



**Investigation into the death of a man
in March 2012 at HMP Frankland**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

August 2013

This is the report of the investigation into the death of a man at HMP Frankland in March 2012. He died of pancreatic cancer. He was 48 years old. I offer my condolences to his family and friends.

A clinical reviewer reviewed the clinical care the man received at Frankland. Staff at Frankland cooperated fully with the investigation. I apologise that our report is late.

The man received a life sentence in 1992 and transferred to Frankland in 2006. He often worried that he was unwell but investigations identified no serious health problems. On two occasions, once in 2008 and then in 2010, he complained of abdominal pain. In 2008, tests revealed no abnormalities and, in 2010, he refused to undergo any tests because he no longer felt any pain.

In October 2011, the man began to suffer with diarrhoea and a prison doctor was sufficiently concerned about his symptoms that he referred him urgently for hospital tests. In January 2012, hospital specialists told him that he had pancreatic cancer. He was not suitable for surgery and declined palliative chemotherapy. He was admitted to the prison's inpatient unit on 1 March, when his health deteriorated. He died there on 10 March.

The man was fully informed about his condition and good efforts were made to involve his family. His views were taken into account about his treatment and care, but there was some confusion about his involvement in a decision about resuscitation in the event of a possible cardiac or respiratory arrest. It also appears that consideration of compassionate release was not given sufficient priority.

The man was not always an easy patient and healthcare staff sometimes had difficulty persuading him to take his prescribed medication, but I am satisfied that staff at Frankland did all they could to ensure that he received a good standard of care which was certainly equivalent to that he might have received in the community.

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.

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Prisons and Probation Ombudsman

August 2013

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SUMMARY

1. The man was sentenced to life imprisonment in 1992. Between 1993 and 1999 he complained of a number of physical health problems including urine and bladder problems, dizziness, vomiting, abdominal pains, pressure pains in his head, blackouts and convulsions. According to his medical records, his fears about his health were generally unfounded. However, he often involved his solicitor because he did not think he was receiving adequate care. He transferred to Frankland in 2006.
2. In January 2008, the man reported pain in his abdomen. He underwent various tests, which revealed no abnormalities. He complained of abdominal pain again in March 2010. A prison doctor arranged for him to be referred for an ultrasound but he refused to attend the appointment in April because he was no longer in pain.
3. The man was examined by a prison doctor in November 2011, when his symptoms suggested a serious health problem and he was urgently referred to the local hospital for further tests. In January 2012, the tests revealed that he had pancreatic cancer. He was told that he was not suitable for surgery and he declined palliative chemotherapy.
4. After he was diagnosed with cancer, the man preferred to continue to live in his cell on a standard prison wing. Prison healthcare staff agreed to support him on the wing until his health needs required him to move to the prison's inpatient unit. Prison staff began consideration of whether he might be suitable for early release from prison because he was terminally ill, but this did not progress before his death.
5. Healthcare staff tried to ensure that the man received appropriate pain relief medication, but he was not always an easy patient. He often refused to take his medication either because he said it made him feel worse or that he did not have the symptoms for which they had been prescribed. Community specialists visited him to advise about pain relief medication but he was often reluctant to accept any advice.
6. On 1 March, as his health began to deteriorate, the man agreed to move to the inpatient unit. It was decided that there should be no attempt to resuscitate him if he stopped breathing or his heart stopped.
7. Prison staff encouraged the man to contact his family and let them know he was not well. His family were able to visit him in the inpatient unit. His father had just visited him when he died in March.
8. We conclude that the man received a good standard of care at Frankland, equivalent to what he might have received in the community. We make one recommendation to ensure that, as far as possible, terminally ill patients are included in decisions about whether or not resuscitation is attempted in the event of a cardiac or respiratory arrest.

THE INVESTIGATION PROCESS

9. The Ombudsman's office was notified of the man's death on 10 March 2012. The investigator issued notices to both staff and prisoners at HMP Frankland to inform them of the investigation and asking anyone with relevant information to contact her. No responses were received.
10. The investigator's colleague visited Frankland later in March and met members of the prison senior management team and other relevant staff. The investigator obtained copies of the man's medical record and relevant aspects of his prison records.
11. The local Primary Care Trust (PCT) appointed a clinical reviewer to review the clinical care the man received at Frankland. He was also given a copy of his medical record. The investigator provided written feedback to the Governor during the investigation. We are sorry that this report is late. The delay was caused by workload pressures in our office which caused a backlog of cases which we are striving to clear.
12. HM Coroner for Durham and Darlington was informed of the investigation and provided the results of the post-mortem investigation. The Coroner has been sent a copy of this report.
13. One of the Ombudsman's family liaison officers contacted the man's son outlining the purpose of the investigation. He had no specific concerns he wished the investigation to consider.
14. The investigation has assessed the main issues involved in the man's care including his diagnosis and treatment, liaison with his family, his location and security arrangements, whether compassionate release was considered and whether appropriate palliative care was provided.
15. The man's family received copies of the draft report. The solicitor representing his father wrote to us detailing his concerns that his son was not receiving the care that would have been expected in the community. These do not impact on the factual accuracy of this report, and we have provided clarification by way of separate correspondence to the solicitor.
16. The service response to recommendations is included in this report.

HMP FRANKLAND

17. Frankland is a purpose built high security prison in Durham. It holds a maximum of 859 category A and category B male prisoners in single cells. Prisoners at Frankland have either received a life sentence, an indeterminate sentence for public protection or a determinate custodial sentence of more than four years. The prison also holds some high risk remand prisoners.
18. Until April 2011, healthcare services at Frankland were provided by the local Primary Care Trust. A private company now provides healthcare services at Frankland and a number of prisons in the area. There is 24 hour inpatient care.

Her Majesty's Inspectorate of Prisons

19. HM Inspectorate of Prison's most recent inspection of Frankland took place in December 2012. At the time of writing, the full report of the inspection has not been published. However, the Care Quality Commission took part in the inspection and has published its findings. They found that the services operated by the private company were of a good standard and working relationships with other partners helped them to deliver effective care. A 2010 inspection found that, after recent staff shortages, health services had improved. However, waiting times to see a prison doctor were described as "unacceptably long". Palliative care arrangements were described as excellent with good links to local services.

Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. In their latest published annual report, covering December 2011 to November 2012, the IMB, like the Inspectorate, were positive about palliative care. About healthcare in general they wrote:

'Healthcare is available equally to all prisoners. ...Outpatient care is generally provided in a reasonable time but staffing levels do give rise to some problems and there are delays with doctor's appointments. Priority cases are always dealt with promptly. Inpatient care is provided according to clinical need with treatment at outside hospitals where necessary and with appropriate security requirements.'

ISSUES

The diagnosis of the man's terminal illness

21. The man received a life sentence for the murder of his partner in 1992. Between 1993 and 1999 he complained of a number of physical health problems including urine and bladder problems, dizziness, vomiting, abdominal pains, pressure pains in his head, blackouts and convulsions. A document in his medical record describes him as complaining of many illnesses and symptoms, which, after investigations, were considered unfounded. He often involved his solicitor because he did not think he was receiving adequate care.
22. In July 2006, the man transferred to Frankland. When he arrived healthcare staff noted that he was asthmatic but otherwise physically well. In 2007, he was given advice about stopping smoking but he said he was not yet in the right frame of mind to give up. In January 2008, he complained of left-side abdominal pain and said that he felt generally unwell. He was prescribed antibiotics and had his blood and urine tested; the results were normal. The problem appeared to have resolved and he did not receive any further treatment for abdominal pain until 2010.
23. On 10 March 2010, the man complained of lower abdominal pain and said that he had been sick once that week. The following day, he was examined by the prison doctor and was referred for an ultrasound to rule out any abdominal problems. An appointment was arranged for 29 April, but he refused to attend because he was no longer in pain. According to his medical record, he made no further complaints of abdominal pain in the following months.
24. On 6 October 2011, the man complained of a four day history of diarrhoea. He provided a stool sample on 10 November and the tests revealed no abnormalities. A prison doctor examined him on 17 November when he told the doctor that he had watery diarrhoea and abdominal pains. He said that he was losing weight and felt tired. The doctor ordered urgent blood tests and referred him to the hospital under the two week rule. (According to National Health Service guidance, when a doctor suspects that their patient might have cancer, the patient should be seen by a specialist within two weeks of the referral.) The doctor recorded that he weighed 69.3 kilograms (kg). The next day he came to the healthcare department to have bloods taken. He fainted before a sample could be obtained and so an ambulance was called and he was taken to hospital. Hospital staff managed to test his blood which revealed that his liver was not functioning normally. He returned to the prison later that day.
25. The man had another appointment with the prison doctor on 24 November. He was weighed again and his weight had dropped to 68.4kg. The doctor noted that he was due to attend a hospital appointment soon to explore the abnormal blood tests. He said that his abdomen was less tender on the left side, but still sore on the right.

26. On 2 December, the man underwent a flexible sigmoidoscopy (when a thin, flexible camera is inserted into the rectum which allows doctors to look at the bowel and lower intestine). The test did not show any problems but, due to his symptoms, cell samples were taken for further examination. He was also referred for a computerised tomography (CT) scan and for an ultrasound.
27. Another prison doctor examined the man on 13 December. She noted that he was jaundiced (yellow in colour) and he said that he had passed pale coloured stools for ten weeks. The doctor recorded that he was still suffering upper abdominal pain. He described feeling hungry all of the time but was not vomiting. She felt his abdomen and noted that there was a large swelling, which can be indicative of a number of different health problems, including liver cancer. The doctor wrote that he urgently needed a CT scan.
28. The CT scan was carried out on 21 December and revealed a possible mass at the head of the man's pancreas, which was suggestive of cancer. The following week, he had an appointment with a gastroenterologist (who specialises in disorders of the digestive system) at a hospital. The specialist wrote to the prison indicating that he appeared to have cancer of the head of the pancreas and that he would need another CT scan on 29 December. Further samples of his blood were taken for testing.
29. The second CT scan was carried out as planned and on 30 December, hospital staff planned to carry out an endoscopy (when a thin, flexible tube with a camera is passed down the throat to look at the upper intestines and digestive system). However, the man found the procedure very difficult and could not tolerate it. Hospital staff concluded that the procedure would need to be carried out under anaesthetic. It took place on 6 January 2012, at the Freeman Hospital. During the procedure a small tube (known as a stent) was inserted in his bile duct to help relieve the symptoms of jaundice. Some cell and tissue samples were taken for testing to provide more information on the nature of his health problems.
30. On 12 January, a doctor noted that the possible diagnosis of pancreatic cancer had not yet been confirmed, nor had any future treatment. She asked the healthcare department's administration team to inform one of the prison doctors as soon as there was any further news so that someone could talk to the man.
31. The prison chased for further information on 18 January, but the hospital specialist was away. On 30 January, the specialist wrote to the prison confirming that the man had cancer of the head of the pancreas. The specialist wrote that he was not suitable for surgery and that he should be referred for palliative chemotherapy.
32. The clinical reviewer identified no delays in the diagnosis of the man's cancer. We agree that healthcare staff at Frankland were appropriately suspicious about the possible causes of his symptoms and quickly referred him under the two week rule for further assessment.

Informing the man about his condition and treatment

33. On 22 December, a prison doctor told the man that his health problems were caused by problems with his liver rather than his bowels. Staff discussed the ongoing diagnostic tests with him and recorded that he understood he was being referred to hospital specialists for further assessment.
34. On 31 January 2012, the man had a hospital appointment and was told that he had cancer. He was told that surgery was not an option but that palliative chemotherapy might help manage the symptoms. On his return to the prison later that day, a nurse visited him on the wing to discuss the diagnosis. She recorded that he was tearful but able to discuss his situation openly. She told him that staff would support him.
35. The man talked to a nurse on 1 February and said that he did not want to receive chemotherapy because he believed it had hastened his mother's death. The nurse recorded that the prison's Head of Healthcare and a Macmillan nurse (who provides specialist care and support to cancer patients), would visit him and discuss his options with him. Later that day, a nurse recorded that she would act as his named nurse. She wrote that he knew that surgery was not an option. She repeated that he was currently refusing chemotherapy because he felt his quality of life would be better without it.
36. On 9 February, healthcare staff met for a palliative care meeting and discussed the man's diagnosis and prognosis (although it seems that the hospital did not give a formal prognosis at any point prior to his death). The staff recorded that he was fully aware of his diagnosis and the treatment options available to him.
37. Over the following weeks, staff made regular entries in the man's medical record indicating that they continued to discuss his condition, treatment and medication with him. The extent to which he was involved in decisions about his medication is explored in detail in a later section.
38. We are satisfied that the man was fully informed about his diagnosis and treatment options.

The man's medical appointments and treatment

39. The man decided that he did not want to receive palliative chemotherapy. As a result, he did not have any further hospital appointments after receiving his diagnosis. Prison healthcare staff managed his ongoing treatment, which focused on providing symptomatic relief.
40. On 22 December, before the cancer diagnosis had been confirmed, the man told healthcare staff that he was finding it difficult to eat a normal diet and was losing weight. As a result, he was prescribed high calorie build up drinks and yoghurts. A month later, on 19 January, the Head of Healthcare discussed

his diet with the kitchen senior officer (SO). The SO agreed to visit him on the wing and discuss his dietary needs. When healthcare staff realised that the meeting had not taken place by 9 February, they contacted the senior officer again. On 16 February, he said that adjustments had been made and he was happy with his diet. He also requested, and was provided with, extra milk.

41. After he was diagnosed with cancer, nurses visited the man every day to monitor his condition.
42. The clinical reviewer concludes that, after he was diagnosed with cancer, the man received appropriate care from Frankland healthcare staff.

The man's pain relief and medication

43. The man began complaining of severe pain in his abdomen on 13 December. A prison doctor prescribed codeine (a pain relief medication) to help relieve the pain. After he said the codeine made him nauseous, she agreed to change the prescription to tramadol (another pain relief medication).
44. The man saw a nurse on 3 January 2012, and complained of increasing pain in his back. The following day, he had an appointment with a prison doctor but denied having any uncontrollable pain and declined a change in his prescribed pain relief medication or an increase in the dose.
45. On 8 January, the man complained that Tramadol was making him feel ill and he refused to take his evening dose. The following day, he said that he was in great pain and thought his stent was blocked. A prison doctor examined him and offered to increase the dose of tramadol. He refused again, saying that he was managing the pain. She prescribed domperidone (to treat feelings of nausea) and lansoprazole (which reduces the amount of acid produced by the stomach).
46. On 1 February, two nurses met the man to discuss his pain relief options in the light of his cancer diagnosis. He said that his current pain level could be managed by ibuprofen and paracetamol. He did not think the other medications he had been prescribed were helping and so he had returned them to the pharmacy.
47. The Head of Healthcare discussed pain relief with the man on 7 February. He said that he was not being given appropriate pain relief medication and had referred the matter to his solicitor. She reminded him that, on 1 February, he had said his current prescription was okay and he needed to be honest with staff about what was helping him. He was prescribed codeine again.
48. On 9 February, a Macmillan nurse and a community palliative care consultant held a meeting with the man, the Head of Healthcare and a prison doctor. The consultant discussed pain relief alternatives with him, but he was unwilling to try a higher dose of tramadol or codeine. She suggested that he be prescribed haloperidol (which helps to treat extreme nausea), morphine (a strong pain relief medication), oramorph (a liquid solution of morphine which is

taken as necessary when pain is not managed by other prescribed medications) and gabapentin (also for pain relief). He refused haloperidol because he said that it made him feel sick.

49. Over the following days, the man often refused to take a variety of his medications because he said that they made him feel worse or because he said he did not have the symptoms they had been prescribed to treat. Healthcare staff often recorded that they had tried to advise him but that he was reluctant to accept their advice.
50. On 26 February, the man said that he thought the gabapentin was making him vomit. It was explained that nausea and sickness were symptoms of his illness and that he had been prescribed medications to help manage this. Staff wrote that they were confused by what he told them.
51. Between 1 and 5 March, the man vomited frequently and was again advised to take medication to help manage his sickness. He continued to be reluctant to take anti-sickness medication and also refused to be given pain relief through a syringe driver (syringe drivers deliver a constant dose of pain relief medication and are often used with terminally ill patients). Healthcare staff wrote that it was difficult to manage his symptoms because he would not accept any help. By 8 March, he was refusing all of his prescribed medication.
52. It is clear from the medical record that staff tried hard to manage the man's pain and other symptoms but found this difficult. This was essentially because he believed that the medication either made him feel worse or did not help him. The clinical reviewer has identified no issues with the management of his pain or other symptoms. Specialist advice was sought and given by the palliative care consultant. We are satisfied that healthcare staff at Frankland did all they could to ensure that he was prescribed and took the appropriate medication.

Liaison with the man's family

53. On 31 January, after he had been diagnosed with cancer, the man said that he wanted to contact his family. A few days later, on 3 February, he decided that he would write to his family rather than telephone them with the news.
54. When staff met on 9 February, they noted that the man was finding it difficult to break the news of his illness to his family and had not yet done so. On 16 February, he said that he had written to his sister. His brother-in-law later contacted the prison and gave them his mobile telephone number.
55. On 7 March, staff discussed with the man whether his family should visit. He agreed that they should do so sooner rather than later. The operational manager responsible for healthcare contacted the man's family on his behalf and his sisters visited him in healthcare on 8 March. While they were at Frankland, they met the Head of Healthcare, the operational manager, a member of the chaplaincy team and the two appointed family liaison officers.

56. The man's father visited him in healthcare unit a few days later, after he was told that his condition was deteriorating. The visit had just ended and he was still on the unit, when his son died.
57. We are satisfied that staff at Frankland gave the man support to contact his family and made appropriate and sensitive arrangements for them to visit him at Frankland.

The man's location

58. On 15 December, shortly after a prison doctor had diagnosed the man with jaundice, staff discussed his case in the healthcare management meeting. They agreed that he should move to the healthcare inpatient unit for observation. However, he said that he wanted to remain on the wing until or unless the pain became too much for him to bear.
59. Healthcare staff continued to discuss where would be the best place for the man but concluded that, for the time being, he was fully independent, and should remain on the wing, as was his preference. They recorded that he understood that he would have to move to the inpatient unit if his health deteriorated or he was less able to look after himself. Wing staff were informed of the decision.
60. On 31 January, after receiving his cancer diagnosis, the man said that he still wanted to stay on his wing. The Head of Healthcare discussed this with him on 3 February and he told her that he was happy on the wing, that his friends knew about his diagnosis and were looking after him. He agreed that relevant information about his condition could be shared with wing staff. She arranged for him to have some additional items to make him more comfortable in his cell, such as an extra pillow and a mattress topper.
61. On 14 February, healthcare and wing staff attended a case conference. The wing officers were worried that the man was unable to get himself out of bed and needed them to lift him, which they were not trained to do. They said that he also needed other prisoners to help him get to the telephone. They agreed that a risk assessment should be carried out. The Head of Healthcare visited him the next day to discuss the concerns and recorded that he was negative about all the suggestions she made for his future care.
62. Staff discussed the man's possible admission to the inpatient unit again on 26 February. Wing officers said that he often called for the night orderly officer (the most senior member of staff on duty at night) to complain about his treatment. Healthcare staff discussed this with him and he agreed to visit the inpatient unit to look around, talk to staff and have a bath (there are only showers on the residential wings). Nurses continued to encourage him to move to the inpatient unit where he could be looked after better. On 1 March, he finally agreed to move to the inpatient unit and he remained there until his death.

63. We are satisfied that staff took full account of the man's wishes when considering where he could best be looked after. Although they made it clear that they would admit him to the inpatient unit if his health needs required it, they delayed a move at his request until he agreed that it would be best for him.

Compassionate release

64. Early release on compassionate grounds (ERCG) is a means by which prisoners who are seriously ill can be permanently released from custody before their sentence has expired. The criteria for early release for indeterminate sentenced prisoners are set out in Prison Service Order (PSO) 4700 and prisoners are usually expected to have less than three months to live. The criteria include that the risk of re-offending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) within the National Offender Management Service (NOMS).
65. After he was diagnosed with cancer, the man indicated that he wanted to apply for early release on compassionate grounds. He told the Head of Healthcare that he would prefer to spend his final days at his sister's house but that, if this was not permitted, he wanted to die on the wing.
66. At a palliative care meeting on 9 February, the Head of Healthcare recorded that the prison had begun the process of applying for compassionate release. The prison's public protection co-ordinator sought confirmation from the healthcare department of the man's diagnosis and prognosis. A meeting was scheduled to take place on 12 March, at which relevant external agencies would be represented, to discuss his request for compassionate release. Sadly, he died before the meeting could take place.
67. The speed at which the man's health deteriorated meant that Frankland had not progressed his application before his death. We are concerned that arranging a meeting to discuss the application over one month after it was first discussed does not suggest that the prison gave this sufficient priority when it was clear that he was very ill and nearing the end of his life.

The Governor should ensure that appropriate priority is given to dealing with applications for compassionate release for terminally ill prisoners.

Palliative care plans

68. The NHS document 'The route to success in end of life care – achieving quality in prisons and for prisoners' sets out how an end of life care pathway might be implemented in prisons. Among the benefits of an end of life pathway are that it helps carers to plan when and how care will be delivered,

and helps patients make choices about how they are cared for towards the end of their lives. There are various examples of end of life care pathways.

69. On 31 January, Frankland healthcare staff began arranging for Macmillan nurses to provide palliative care advice. The Macmillan nurse and community palliative care consultant visited the man at Frankland on 9 February.
70. As part of the palliative care plan, a mental health nurse conducted a mental health review with the man on 11 February. She offered support in relation to various aspects of his diagnosis, including breaking the news to his family.
71. At the beginning of March the man's health began to decline rapidly. He was vomiting very frequently and found it hard to keep food or fluid down. On 7 March, the Head of Healthcare wrote that she had reviewed his condition that day and that he was able to remember the information staff gave him and was able to make decisions about his care. However, the same day, she and a prison doctor completed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form, which meant that no resuscitation would be attempted if he stopped breathing or his heart stopped. On the form, she ticked the box indicating that he did not have the capacity to make the decision for himself. She noted that his family had been informed of the decision.
72. The clinical reviewer highlights the apparent confusion about whether or not the man had the capacity to be involved in decisions about his care. NHS guidelines on best practice in end of life care make clear the importance of involving the patient in decisions about their treatment wherever possible. He notes that although healthcare staff's actions were not in line with best practice, they were within the boundaries of reasonable practice because it is unlikely that CPR would have been successful in this case. Nevertheless, we are concerned about the lack of clarity on the record and make the following recommendation:

The Head of Healthcare should ensure that healthcare staff document in the clinical record the extent of patient involvement in an advance decision not to attempt resuscitation and that such decisions are made in line with current national resuscitation guidelines.

73. On 8 March, a prison doctor wrote that the man's level of consciousness was fluctuating and it was not possible to have a "useful conversation" with him. However, his pulse was strong and he did not seem agitated or distressed. A priest also visited him that day.
74. On 9 March, as the man's condition deteriorated further, the Head of Healthcare recorded that he met the criteria for an end of life care pathway. The Macmillan nurse visited him again that day and a priest from the chaplaincy team was informed of his failing health.
75. The man's medical record indicates that healthcare staff appropriately considered his palliative care needs. Macmillan nurses and the community

palliative care consultant offered specialist input and ensured that the care offered to him was in line with recognised end of life care pathways.

Restraints, security and bed watch

76. When a prisoner is taken out of prison, a risk assessment should be carried out to decide the security arrangements and the level of restraints to be applied. After the man was diagnosed with cancer at the end of January there was no treatment possible other than palliative chemotherapy which he declined. Therefore, during his terminal illness, he had no hospital appointments or stays in hospital which required an assessment of his security risk and whether restraints needed to be used.

RECOMMENDATIONS (*Service response in italics below*)

1. The Governor should ensure that appropriate priority is given to dealing with applications for compassionate release for terminally ill prisoners.

Accepted: *No application can be found from the man or his legal advisors requesting release on compassionate grounds. Had such an application been received by the Public Protection Office this would have been actioned immediately in accordance with PSO6000*

2. The Head of Healthcare should ensure that healthcare staff document in the clinical record the extent of patient involvement in an advance decision not to attempt resuscitation and that such decisions are made in line with current national resuscitation guidelines.

Accepted: *It is important to note that all policies and procedures are in place regarding Advanced Decision making and DNR status and this is in accordance with national guidance. The man did not wish to discuss DNR with nursing staff, therefore the decision was made not to make a decision that he was not comfortable in doing. As the patient deteriorated and was unable to make that decision, based the 'Deciding Rights' document regarding End of Life Care, a DNR decision can be made without patient's consent if the clinician feels that clinically that resuscitation would be futile.*