prisoner at HMP Long Lartin, in March 2010. He was born with bronchial pneumonia and suffered from lung disease throughout his life. He was 58 years old when he died. I would like to offer my sincere condolences to his family and to all those who knew him and were saddened by his death.

An investigator conducted the investigation. An independent review of the man's medical care was undertaken by clinical reviewers on behalf of the local Primary Care Trust (PCT). I am very grateful to them for their comprehensive review and very valuable contribution to my report.

I would also like to thank the Governor of Long Lartin and his staff for their cooperation. I would like to express my appreciation and thanks to the prisoners and staff on Perrie Wing who knew the man well and provided valuable information to the investigator.

The man's life expectancy was significantly reduced due to his chronic lung disease. In the light of his medical history, I accept that his death at the age of 58 was understandable and unavoidable. The clinical review has found a number of examples of good practice in managing his health with evidence of good care planning, record keeping and prescribing. The reviewers placed particular emphasis on the professionalism of healthcare staff and the standard of care offered to him whilst he was at Long Lartin. He refused a number of hospital admissions and often declined to take his medication because he found the side effects difficult to tolerate. Healthcare staff made significant efforts to find alternative solutions that he would accept.

In the last few months of his life, the man relied on nutritional supplements rather than a normal diet. However, owing to poor organisation in stocking adequate quantities, he was not always given the amount prescribed. There was also some confusion as to where some medication was held. The investigation also revealed a difficulty in supplying developer fluid for x-rays which resulted in staff being unable to carry out an urgent x-ray at a critical stage of his care. I make three recommendations regarding the need for better coordination and procurement of medical supplies. I also question why compassionate release from prison was not considered when his condition was known to be terminal and I make a further recommendation in this regard. My final recommendation concerns the absence of a hot debrief for staff following his death.

My recommendations aside, the investigation found that healthcare and prison staff provided a very high standard of care for the man despite his lack of cooperation at times.

The National Offender Management Service has accepted my recommendations and their response is documented on page 26 of my report.

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.

Jane Webb
Acting Prisons and Probation Ombudsman **January 2011**

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SUMMARY

The man was born with lung disease and he was suffering from emphysema when he was remanded to HMP Woodhill in May 2005. He received a life sentence for murder in December 2006 and was sent to HMP Long Lartin in August 2007. This was not his first experience of prison.

In an interview at Woodhill on the day he arrived, the man told healthcare staff of his lung related health problems and also that he had an alcohol problem. Staff placed him on constant supervision in the inpatient healthcare centre as he felt suicidal and an automatic referral was made to the Mental Health Inreach Team because of his offence. He was prescribed medication for depression and detoxification, although it was not specifically mentioned in the clinical record that he was suffering from alcohol withdrawal. After spending a short time in healthcare, he was considered fit to live on a wing.

While at Woodhill, the man attended a number of healthcare clinics including those for management of his lung condition. He transferred to HMP Long Lartin on 22 August 2007 and again, had a first reception healthcare interview with a member of the healthcare staff. His history of chronic obstructive pulmonary disease (COPD)[1], depression, emphysema, alcohol misuse and previous overdose attempt were recorded. He was assessed as unfit for work and his chest problems gave cause for concern so he was referred to a prison doctor.

The man had been referred to a hospital for his chest problems while he was living in the community. The prison wrote to the Consultant Physician at hospital to ascertain diagnosis and treatment in the past. The Consultant confirmed that the man had previously suffered from a non-contagious form of tuberculosis. Tests showed that he had mycobacterium kansasii[2]. He was prescribed rifampicin,[3] ethambutol[4] and clarithromycin[5].

Throughout his sentence, the man's health deteriorated. He was unwilling to take the medication prescribed to treat the tuberculosis on the basis that he had taken it in the past and it made him worse. Despite encouragement by staff, he took his medication sporadically, and continued to smoke against medical advice. Staff adopted a flexible attitude with him to try to find acceptable compromises. He also refused to go to hospital on occasion because he felt that wearing restraints was undignified.

As the man's health deteriorated, he had difficulty in eating and lost weight. He was prescribed nutritional supplements, but at times, the prison did not order sufficient

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[1] Chronic obstructive pulmonary disease (COPD) is the collective name for lung disease.
[2] Mycobacterium kansasii is a non transferable form of tuberculosis contracted from contaminated water. The man had worked in drainage sewers in the past.
[3] Rifampicin is an antibiotic drug of the rifamycin group. It is typically used to treat mycobacterium infections.
[4] Ethambutol is a drug prescribed to treat tuberculosis.
[5] Clarithromycin is an antibiotic used to treat a wide range of infections caused by bacteria and other micro-organisms.

supplies to satisfy the demand for all the prisoners who needed them. In addition, on one occasion, staff were unable to carry out an urgent x-ray owing to a lack of developer fluid for the x-ray machine. The clinical review also identified a lack of communication regarding the storage of medication which caused a short delay in him receiving vital treatment. I have made recommendations regarding these issues concerning medical supplies.

In late December 2009, the man underwent a mental health assessment to gauge his mental ability to make decisions for himself. The assessment concluded that he was capable. His health continued to deteriorate but he was not allowed to have oxygen in his cell because this, combined with his smoking, was a fire risk. He was adamant that he wanted to remain on the wing and refused to stay in healthcare where oxygen was available and he could be monitored.

The wing history sheet completed by discipline staff on 16 February shows that they were aware that the man knew he was terminally ill. Healthcare staff also knew that he had completed the paperwork to confirm that he did not want to be resuscitated in the event of a collapse. There is no evidence to suggest that a release from prison on compassionate grounds was considered at this or at any other point and I have made a recommendation reminding the Governor to consider the suitability of terminally ill prisoners for release on this basis.

On 25 February, the man was taken to hospital with severe breathing difficulties. His family were told and visited him two days later. Despite the efforts by healthcare and hospital staff, he died in March. His next of kin were told in accordance with their instructions previously given to the prison.

The clinical review judged overall that the clinical care the man received at the prison was good. The clinical reviewers commented on the professionalism of healthcare staff, quality of history taking and appropriate prescribing. Care plans and their implementation are described as “excellent”. I concur with their view that he was well cared for in spite of his reluctance to adhere to medical advice.

INVESTIGATION PROCESS

1. The man died in March 2010. This office was notified of his death later that night. Terms of reference and notices were issued to staff and prisoners at Long Lartin telling them that an investigation would be taking place, and inviting those who wished to see the investigator to make themselves known. The investigator requested copies of his core record, clinical record, and other records relevant to his time in custody and his death.

2. The investigator also contacted HM Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem report.

3. The investigator visited Long Lartin on 20 April. She toured Perrie Wing, where she met and spoke with prisoners and staff who knew the man well. She spoke with the governor responsible for Perrie Wing, the Head of Healthcare and a prison officer on Perrie Wing.

4. A clinical review of the man's medical care was commissioned from the local Primary Care Trust and undertaken by two clinical reviewers. They also interviewed relevant staff and prisoners jointly with the investigator. Their comprehensive review appears as annex to the report.

5. One of my family liaison officers contacted the man's sister, as his next of kin, to advise her about my investigation and give her the opportunity to raise any questions or concerns to be considered. His sister had no concerns regarding the care her brother received at Long Lartin.

HMP LONG LARTIN

6. HMP Long Lartin is part of the high security estate and accommodates prisoners with a sentence of four years or over, including those serving a life sentence. During the past year, the prison has increased its maximum capacity from 454 to 622 prisoners. The prison population at Long Lartin includes both remand and sentenced category A and B prisoners[6].

7. The man was accommodated in Perrie Wing, one of the six residential wings. The unit holds a mix of category A and B prisoners and is divided into two spurs, red spur and blue spur holding 44 and 76 prisoners respectively. He was a category B prisoner on blue spur.

12. The Independent Monitoring Board (IMB)[7] report for the period 1 February 2009 to 31 January 2010 acknowledged the challenges the prison faced in dealing with the sudden significant increase in the population at Long Lartin and specifically the increase in older prisoners held at the prison.

13. Following an announced inspection in July 2008, HM Inspectorate of Prisons, praised Long Lartin for successfully managing the recent significant increase in vulnerable prisoners while ensuring the prison remained a generally safe place, despite a very challenging population.

14. The Inspectorate described primary healthcare services as good with a broad range of nurse led clinics and visiting consultants. The recent rapid increase in the population was not matched by a corresponding increase in healthcare staff, although a nurse had been appointed as a specialist elderly care nurse. At the time that my investigator visited, the head of healthcare said that the prison was in the process of recruiting healthcare staff to address the issue. Prisoners who spoke to the investigator said that healthcare staff were stretched with additional prisoners to care for. The Inspectorate found some deficiencies in the pharmacy arrangements, including difficulties with named prisoner medicines being mixed with ordinary stock. A recommendation was made that the pharmacist should control stock supplied and introduce a dual-labelling system to ensure that it can be audited. Issues with prescribed pharmacy supplies for the man have been highlighted in my report.

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[6] Prisoners are risk assessed and given a category based on their offence and the risk that they pose to the public should they escape. There are four levels: A, B, C and D. Category A prisoners are those whose escape would be highly dangerous to the public, the police or to the security of the state. Category B are prisoners for whom the highest security conditions are not necessary but for whom escape must be made very difficult.

[7] All prisons in England and Wales have an Independent Monitoring Board (IMB). The IMB is staffed by volunteers from the local community. They have access to every area of the prison, monitoring standards of decency, answering prisoners' queries and investigating complaints. The IMB is required to publish an annual report to the Secretary of State highlighting good practice and areas of concern.

15. There have been three self-inflicted and two natural cause deaths at Long Lartin since my office assumed responsibility for investigating deaths in custody in 2004. There are no similarities between the man’s death and those of previous prisoners at Long Lartin.

KEY FINDINGS

16. The man was remanded into custody at HMP Woodhill on 19 May 2005. This was not his first experience of prison.[8] Prison staff completed a Suicide/Self-Harm Warning Form on his arrival as he had told a member of the escort staff taking him from the court to the prison that he would take his own life at the first opportunity. He was sentenced to life imprisonment for murder on 20 December 2005, with a 13 year tariff[9].

17. A First Reception Healthscreen assessment was completed when he arrived at Woodhill on 19 May. The document said that a referral to the Mental Health Inreach Team (MHIT) should be made automatically because of the nature of his offence and this was done. He told healthcare staff completing the form that he had emphysema and had been tested for tuberculosis (TB) bacterium kansaii, (a non-contagious form of TB) in the past. He also said that he suffered from a persistent cough and had difficulty on exertion. While he denied drinking alcohol to excess or taking drugs, sentence planning records show that he had a longstanding problem with alcohol.

18. Detailed clinical notes were completed by healthcare staff on the evening of 19 May. The man told staff he was under the care of a consultant physician at hospital and was last seen a year before when he was admitted as an emergency case for his COPD to be treated. On that occasion, he was given medication to treat his condition and sent home. He revealed that in the past he had smoked around 80 cigarettes a day, but had managed to reduce this to ten to 15 per day at that time. Three years before, he had been referred to a psychiatrist at hospital for depression and was prescribed Librium.[10] He confirmed that he was not taking antidepressants although he had attempted suicide in the past. He described being found in a coma following an overdose after a serious attempt to take his life. He told healthcare staff he felt suicidal but was uncertain how he would carry out any attempt to take his life. He was described as "dishevelled, tired and tearful" on interview.

19. Healthcare staff were concerned that the man was at risk of suicide and an action plan to support him was created. He was to be accommodated in the healthcare centre immediately. He was also to be given 30mg of Librium, 40mg of Sominex at night [11] and 10 mg of citalopram[12] with referrals to the Mental Health Inreach Team and for detoxification. It is unclear what the detoxification process specifically referred to.

20. Staff completed an undated Healthcare Centre Inpatient Assessment form. The man was noted to have a number of chronic physical complaints, a known history of

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[8] The First Reception Healthscreen said he had been in prison at Woodhill two years previously.
[9] A tariff is set by a court and is the minimum amount of years that must be served before the first application for release into the community can be considered by the Parole Board for England and Wales.
[10] Librium is a tranquiliser used in the treatment of anxiety and acute alcohol withdrawal.
[11] Sominex is to aid sleep.
[12] Citalopram is an antidepressant drug used to treat major depression.

depression with serious suicide attempts in the past,[13] and he had expressed suicidal thoughts and intentions. Care plans to manage his physical and mental wellbeing were made. He was taken to the inpatient healthcare centre where he was placed under close supervision by staff. Staff also put in place the prevention of suicide and self-harm procedures and opened an Assessment, Care in Custody and Teamwork (ACCT)[14] document. He remained in the healthcare centre until 6 June 2005, when a doctor assessed him as having improved and well enough to move to a residential wing.

21. While at Woodhill, the man saw healthcare staff on a number of occasions for help with dentistry and COPD management. He failed to attend asthma clinics on two occasions but the reasons were not recorded.

22. He transferred to Long Lartin on 22 August 2007. Entries in the computerised clinical record at Long Lartin start on that date. His COPD, depression, emphysema, alcohol misuse and previous overdose attempts were recorded. Nurse A saw him on the day he arrived. She recorded that she was unhappy to assess him as fit for work and he needed to be seen by a prison doctor for review because of his chest problems.

23. Nurse A's detailed entry in the clinical record two days later questions whether the man had tuberculosis. She was aware that he had undergone investigations around two years before and plans were made to ask for information from the Consultant Physician at hospital who had treated him in the past.

24. On 24 August, Prison Doctor A, wrote to the Consultant Physician. He believed that the man was suffering from COPD and emphysema and asked if the Consultant could comment on whether the man had ever had TB.

25. The Consultant Physician gave a comprehensive reply on 6 September. He said that he first saw the man in 2003 in the casualty department. The man described a family history of TB and having a lifelong cough that had worsened in the previous five or six months. Tests showed that he had mycobacterium kansasii[15]. He was prescribed rifampicin, ethambutol[16] and clarithromycin for at least 12 months. He had started the course in 2004, "but unfortunately as predicted his attendance was sporadic and compliance was a problem". The Consultant said that he had never proved that the man had tuberculosis.

26. In February 2008, healthcare staff advised the man to stop smoking, but he continued to do so against medical advice. He went to healthcare for repeat

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[13] Overdose with tablets prescribed for diabetes.

[14] The ACCT process is opened to monitor and support prisoners at risk of suicide or self-harm. Staff interact with, observe and monitor the prisoner at regular intervals depending upon the level of the risk. Regular multidisciplinary reviews should be held where the prisoner and all staff involved in their care attend to review progress and offer practical and emotional support until the crisis has passed.

[15] Mycobacterium kansasii is a non transferable form of tuberculosis contracted from contaminated water. The man had worked in drainage sewers in the past.

[16] Ethambutol is a drug used to treat tuberculosis. It is used in combination with other drugs.

prescriptions of salbutamol[17] and for other minor ailments, such as backache, for which he was prescribed paracetamol.

27. The man went to the evening healthcare clinic on 10 March 2009. When he arrived, he was unable to talk in complete sentences because of shortage of breath. He complained of having been unwell for the previous three weeks with worsening emphysema. He was given salbutamol by a nebuliser. Nurse B added his name to the list of prisoners to be seen by the doctor in the morning, despite noting that the list was already full.

28. Nurse B notified the out of hours doctor[18] in the community of the plan she had made to manage the man's condition overnight to ensure that it was appropriate for him to wait for the following day to see the prison doctor. The out of hours doctor said that the man should be given penicillin and prednisolone (a steroid to treat inflammatory and allergic conditions) eight times a day for two days. He faxed confirmation of his opinion to the prison. This appears to be the first indication that his physical condition was deteriorating.

29. The man's health continued to worsen. On 23 March, Prison Doctor B wrote that the man preferred to continue to work as resting in his cell "felt like being in segregation". In this entry, the doctor reflected on whether the man may have a tumour and considered whether a chest x-ray would confirm this. If there was no improvement by Wednesday (two days later), he planned to make an urgent referral for an appointment with the respiratory physician. The case would then be reviewed after the results of the chest x-ray were known. The doctor noted in the "history" part of his entry that the man did not have a chest x-ray the previous week because there was "no developer fluid". This presented an avoidable delay and the clinical review comments on the consequences of this problem.

30. Prison Doctor C reviewed him on the following day. The doctors concluded that an urgent referral should be made to a respiratory physician for an opinion. The doctor wrote to the respiratory team at hospital describing the man as "having kept himself largely below prison healthcare radar" until two weeks before. The doctor summarised the condition, including his concern that there may be an underlying tumour.

31. A second consultant physician at hospital assessed the man in his clinic on 15 April. He gave further information to the consultant, who summarised his findings in a letter to Prison Doctor B. The man told him that he was currently smoking at least three packets of tobacco each week and had previously worked in the building trade as a plasterer. There was a family history of TB. The Consultant prescribed further medication and arranged for him to undergo a computerised tomography (CT)[19] scan.

[17] Salbutamol is used in the treatment of asthma.
[18] The out of hours doctor attends the prison during the evenings and weekends when no doctor is on duty in the prison.
[19] A computerised tomography (CT) scan takes detailed three dimensional pictures of the body in order to diagnose disorders.

32. An entry in the clinical record dated 28 April, showed that Nurse C spoke with a TB specialist nurse. The specialist's advice to was that the man should stay in the healthcare centre for the first two weeks of his TB treatment. Staff considered that there was no need for barrier nursing[20] until there was a confirmed diagnosis.

33. While awaiting the results, the man told healthcare staff that he was unhappy living in healthcare. He said it was "like being punished". He complained that he was late for a visit with his brother whom he had not seen for five years. He refused to take the medication prescribed for TB as he remembered that it had made him ill when he took it before. He told medical staff that he may consider looking at different options once the results of the tests were known. Medical staff continued to encourage him to take the medication but without success. Prison Doctor C asked him who he used to spend time with on the wing, in case he had TB and healthcare staff had to screen other prisoners. He replied that he was a 'bit of a loner' and did not spend time with anyone.

34. On 14 May, the second Consultant Physician wrote to Prison Doctor B confirming that, as before, the man had tuberculosis kansasii. He suggested treating him with the same medication he had received in the past. The clinical record shows that, while the prescription was given on 14 May, healthcare staff did not find the medication until 16 May when it was given to him to start with immediate effect. I refer to this in the Issues section of the report.

35. The second Consultant Physician reviewed the man again on 28 May. He was very breathless on exertion. The doctor suggested a further review in September.

36. A prisoner on Perrie Wing knew the man well and spoke to my investigator and clinical reviewer. He recalled that a year before his death, the man was working in the prison craft workshop. He remembered that he had a chest infection in addition to his emphysema but he was still mobile. He was unhappy with the medication prescribed and showed him the medication leaflet. The prisoner described the list of potential side effects as "horrendous" and advised him to give the details to his family. The man thought that the medication was doing more harm than good.

37. The prisoner was aware that the man was in healthcare and friends on the wing could not visit. He described him as being "locked in a cell and fed through a hatch" and concluded that healthcare staff must have thought he had TB. In the prisoner's opinion, the man would not have had his medication but for his carer collecting it for him. He told the investigator and clinical reviewer that the prison "kept running out of Ensure[21]". He said that wing staff were not involved in the man's care and he was looked after by other prisoners. The man had numerous visits from healthcare staff during the last fortnight of his life.

[20] Barrier nursing is the practice of nursing of patients with infectious diseases in isolation to prevent the spread of infection.
[21] Ensure is a liquid nutritional supplement.

38. Officer A who worked on Perrie Wing spoke to the investigator and clinical reviewer. She said that the man knew that he was dying before he came into prison and wanted to be left alone because he felt it was all a “waste of time”. She described him as a quiet man who was not a problem to staff. The prisoners to whom my investigator spoke said that he knew that he was terminally ill.

39. The investigator and clinical reviewer spoke with another prisoner on Perrie Wing who knew the man well. The prisoner described the wing as having a high percentage of elderly and very sick prisoners. He was aware that healthcare resources were thinly spread with trying to deal with four wings of vulnerable prisoners. He said that he collected water and medication for the man and knew that there were periods of time when he did not come out of his cell. He added that the man should have had two Ensure drinks each day and, although he could remember healthcare staff bringing them to him, he could only once remember collecting all prescribed 14 Ensure drinks. He described him as a very private man inferring that he would not have wanted to make a fuss.

40. However, in June, the man seems to have lost patience with healthcare staff. He was prescribed 14 Ensure drinks and had only been given six. Healthcare staff told him that the prison did not have enough and, had he been given 14, the drinks would have been in short supply for other prisoners. On 9 August a mental health nurse visited him on the wing. He told her that he had not had the Ensure drinks “for some time” although they have been prescribed to him. She discussed the matter with colleagues who agreed that he was fit enough to collect the drinks himself from treatment sessions on the wing. The next prescribed 14 drinks were due on 11 August. The clinical reviewer is critical of this aspect of the care and I refer to this matter in the Issues section of the report.

41. In mid-June, Prison Doctor B wrote to the second Consultant Physician with his concerns regarding the man’s “dire spirometry results”[22]. He said he could not persuade him to take his medication. He had refused to take antibiotics after the first few days because he had chest pains when taking them. He felt constantly sick and could not eat.

42. In August, the man refused to go to a hospital appointment with the second Consultant Physician. An entry in the clinical record dated 4 September says that the prison did not tell the healthcare department that he had refused to attend and they found out by chance. This appears to be the only instance where they were not told. Healthcare staff made an appointment with the prison doctor to assess whether another referral was needed.

43. The clinical record charts a series of refusals to attend clinics for immunisations and a further hospital appointment on 11 November. The man signed a Refusal of Treatment disclaimer the following day. His reason for refusing to go to hospital was

[22] Spirometry is a lung function test.

because he did not wish to attend outside hospital appointments while in handcuffs attached to officers.

44. The man's health deteriorated in late December. Healthcare staff were asked to attend the wing as he had difficulty in breathing. He saw a prison doctor later that day but refused to have prednisolone[23] because he said his health had worsened since it was last prescribed. An entry in his wing history sheet on 12 December shows that he was due to attend a sentence planning meeting which would look at ways to reduce his risk of harm and re-offending. He told wing staff that he had no intention of doing offending behaviour courses in prison.

45. On 30 December, he refused to go to a hospital appointment. The clinical record says that he refused steroids, nebulisers and admission to the healthcare centre although he was smoking in his cell.

46. The following day, a second mental health nurse visited the man on the wing to assess his mental capacity to make decisions for himself. The nurse found him "lucid and focussed with no evidence of thought disorder or mental illness". He said the man was angry and frustrated "due to his perception of security protocols" around being taken to hospital and the use of restraints. He made his feelings known to the nurse regarding why he was being prescribed medication that had made him ill in the past. He continued to take the antibiotics.

47. The man spoke with his personal officer on 14 January 2010. (Each prison has a personal officer scheme in which a certain number of prisoners are allocated to a named officer as a point of contact. The officer completes reports on prisoners for which they are responsible, ensures entries are made in their wing history files and offers general advice.) He told the officer that he felt a little better and was eating, but still felt weak and breathless. When asked if healthcare staff had been in contact with him, he said they had not and he had no faith in their ability to help him.

48. The personal officer spoke with him again on 2 February while he was still managing to walk a little around the wing. A week later Prison Doctor D visited the wing and saw him walking about. The doctor spoke to the wing principal officer who confirmed that the man was able to walk slowly about the wing.

49. On the morning of 14 February, Nurse D visited the man on the wing to deliver his Ensure drinks. She recorded that, on examination, he had lost 8 kilograms in weight since May. He now relied on the Ensure drinks as he ate very little and was beginning to suffer from pressure sores on his lower back. A special mattress to help relieve pressure was ordered the following day and delivered two days later. However, he said he could not use it as he "falls off it" and could not lie down as he was unable to breathe. He wanted oxygen in his cell but this was refused as he still smoked. The combination of oxygen and smoking was an explosion risk. She suggested to him that he should be admitted to healthcare but he refused. As a

[23] Prednisolone is a synthetic steroid similar to cortisone to treat lung conditions.

compromise, she suggested that he remain on the wing during the day for association with his friends but be admitted to healthcare at night where he could have oxygen. Healthcare staff would take him to and from healthcare in a wheelchair every evening. Later that day, he agreed to go to healthcare in the evening on a trial basis.

50. The following day, Prison Doctor E reviewed him in the healthcare centre and noted that his health had deteriorated generally over the past six weeks. The man asked for a Do Not Resuscitate form, meaning that he did not want to be resuscitated if he was taken ill. The doctor indicated that he would re-refer him to the chest physician as previously planned.

51. Nurse D saw the man on 16 February. He had decided that he did not wish to remain in the healthcare centre overnight again, but wanted to return to the wing. He told her that he had not been having any visits from family or friends as he could not walk far. She offered to take him in a wheelchair to the visits hall. She commented in the clinical record that there needed to be more communication between prison and healthcare staff. She also advised him to speak to his family about his health. The wing history sheet shows that staff thought he knew that he was terminally ill. He was also aware that help was available to him if he needed it. There is no evidence to suggest that a release from prison on compassionate grounds was considered at this or at any other point.

52. A case conference was held on the wing on 16 February. This is not noted in the wing history sheet but is recorded in the clinical record. The man, wing and healthcare staff attended. He told staff he wanted to remain on Perrie Wing where prisoners, who were also his friends, looked after him. They helped him collect meals and to shower. Wing staff said they were happy to take him in a wheelchair to visits so that he could see his family. He did not have any religious beliefs and did not want to see the chaplain.

53. On 16 February, it was recorded that the man looked very tired and breathing was difficult. Staff were aware that he had asked not to be resuscitated in the event he collapsed and that the appropriate paperwork was being completed. An oxygen machine was given to him in his cell on 23 February. He was shown how to use it and advised to stop smoking.

54. Nurse C sent an email to the head of security asking for access to the man's cell at night and at any time during the day when prisoners were usually locked in their cells. This was to allow healthcare staff to give him his medication and help him when necessary.

55. The following day, Prison Doctor B wrote to the second Consultant Physician again. He said that on his return to the prison following a five week absence, the man had deteriorated considerably. The doctor asked for an opinion as to whether he was terminally ill and what other measures the prison could take. He still refused to take

his medication on the basis that it made him feel worse. He had, however, agreed to see the physician again. In the physician's absence and, following a conversation between the doctor and a third consultant physician, the consultant replied in a letter dated 18 February. He said that the TB treatment regime should start again. The doctor visited the man on the wing and noted that he sounded "fed up with it all and resigned to not improving".

56. An entry in the wing observations book by prison staff, dated 23 February, said that the man was very ill and had lost his voice. Healthcare staff would see him daily and more often if necessary. He did not want to go to hospital but could change his mind if he wanted to. However, he was adamant that he wished to remain on the wing. Later that day, his case was discussed. It was agreed that a member of healthcare staff would contact the Macmillan Nurses (specialist nurses in palliative care). Pain relieving medication would be ordered in case he deteriorated rapidly and the use of specialist oxygen equipment would be discussed with wing staff and himself.

57. The wing governor spoke with the man the following day and recorded the contents of their conversation in the history sheet. The man remained adamant that he wanted to remain on the wing despite the provision in the healthcare centre which would offer him a better level of care.

58. It is recorded in the wing observation book that, on 25 February, during the lunch period when prisoners are locked in their cells, the man pressed his cell bell at 12.20pm. (Each cell has a bell to be used by prisoners in the event of emergency or if they require a member of staff's attention.) Officer B went to the cell and found him in distress and wearing his oxygen mask. The officer made a code blue[24] radio call over the radio net to ask healthcare staff to go to the wing urgently. Nurse E responded to the call. When she arrived at his cell she found him breathless and complaining of pain in his chest. He agreed to go to hospital and an emergency ambulance was called. The paramedics arrived at 1.00pm and gave him hydrocortisone and venflon[25] medication intravenously.[26] The Person Escort Record (PER) shows that he left the prison by ambulance at 1.41pm and arrived at the hospital at 2.10pm. (The PER is a form that accompanies staff on all prisoner escorts. It provides a chronological record of the escort, eg meals served, times journey started and so on. It also serves as a communication tool about the risks a prisoner poses on escort or transfer.)

59. The Bedwatch Shift Log shows that the man was taken to the hospital under restraint (handcuffs) and, following permission from the prison, an escort chain was applied when they arrived at the hospital. His wish not to be resuscitated was recorded in his hospital notes. (The bedwatch log is a history, recorded by officers,

[24] Code blue and code red are the radio codes used by the prison to call medical staff to deal with an urgent medical incident. Code blue means that a prisoner is having difficulty with or is not breathing; code red means that there has been an incident of self-harm or accident involving blood.
[25] Hydrocortisone is used to treat inflammatory conditions and venflon is a catheter.
[26] Intravenously is by means of a needle into a vein.

of the time and events which take place while a prisoner is out of the prison as an inpatient at hospital. An escort chain is a single handcuff attached to the prisoner with a length of chain to connect it to another cuff worn by an officer. This allows more freedom of movement for the prisoner and makes it easier for nursing staff to administer treatment.) The investigator spoke with a governor of Perrie Wing who explained that current and historical risks are considered in determining the level of restraint and escort. The man would have been accompanied by a senior prison officer and two main grade prison officers.

60. An entry in the clinical record shows that Nurse A contacted the hospital later that day and was told that the man had improved slightly but he still refused any medication. She contacted the hospice and left a message for them to contact her. As he continued to refuse medical treatment, the hospital planned to discharge him back to the prison.

61. The Bedwatch Shift Log covering the escort officers' day shift on 26 February confirmed that the man's Do Not Resuscitate form from the prison was within the hospital file. The hospital asked for his next of kin to be told of the seriousness of his condition.

62. At 3.25pm, a Principal Officer (PO) contacted the prison and asked the duty governor if the man's restraints could be removed in the interests of decency. The risk assessment was reviewed at 3.45pm and the restraints removed. At 4.05pm, the log shows that the man's next of kin telephoned the prison and told officers that they hoped to visit the following day. The Bedwatch Management Checklist shows that he was anxious to receive a visit from his family.

63. In the early hours of 27 February, Officer C commented on the Bedwatch Shift Log that a nurse came to treat the man at around 4.10am. He asked her if the morphine he had been given would "help him pass away". The nurse confirmed that it would not, to which the man replied that he would have to do it himself. Despite the comment, there is no evidence to suggest that he actually made any attempt to end his life.

64. The clinical record shows that prison and healthcare staff visited the man on 27 February. They asked him if he wished to return to the prison or to have any items from his cell. He said he did not. Hospital staff confirmed that he was taking his medication.

65. Comments made by prison staff on duty at the hospital show that he had a good relationship with hospital staff. He seemed content with the standard of care he was given and appeared to be as comfortable as possible. His family visited at around 10.00am on 27 February.

66. On the same day, an entry in the clinical record shows that Nurse A telephoned the healthcare centre from the hospital, following her visit to the man. She said he

looked frail and unwell and had received visits from his relatives. The plan was for him to remain in hospital over the weekend and he would be reviewed by the consultant on Monday. She said he would think about whether he wanted to return to Long Lartin.

67. On the day that the man died, he told hospital staff that he wanted to return to Long Lartin. Meanwhile, a senior management meeting was held at the prison regarding the management of his care. The Head of Healthcare commented to my investigator that he had deteriorated much more rapidly than the prison expected.

68. Later that day, at the prison, a referral was made to a hospice for palliative care. Nurse A visited again, but the man found it too much effort to try to speak. He managed to say that he wished to remain in hospital. His medication had been reviewed and he was prescribed Fentanyl patches,[27] Diamorphine[28], paracetamol, Atrovent[29] and Ventolin. She spoke to a staff nurse at the hospital and said that he could be referred to the Macmillan team at the hospital. The staff nurse said she would pass this information to medical staff.

69. The bedwatch log shows that the man was visited by a number of senior members of prison and healthcare staff. He was noted to be very poorly. Prison staff asked if he had made a will and he said that his sisters and brothers knew his wishes. Officer A told the investigator that she was aware that he had a living will[30]. He asked that his carer be given his toiletries and that he wanted his sister to be contacted after his death.

70. At around 5.00pm, the Governor spoke with the man's sister and asked if she would like to be told of his death immediately if it was known that he had died. She said she did not need to be told if he died during the night, but the next day would be appropriate. The Governor offered support from the prison. She said that she was happy with the care her brother had received. He died at 8.10pm that evening. Records show that his sister was given the news of his death at 8.20pm.

71. Officer A told the investigator that a hot debrief for staff (in accordance with Prison Service Order 2710, paragraph 5.3) was not held. She said that it was a difficult time for staff as two prisoners on Perrie Wing had died only days apart from each other.

72. The Governor issued a notice to the prisoners on the wing announcing the man's death and staff from the chaplaincy went to the wing to provide support for those who needed it. My investigator and the clinical reviewer spoke to staff about the

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[27] Fentanyl patches are for pain relief.
[28] Diamorphine is a narcotic for pain relief.
[29] Atrovent is an inhaler.
[30] Advance health care directives, also known as living wills, advance directives, or advance decisions, are instructions given by individuals specifying what actions should be taken for their health in the event that they are no longer able to make decisions due to illness or incapacity.

level of care they received from the prison after his death. Some members of staff said that they did not feel supported by senior management at the prison.

ISSUES

Clinical care

73. The clinical review was undertaken by two clinical reviewers for the local Primary Care Trust (PCT). Their review is based on prison medical and other records, interviews with staff and prisoners as well as documents and interviews with hospital staff.

74. The review has judged that, overall, the care the man received at Long Lartin was generally well organised and documented by healthcare staff. In addition to the general good care he received, the reviewers have commented on the professionalism of healthcare staff, quality of history taking and appropriate prescribing. Care plans and their implementation were described as "excellent".

75. The review commented that the man had a serious chest disease before he went into prison and this accounted for his symptoms during his time there. It is judged possible that he was never free from mycobacterium kansaii, diagnosed in 2004. In the circumstances, he survived for longer than his respiratory physician would have expected. This was especially notable considering that he frequently refused medication and did not heed medical advice.

Shortage of prison and medical supplies

76. On 23 March, Prison Doctor B noted in the clinical record that the man should have had an x-ray at the prison the previous week but this did not take place because there was no "developer fluid". Another x-ray was scheduled for 25 March but was not reviewed by a prison doctor until five days later on 30 March. The clinical reviewers comment that, even though it was 12 months before his death, this was a critical time in his care, diagnosis and treatment. The "inability to provide an urgent chest x-ray in the prison for at least a week is a cause for concern". I endorse these findings and support their recommendation.

    The Governor and Head of Healthcare should ensure that adequate supplies of developing fluid for the prison x-ray machine are always available. This will prevent unnecessary delays in the diagnosis and treatment of serious chest conditions in the future.

77. From June 2009 onwards, the man relied upon Ensure food supplement drinks because he was not eating and losing weight as a result. Initially, there was a misunderstanding as to whether they would be delivered to the wing or whether he was expected to collect them. Also, on one occasion, it was recorded that he was given insufficient supplies, only six of the 14 drinks prescribed, as there were not enough for all the prisoners who needed them. The second prisoner, and the man's friend, remembered collecting a complete prescription on only one occasion and other prisoners recalled that he was rarely given the prescribed amount as "it was

not in stock". Another entry in February 2010 indicated that he had been without it for two weeks as the healthcare centre had run out. It is evident that there were shortcomings in the ordering process and, as a result, there were insufficient supplies to meet prisoners' needs. I believe that this is unacceptable and avoidable. The clinical reviewers considered that this would have caused some distress and "would not have supported the care plans that were in place".

The Head of Healthcare should ensure that ordering procedures and responsibilities are reviewed and, there are ample supplies of nutritional supplements to meet the needs of prisoners.

78. On 14 May, the second Consultant Physician at hospital wrote to Prison Doctor B confirming that the man had tuberculosis kansasii. He did not receive the medication which the Consultant prescribed until two days later on 16 May. The clinical reviewers conclude that the delay in finding the medication was of some concern given the importance that healthcare staff placed on him taking the medication to prevent "irreversible lung damage". They judge that the slight delay is unlikely to have had any harmful effect, particularly as he was refusing his medication some days later. However the review has found a lack of communication "from one healthcare contact to another and a lack of clarity as to where 'current' medicines might be stored and checked". I endorse their finding and recommendation.

The Head of Healthcare should ensure that healthcare and pharmacy staff responsible for accounting for and storing medicines, advise all healthcare staff where medicines prescribed for specific prisoners are held. This should ensure that prisoners receive their medication in a timely manner.

Restraints

79. The clinical review has raised the question of whether the restraints were appropriate given the man's condition. I note the comment from a doctor who appears to agree with the man's issue about being sent to hospital wearing restraints.

80. The investigator discussed the use of restraints with one of the governors on Perrie Wing. She also reviewed the risk assessment paperwork and Bedwatch log completed by the escort officers. Although unwell, the man was a life sentenced prisoner who did not comply with his sentence plan by working to reduce future risks of offending when returned to the community. I am satisfied that restraints were used appropriately in accordance with security policies and procedures. The restraints were removed on 26 February, the first appropriate opportunity in accordance with prison guidelines.

Compassionate release

81. Records show that prison and healthcare staff were aware that the man was terminally ill in February 2010. Prison Doctor E, who had been absent from the prison for a five week period, noticed the marked deterioration in his condition on 15 February. Nurse D saw him in his cell on 16 February and discussed end of life care and the completion of "Do Not Resuscitate" forms. A case conference was held on the wing on the same day where options for managing his condition were discussed. They included consideration that he was terminally ill and felt that he was dying. There is no evidence that any discussions took place with him to ask whether he would like to apply for compassionate release to a hospice because of his terminal condition. It may have been the case that he would not have wished to do so, but that conversation should been recorded if it took place. The evidence suggests that it did not. Neither is there evidence that the prison consulted the National Offender Management Service regarding the possibility of release on compassionate grounds or the medical professional for an opinion as to life expectancy.

    The Governor should ensure that terminally ill prisoners are considered for their suitability for compassionate release in accordance with Prison Service Order 6000, Chapter 12. The multi agency decision making process should be recorded in both the clinical and core record.

Hot debrief

82. Although the man died in hospital, the circumstances leading to his admission had been difficult for both staff and prisoners. He was attended by both healthcare staff and paramedics before being taken to hospital. He was then under escort for several days. Prison Service Order 2710 requires prisons to hold a hot debrief after the death of prisoner. Many staff and prisoners had been involved in the care and treatment of him over an extended period and this was the second death on that wing within a matter of days. A debrief would have provided coordinated reassurance and support for those involved.

    The Governor should remind managers of the need to hold a hot debrief after the death of a prisoner, in accordance with Prison Service Order 2710.

Visits by other prisoners to the man while in the healthcare centre

83. The clinical reviewers commented that prisoners' friends are unable to visit sick prisoners in inpatient healthcare and recommended that the policy be reviewed and appropriate facilities provided. Long Lartin is part of the high security prison estate, therefore security of the prison is paramount. I judge that the decision as to whether a prisoner, accommodated on a normal wing, should be allowed to visit another prisoner in healthcare, is a decision for the Governor, taking account of all relevant circumstances and resources. In the circumstances, I am unable to support this recommendation. However, I encourage the Governor to consider the suggestion.

Many Long Lartin prisoners will have developed long term friendships and been supported by other prisoners. Being able to see his friends might have encouraged him to agree to admission to the healthcare centre.

Good practice

84. The clinical reviewers have highlighted good practice which I am pleased to endorse. They found that although healthcare do not have a formal end of life pathway, the healthcare arrangements for managing the man's terminal illness were excellent. The review highlights his involvement in the decision-making processes.

85. The man refused a number of hospital admissions, and did not always listen to medical advice or take his medication. The clinical review has suggested that this may have hastened his death although it acknowledges that he found the treatment very unpleasant and remembered how he felt the first time he took it. However staff always encouraged him to take it and found alternatives where possible. They were proactive in seeking compromises that he would accept. This was apparent when he refused to go to healthcare, where oxygen was available, when he struggled to breathe and wanted to remain on the wing. Nurse D suggested that staff could take him to healthcare to spend each night and they could bring him back in the morning. After some hesitation, he agreed to try this. This demonstrated flexibility and sensitivity to his wishes and the ability to seek compromises to improve his health and wellbeing.

CONCLUSION

83. The man was a life sentenced prisoner who was already in poor health when he went into the prison system in poor health. He had a serious chest condition and tuberculosis kansaii. He did not always take his medication and continued to smoke against medical advice. At times he refused to go to hospital for treatment because he found that wearing restraints a degrading experience. The clinical review has commented that his life expectancy was significantly reduced, but he exceeded the expectation of his chest physician.

84. The clinical review has judged that, overall, the man received good clinical care at Long Lartin, with areas of good practice. Healthcare staff were professional, caring and flexible in their approach to him. His fellow prisoners also assisted him when he felt unable to leave his cell. My recommendations aside, I judge that the care he received was comparable to and possibly exceeded that which he would have received in the community.

85. In particular, I am pleased that the man was consulted about the sort of treatment which he would accept and that the restraints were removed for the last few days of his life.

RECOMMENDATION

1. **The Governor and Head of Healthcare should ensure that adequate supplies of developing fluid for the prison x-ray machine are always available. This will prevent unnecessary delays in the diagnosis and treatment of serious chest conditions in the future.**

   Accepted. The ordering system has since been revised to ensure that there is always a spare supply of developing solution in stock.

   We hope to replace the existing x-ray machine with a new digital machine which will negate the need for x ray solution.

2. **The Head of Healthcare should ensure that ordering procedures and responsibilities are reviewed and, there are ample supplies of nutritional supplements to meet the needs of prisoners.**

   Accepted. The ordering system for pharmaceutical supplies have been reviewed and revised. The process is supported by a Senior Pharmaceutical adviser and the appointment of a pharmacy technician.

3. **The Head of Healthcare should ensure that healthcare and pharmacy staff responsible for accounting for and storing medicines, advise all healthcare staff where medicines prescribed for specific prisoners are held. This should ensure that prisoners receive their medication in a timely manner.**

   Accepted. The ordering, stock control and administration systems system for pharmaceutical supplies have been reviewed and revised. The process is supported by a Senior Pharmaceutical adviser and the appointment of a pharmacy technician.

4. **The Governor should ensure that terminally ill prisoners are considered for their suitability for compassionate release in accordance with Prison Service Order 6000, Chapter 12. The multi agency decision making process should be recorded in both the clinical and core record.**

   Accepted. We did not consider the man to be terminally ill at that point, he had an acute exacerbation of a chronic illness and may have recovered if he had accepted treatment. Each case will be judged on its own merits and consideration will be given for future cases should they arise.

5. **The Governor should remind managers of the need to hold a hot debrief after the death of a prisoner, in accordance with Prison Service Order 2710.**

   Accepted. Contingency plans will be reviewed in line with PSO 2710.