Investigation into the circumstances surrounding the death of a man in hospital in December 2010, whilst in the custody of HMP Swaleside

Report by the Prisons and Probation Ombudsman for England and Wales

June 2011

This is the report of an investigation into the death of a man, a prisoner at HMP Swaleside. He died at outside hospital in December 2010, having been admitted two days earlier. He was 67 years old. The cause of death was found to be septicaemia (blood poisoning) due to diabetic nephropathy (damage to the kidneys due to diabetes) with a secondary condition of congestive cardiac failure. I offer my sincere sympathy and condolences to the man's family and all who have been affected by his loss.

The investigation was carried out by one of my colleagues. A review of the man's medical care in prison was carried out by a clinical reviewer on behalf of Eastern and Coastal Kent Primary Care Trust. I am most grateful to him for his assistance.

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

It is clear to me that the man was a difficult prisoner to treat. He refused to take his medication for the majority of his time at Swaleside. He had a long standing history of diabetes and high blood pressure associated with this. My investigation has found that staff made consistent efforts to encourage the man to accept treatment for his illness, but he resisted most of the time. The man's capacity to refuse treatment for his condition was assessed and he was found to have adequate mental capacity to make this decision. However, this could have been recorded more formally.

My report concludes that the man received a high standard of care from Swaleside but makes three recommendations regarding improvements that could be made to record clinical care at the prison.

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.

Thea Walton
Acting Deputy Ombudsman **June 2011**

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SUMMARY

1. The man was remanded to HMP High Down in August 2005. He was diabetic and, at the time, took anti-diabetic medication and medication for high blood pressure. The following year he was sentenced to life imprisonment, and subsequently moved to HMP Swaleside on 1 December 2006. The following year, he began to use insulin pens (to supplement the insulin the body produces naturally) as opposed to the anti-diabetic medication.

2. In late December 2007, the man stopped taking his insulin. He told healthcare staff that this was because he was no longer prescribed tamsulosin (medication to reduce obstruction in the flow of urine, which he had been prescribed the previous summer). Around a month later, tamsulosin was represcribed and, another month after this, he began to take insulin again.

3. However, in August 2008, the man stopped taking insulin for a second time. On account of his symptoms, he was admitted to the healthcare inpatient facility (initially at the neighbouring HMP Elmley as there was no space in Swaleside inpatients). Over the following two years, he regularly refused insulin and other medication. His acceptance of medication varied, but he refused more often than not and often for significant periods of time. Staff said that he only took his medication if he felt particularly unwell and he adjusted his diet to counteract the effects of not taking insulin. Despite evidence that he was a difficult prisoner to manage, the investigation found that healthcare staff made considerable efforts to enlist the man's co-operation in his medical care. However, I take the view that his capacity to refuse treatment could have been assessed and recorded more formally and make a recommendation in relation to this.

4. On 6 December 2010, the man was admitted to outside hospital after developing a worsening chest infection. He remained in hospital for 11 days, during which time he was treated for an enlarged heart and had a catheter inserted. He was taken to hospital for a few hours two days later, on 19 December, after passing blood in his urine. He was diagnosed with sepsis and prescribed antibiotics. The following day, he was admitted for a third time after passing a large amount of blood in his urine. He remained in hospital and deteriorated the following day. He died at 1.10am on a day soon after.

5. The clinical reviewer finds that the man received care to a “very high standard” which was at least equivalent to that which he might expect to receive in the community. In addition to that regarding the assessment of his capacity, I make a further two recommendations: firstly regarding the recording of changes to a prisoner's medication and, secondly, carrying out action points set out in care plans.

THE INVESTIGATION PROCESS

6. The investigation was opened on 22 December 2010 when the investigator issued notices announcing the investigation to staff and prisoners. These notices included an invitation to those who wished to submit information relating to the man's death to make themselves known to the investigator. No one came forward as a result.

7. The investigator visited Swaleside on 30 December 2010. During the visit he met with the head of decency (the senior manager on duty), a representative of the local Independent Monitoring Board (a body of local people who independently monitor and report on the prison), and the prison's family liaison officer. He also visited the healthcare centre and met a senior nurse who knew the man well. The investigator was provided with copies of the man's prison records.

8. An independent clinical review of the man's medical care in custody was undertaken by a clinical reviewer on behalf of Eastern and Coastal Kent Primary Care Trust. I am grateful to him for his assistance in this matter.

9. One of my family liaison officers wrote to the man's daughter on 17 January 2011. She explained the purpose of the investigation and provided the opportunity for the man's daughter to ask any questions or raise any concerns she might have. No reply was received. I hope this report clarifies any issues that might remain unclear for his family and helps them better understand what happened in the time leading to his death.

10. My report was issued in draft to the National Offender Management Service (NOMS). Their response to my recommendations is included at the end of this report

HMP SWALESIDE

11. Swaleside forms part of a cluster of three prisons on the Isle of Sheppey in Kent. (The other prisons in the cluster are HMP Elmley and HMP Standford Hill.) Each of the three prisons in the cluster retains a dedicated Governor, but the cluster is run by a single Chief Executive. Swaleside is a category B training prison, holding adult male prisoners who are serving sentences of four years or more with at least 18 months left to serve. The operational capacity of the establishment is 1,132.

12. Healthcare at the cluster is commissioned by Eastern and Coastal Kent Primary Care Trust. Doctors from a local surgery provide daytime sessions at Swaleside on Monday to Friday, with an out of hours service provided by South East Health. Primary care services include clinics for long term illnesses such as diabetes. The prison has an 18 bed inpatient unit for prisoners with physical or mental health problems, which is staffed 24 hours a day.

13. HM Chief Inspector of Prisons last inspected Swaleside in April 2008. The then Chief Inspector reported that the management of long term illnesses was good, as was the service provided by prison doctors.

14. The Independent Monitoring Board (IMB, a body of local people who independently visit, monitor and report on the establishment) annual report for 2009-10 concluded that Swaleside was a well run prison with good staff/prisoner relationships. They noted that there has been some difficulty recruiting nursing staff and, as such, a number of agency staff have been employed.

15. This is the eighth death of a prisoner at Swaleside since January 2009. Five of the previous seven deaths were as a result of natural causes. One of these previous investigations involved a man who had spent a considerable time living on the prison's inpatient unit. The report concluded that the man received care of a high standard which exceeded that which he might expect to have received in the community.

KEY EVENTS

16. On his arrival at High Down on 17 August 2005, the man saw a nurse for a standard health assessment for new arrivals. He said he was diabetic and had taken medication for this in the past, but could not remember what the medication was. Around four weeks later he complained of feeling dizzy. His blood sugar and blood pressure were checked, both of which were high. He was subsequently prescribed ramipril (for high blood pressure) and gliclazide (an anti-diabetic medication that increases insulin production and therefore lowers blood sugar).

17. The man moved to HMP Belmarsh on 3 February 2006, and, two months later, was sentenced to life imprisonment with a tariff of 15 years. He moved to Swaleside on 1 December. This was a progressive move to allow him to begin the offending behaviour courses that his sentence plan required.

18. At a diabetic review on 20 December, it was noted that the man had "very little insight" into his diabetes. His blood sugar reading was very high and he was therefore admitted to the inpatient unit for monitoring and assessment. He discharged himself three days later, against the advice of healthcare staff.

19. In mid-2007, the man's prescription of gliclazide was stopped. Instead, he was given insulin pens to use daily. (Using these pens enabled him to supplement the insulin that the body naturally produces and subsequently lower his blood sugar.) At around the same time he was prescribed the medication tamsulosin after complaining of pain when urinating. (Tamsulosin helps muscles in the prostate and bladder relax, which reduces obstruction in the flow of urine.)

20. As a result of his pain when urinating, the man was referred to a consultant urologist at outside hospital. He went to an outpatient appointment at the hospital on 23 July, at which an ultrasound showed that his kidneys were normal apart from a small cyst in his left kidney. His symptoms were noted to have improved since he started taking tamsulosin. The consultant recommended a surgical procedure, but the man was not keen on account of the recent improvement in his symptoms.

21. On 29 December, a nurse was called to see the man on his wing as he was exhibiting strange behaviour. He was reportedly throwing things and trying to hit people. He told the nurse that he was not taking his insulin and wanted his "tablets". (The specific medication is not mentioned in the note, although later entries indicate that he was referring to tamsulosin.) As he had not taken his insulin, the nurse asked him to come to healthcare for assessment, but he refused. That afternoon, he saw a diabetic specialist nurse for an urgent review. He had now calmed down and said he would start to take his insulin.

22. Two days later, a nurse visited the man in his cell. He confirmed that he declined to take his insulin in protest at not being given tamsulosin. It is not clear from the records when and why tamsulosin was stopped. Prescription charts for November and December are not available, so the last confirmed prescription was a 28 day supply on 17 October. The man received his medication 'in possession', meaning that he received the medication in batches to keep in his cell and take as prescribed. The nurse arranged for him to see a doctor the following week for a medication review. He did not attend the appointment, however, for reasons which are not recorded.

23. The man continued to refuse his insulin over the following weeks. On 30 January 2008, he saw a nurse and told them that he was not taking insulin because he had not had tamsulosin for a month. The nurse later discussed this with a nurse practitioner (a registered nurse who has completed an advanced nursing education and can prescribe some medication) and it was noted that this nurse would "sort it out". On 4 February, he was prescribed tamsulosin again. He now said he would take his insulin again and agreed to have his blood sugar levels monitored.

24. However, there is no indication that the man did begin to take insulin again. On 19 February, he was reviewed by a nurse after concern was raised by staff on his wing. He said he did not usually take his medication and that he was hearing voices. He was admitted to the healthcare inpatient unit for observation and to stabilise his diabetes.

25. The following day, the man was reviewed by a member of the prison's mental health in-reach team. He said he had been hearing voices for around three months. The nurse noted that he was hostile and aggressive and appeared paranoid about prison officers. She also noted that he had not taken his insulin for some time. Her consideration was that his symptoms could be caused by physical and external factors and she recommended that he remain in the inpatient unit for observation and review.

26. A care plan was written on 22 February to set out what action healthcare staff should take to ensure the man's diabetes remained stable and controlled. The recommended action included daily monitoring of his blood sugar levels and to encourage him to take his medication as prescribed.

27. It appears that the man returned to his wing shortly afterwards. In early March it was noted that he was now cooperating with his medication, including insulin. Later that month, however, he refused to attend an appointment at the diabetes clinic at outside hospital. The hospital subsequently removed him from their clinic list by the hospital. In April, the man declined to attend the prison's regular clinic for older prisoners.

28. An Assessment, Care in Custody and Teamwork (ACCT) form was opened on 19 August. (ACCT is the process used for monitoring and supporting prisoners assessed as at risk of suicide or self-harm.) The man told an officer that he wanted to die and he had not eaten or used his insulin for two days. At the assessment interview that takes place on the day an ACCT is opened, he was described as "unable to talk with any clarity, totally confused, almost impossible to follow what he is talking about".

29. The following day, the man was brought to healthcare because he was not eating or taking his insulin. He was assessed by a prison doctor. The man refused to allow blood to be taken for testing, or to be examined in any other way. He said that he "did not care" about taking insulin. The doctor considered that the man had the mental capacity to make decisions regarding his welfare. He asked that the man be admitted to the inpatient unit when a bed became available.

30. No bed was available that day, so the man returned to his wing. The ACCT form was closed the same day. He was described in the review as cheerful and willing to talk. He said it was his choice not to take his insulin, but that he did not intend to deliberately harm himself.

31. The man was reviewed by a prison doctor on 21 August. The doctor noted that the man had poor control of his diabetes on account of not taking insulin. He was described as "generally frail, lethargic, dehydrated". The doctor repeated his view that the man retained the capacity to make decisions about his own welfare. He again recommended that he should be admitted to the inpatient unit.

32. As there was still no bed available, the man was admitted to the inpatient unit at HMP Elmley, a neighbouring prison in the Sheppey cluster. After three days at Elmley, he was admitted to outside hospital as he was still not eating or taking insulin. He returned to Elmley on 2 September.

33. In the following days, charts were started to monitor the man's food and fluid intake. Care plans were written with the aim of stabilising his blood sugar levels through monitoring and encouraging him to take medication. Over the following weeks, he took his medication regularly again. At a mental health assessment on 4 November, he said that he no longer heard voices talking to him.

34. On 12 November, the man returned to Swaleside and moved into a cell in the healthcare inpatient unit. For the remainder of the month he took his insulin and was compliant with blood sugar tests. He was reported as generally in good humour, although there were some occasions in which his short temper was noted. In December, he refused his insulin on a number of days. No reason for these refusals is noted.

35. In January 2009, the man often refused one batch of insulin per day. He was re-referred to the diabetic consultant at outside hospital in early

February. Through the remainder of that month and into March, he usually took his insulin but refused all other medication. From mid-March onwards he began to refuse his insulin too. He declined to attend his scheduled appointment with the diabetic consultant on 23 March, as he said he felt much better since he stopped taking insulin.

36. Through the second quarter of 2009, the man continued to refuse most of his medication and took insulin only sporadically. He became more withdrawn and began to spend the majority of his time in his cell, coming out only to collect his meals. The man was occasionally incontinent of urine. A prison doctor reviewed him on 16 June, giving particular consideration to his mental state. He found that he had no impairment of his memory, concentration or capacity to consider his actions.

37. The following month, the man showed some signs of paranoia. He was seen by a nurse talking to himself and saying that his sister, staff and other prisoners were talking about him behind his back.

38. A new care plan was written on 1 August, with the aim of stabilising the man's diabetes. As previously, the care plan advised that nursing staff should explain to him the benefits of accepting his insulin and having his blood sugar tested. The care plan also advised that he should be reviewed by a prison doctor each week whilst he was continuing not to take his medication regularly.

39. The man's medical record indicates that he was reviewed sporadically by prison doctors, but not on a weekly basis as his care plan advised. He saw a prison doctor on 3 August to discuss his continued non-compliance with his medication and insulin. Although the doctor explained the potential consequences, the man refused to reconsider his decision. The doctor noted that healthcare staff should continue to offer the man his medication as and when it was due.

40. Throughout the remainder of 2009, the man continued to refuse all of his medication and insulin, with only very rare exceptions. He also continued to spend the vast majority of his time in his cell.

41. On account of his urinary incontinence, the man was visited by bladder and bowel specialist nurses on 2 November. The nurses visited him in prison as he refused to go to their clinic at the local hospital. However, he refused to see the nurses and they were therefore unable to assess him. The nurses asked that the man keep a 'bladder diary', but he refused to do so. He was reviewed by a prison doctor ten days later, who advised healthcare to undertake observations "of the type that don't upset him". A note indicated that, by this, he meant that staff should informally consider the man's mental capacity to make decisions. He added that mental health professionals would be asked to assess the man should staff consider that he had started to lose capacity.

42. In mid-December, the man complained again of pain when urinating. He now agreed to see the specialist nurses if they returned, and a new referral was subsequently made. He began to take his medication quite regularly in the second half of the month and into January 2010. He also agreed to a blood test, which showed a high prostate-specific antigen (PSA, a screening test of the prostate), indicating disease of the lower urinary tract (the urinary tract consists of the kidneys, bladder and the tube that connects them). The results matched national guidelines for an urgent urology referral, which was subsequently completed.

43. A hospital appointment was made for 6 January 2010. The man went to hospital but, shortly after his arrival, reportedly became abusive to hospital staff. On account of this abuse, he was taken back to prison without being seen by the consultant.

44. Through the remainder of January and into February and March, the man again refused all his medication and insulin. An entry in his medical record by the healthcare manager on 11 February, noted that he did not appear to be "suffering any ill effects" from not taking his medication.

45. A new appointment was made with the Department of Urology at the local hospital for 15 March. However, the man declined the appointment. He told a prison doctor that he thought the specialists at the hospital could do nothing for him. The prison doctor noted that the man had the right to make this decision as he "has capacity".

46. A bladder and bowel specialist nurse visited the man on 18 March, following the referral three months earlier. However, the assessment was terminated at an early stage as the man reportedly "became irritable".

47. The man continued to refuse all medication and insulin throughout the second quarter of 2010. In mid-April he was again observed by the healthcare manager as showing no ill effects. On 14 April, he declined to attend a hospital appointment at the diabetic retinopathy clinic. (Diabetic retinopathy is damage to the retina as a common side effect of diabetes.)

48. The care plan was reviewed on 25 May, with no major changes from that of the previous August. As previously, the care plan advised that the man should be reviewed each week by the prison doctor whilst he refused treatment. Again, there is no indication from his medical record that he was reviewed as frequently as specified.

49. In June, the man began to eat less. He continued to spend most of his time in his cell. He again showed signs of paranoia later in the month. He reportedly "became threatening" if he thought anyone was talking about him, and believed that any laughter he heard was aimed at him.

50. Throughout July, August and September, the man refused all medication and insulin. In October, he was noted to have lost weight and it was requested that he should be weighed each week. He refused to comply

with these requests. However, he was now reported to be eating well again.

51. On 26 October, the man complained of feeling light headed. He was assessed by a prison doctor. After examining the man's chest, the doctor diagnosed a chest infection and prescribed a course of cefalexin (an antibiotic). The man took the antibiotic on the following two days, but refused all other medication.

52. The man ate very little on 28 October. On account of his infection and unstable diabetes, the doctor advised that he should be admitted to outside hospital for assessment. However, the man refused to go. He was monitored regularly for the remainder of the day and through the night. At around 1.45am on 29 October, he was found "shaking uncontrollably". He now agreed to go to hospital and an ambulance was called.

53. On his arrival at hospital, the man was reportedly abusive to hospital staff. He was therefore taken back to Swaleside without receiving any treatment. Later that day he saw a prison doctor and agreed to restart using insulin. The doctor also prescribed metformin (an anti-diabetic drug) on account of the length of time since he had last taken insulin. He took all of his prescribed medication later that day and for the rest of the month.

54. From 3 November, the man began to refuse medication regularly again. In the remainder of the month he took his medication occasionally but usually refused insulin. In late November, he developed swollen legs. This was diagnosed as oedema (fluid retention in skin tissue). At a review with a prison doctor the man said that he would now start to take his medication. The doctor noted that, if this proved to be the case, he could prescribe medication to treat the oedema. However, he continued to refuse his medication when offered it.

55. The man developed a chesty cough on 3 December, and was prescribed a course of antibiotics by a prison doctor after being diagnosed with an infection. He took the antibiotics over the following three days, but declined all other medication. He continued to remain in his cell most of the time and was reportedly "verbally aggressive" when offered help.

56. On the morning of 6 December, a prison doctor examined the man and found that his chest was very congested. He arranged for him to be admitted to outside hospital for assessment. He agreed to go to hospital.

57. Each time a prisoner is escorted outside the prison to hospital, a risk assessment considers the risk to the public, potential for escape and likelihood of outside assistance. The assessment informs the decision about the number of escorting officers and the type of restraint to be used. The risk assessment determined that the man was to be accompanied by two officers and cuffed to one of them by means of an escort chain (a long chain with a handcuff at each end) and that his hands would be cuffed

together by a standard set of handcuffs. This combination of two sets of restraints is known as ‘double cuffs’.

58. The man remained in hospital until 17 December. During this time he underwent various tests, including a chest x-ray which showed cardiomegaly (an enlarged heart, that can be caused by various conditions including high blood pressure). He also had a catheter inserted on account of slow urine production, which was caused by poor kidney function. On account of his behaviour in hospital, the man remained on double cuffs until 10 December (although the standard handcuffs were removed at meal times). He was reported as verbally abusive to hospital staff and “trying to push them about”. When the standard handcuffs were removed on 10 December, on account of a deterioration in his health, the man was restrained by an escort chain. His conduct remained poor throughout the rest of his time in hospital, and on one occasion the standard handcuffs were reapplied briefly when he tried to get out of bed to “get at staff”. He continued to refuse insulin whilst he was in hospital.

59. The day after he returned to Swaleside (18 December), the man took all of his prescribed medication with the exception of insulin. He was described as “still extremely independent”, although he was a little weak. The following morning, a large amount of blood was found in his catheter and an emergency ambulance was called to take him to outside hospital. As previously, a risk assessment determined that he should be accompanied by two officers and, initially, double cuffed.

60. At hospital, the man was diagnosed with a urine infection and urinary sepsis (a bacterial infection of the blood). A blood test also showed that his haemoglobin level had fallen (haemoglobin in the blood carries oxygen from the lungs to the rest of the body). He was prescribed trimethoprim (an antibiotic used for bacterial infections).

61. The man returned to Swaleside the same afternoon. The healthcare manager telephoned the hospital before the man’s return for an update. He was told that the hospital doctors thought no further action was required at the time. The healthcare manager was concerned about the man’s return and asked that the discharge papers be given in hard copy to the escort staff, rather than being sent by the normal means. This was so that healthcare staff had information about the man’s condition and his treatment when he returned. The healthcare manager noted in the medical record that the hospital doctor “became a little ‘prickly’ at this point and asked if I was looking for somebody to blame should anything happen”.

62. On the morning of 20 December, the man passed a lot of blood in his urine. He was reviewed by a prison doctor. The doctor described the man as “dehydrated and confused” and he told her he felt like he would “pass out”. Over the following three hours, the doctor made three attempts to telephone outside hospital to discuss the man’s symptoms and potential admission, but the telephone was not answered. In view of

the man's, symptoms, which she described as "potentially critical", the doctor asked for an ambulance to be called to take him to accident and emergency. The ambulance was requested at around 2.00pm and arrived at around 3.15pm. The ambulance left the prison with the man at around 3.40pm.

63. The risk assessment determined that the man should again be accompanied by two officers and, on this occasion, initially cuffed to one of them by an escort chain. The following morning, hospital doctors asked for the man's family to be told of his admission as his condition was deteriorating significantly. At 10.50am the duty governor gave permission for the escort chain to be removed on account of this deterioration. The man's sister was contacted that afternoon and visited later in the evening with three other members of his family.

64. The man died at 1.10am on a day in December, with his sister and family at his side. The cause of death was later established as septicaemia (blood poisoning) due to diabetic nephropathy (damage to the kidneys due to diabetes) with a secondary condition of congestive cardiac failure. The man's funeral was held locally on the Isle of Sheppey on 12 January 2011. The costs of the funeral were met by the prison.

ISSUES

Clinical care

65. The man spent a significant time at Swaleside living on the healthcare inpatient unit. During this time, he refused his medication and insulin more often than not. The clinical reviewer considers that the man's medical records were "detailed and comprehensive" throughout his time in prison. He goes on to comment as follows on the overall standard of care that the man received:

> "This was found to be of a very high professional standard despite [the man] being a challenging individual. [It was] certainly equivalent if not better than could have taken place in the community."

66. In the paragraphs below, I discuss in more detail the clinical care provided to the man, as well as other issues.

Refusal of medication and insulin

67. The man first stopped taking his prescribed insulin in late December 2007. He told nursing staff that this was because he was no longer prescribed tamsulosin (which he was first issued in summer 2007 on account of difficulty passing urine). There is no indication in his medical record as to when and why tamsulosin was stopped. The last confirmed prescription was on 17 October, when he received a 28 day supply. Prescription charts for November and December 2007 are missing.

68. In early February 2008, the man was again prescribed tamsulosin. There is again no indication why the medication was represcribed, other than a note from a nurse practitioner saying she would "sort it out" when the man complained about not receiving tamsulosin.

    The head of healthcare should remind prison doctors and nurse practitioners to record the reasons for any changes to a patient's medication in the patient's medical record.

69. Despite his prescription for tamsulosin being renewed, the man continued to refuse insulin for another month. After encouragement from staff he began to take his insulin again in early March, and continued to do so for several months. During this time, however, he refused to attend an appointment at the diabetes clinic at a local hospital.

70. The man began to refuse his insulin again in August 2008. On this occasion, he told a prison doctor that he "did not care" about taking the medication. He said it was his choice not to take insulin and he was not doing so to deliberately harm himself. He was admitted to the prison's inpatient unit to monitor his diabetes (although initially stayed in the inpatient unit at Elmley for around three months due to a lack of space at Swaleside).

71. For the remainder of his life, the man refused his insulin and other medication more often than not. His compliance tended to fluctuate and there were some periods in which he refused all medication and insulin for several weeks at a time. He usually refused to let staff measure his blood sugar levels or carry out other health monitoring programmes, such as regular checks of his weight. He also refused several hospital appointments. When he did agree to go to hospital, the appointments were terminated early on account of his poor conduct.

72. The man gave very little reason for refusing his medication and insulin. The inpatient manager at Swaleside told the investigator that the man appeared to take insulin when he did not feel very well. The man did not attend some hospital appointments as, he said, he thought that the consultants could do nothing for him. He also said on occasions that he "felt better" since he stopped taking insulin. Despite regularly refusing medication and insulin for such a long period, the man showed little physical sign of illness. A senior nurse told the investigator that the man was able to manage his diabetes reasonably well by adjusting his diet to counter the effects of not taking insulin.

73. Several care plans were written and reviewed once the man began to consistently refuse insulin. The care plans instructed staff to continue to encourage him to take insulin and allow his blood sugar to be tested, by explaining the benefits of this action. There is clear evidence in his notes that staff regularly spoke to him about these benefits and tried to monitor his blood sugar and take other observations as best as he would allow.

74. Care plans written on both 1 August 2009 and 25 May 2010 advised that, whilst he refused his medication, the man should be reviewed by a prison doctor on a weekly basis. However, there is no indication that formal reviews took place on such a regular basis. Following the August care plan, the man was reviewed on 3 August, but not again for several weeks. Similarly, when the care plan was reviewed in May, he again did not see the prison doctor for a formal review for a number of weeks.

    The head of healthcare should ensure that care plans are shared with all healthcare staff and that all actions are carried out as the care plan sets out.

75. It is apparent that considerable, on-going efforts were made by staff to enlist the man's co-operation in his medical care. He was described by a senior nurse as "difficult to deal with" and "obstructive, boisterous". Conversely, he was a man who kept himself to himself and would often spend all day in his cell, only coming out to collect meals. I will discuss his capacity to refuse treatment in more detail later in this report. However, I am satisfied that staff at Swaleside could have done nothing further to encourage him to engage in and comply with his treatment plan.

The man's mental capacity to refuse treatment

76. As I have described above, the man regularly refused insulin and other treatment for the last three years of his life. During this time, he reported hearing voices and showed signs of paranoia and other bizarre behaviour. He was formally assessed by a member of the prison's mental health in-reach team in February 2008 after saying he heard voices. A second assessment took place in November 2008, at which the man said he no longer heard voices. On a number of other occasions, he expressed the view that prison staff, family members or other prisoners were talking about him or laughing at him behind his back. There were also occasions in which his speech was described as rambling, or making no sense.

77. A prison doctor considered the man's mental capacity to refuse treatment on several occasions. In August 2008 (shortly after the man began to refuse insulin for a second time), he twice noted his view that the man retained the capacity to refuse treatment. At a review in June 2009 that mainly focused on his capacity, the prison doctor concluded that he had no impairment of his memory, concentration or capacity to consider his actions. Five months later, he asked staff to informally observe the man's capacity and noted that mental health professionals should be contacted if it was considered that he had started to lose capacity. Finally, in March 2010, the doctor noted his view that the man had the capacity to refuse a urology appointment.

78. In addition, a senior nurse told the clinical reviewer that at no time did he consider that the man did not have capacity to decide whether to take his medication. He added that this was "continually assessed both formally and informally".

79. The clinical reviewer considers that the "main issue" of the man's medical management was whether he had the capacity to refuse treatment. The Mental Capacity Act 2005 outlines five key principles that must be taken into account when determining an individual's capacity. The first of these states that:

    > "Every adult has the right to make his or her own decisions, and should be assumed capable of doing so unless it is proven otherwise."

80. The clinical reviewer concludes as follows:

    > "I could not find evidence that at any time during his detention within the prison system that he did not have the capacity to determine whether he should receive his medical treatment."

81. However, as I have described above, the man sometimes showed signs of paranoia, spoke in a rambling manner, and began to spend more and more time withdrawn in his cell. The healthcare manager told the investigator that, as well as his physical condition, it was not feasible for the man to return to a normal wing as his mental state and abusive and

cantankerous behaviour meant that he would not get on with other prisoners.

82. I accept the clinical reviewer's view (and that of the prison doctor and other healthcare staff) that there is no indication that the man did not have the capacity to determine his own treatment. However, given the factors described above, I am surprised that a further assessment was not made by a mental health professional in the last two years of the man's life. It would also have been helpful had other members of staff, in addition to this particular prison doctor, formally recorded their opinion of the man's capacity in his medical record.

    The head of healthcare should ensure that, when a prisoner is refusing treatment, consideration of their capacity to do so is formally recorded on a regular basis by staff of a variety of grades and disciplines. Consideration should be given as to whether psychiatric assessment should be made.

Use of restraints in hospital

83. A risk assessment was carried out on 6 December 2010, when the man was admitted to hospital. The purpose of this initial assessment is to determine the security arrangements necessary in the ambulance and on escort in hospital. It was determined that he would be accompanied by two officers and that a standard set of handcuffs would be applied, together with an escort chain cuffing him to one of the officers (the use of two sets of handcuffs is known as 'double cuffs').

84. On account of the man's disruptive conduct in hospital, both sets of restraints remained in place for several days. During this time he was verbally abusive to hospital staff and was reported as "trying to push them about". When his health deteriorated on 10 December, the standard handcuffs were removed so only the escort chain remained in place. Despite his deterioration, the man's behaviour remained difficult to manage. The standard handcuffs were reapplied briefly on one occasion when he reportedly tried to get out of bed to "get at staff". The escort chain remained in place until he returned to the prison on 17 December. I also note that previous hospital appointments had been cancelled on account of the man's abusive behaviour towards hospital staff. Given his conduct in hospital, I consider the use of restraints to be appropriate at this time.

85. The man was next taken to hospital for a few hours on 19 December. Double cuffs were applied throughout this hospital visit. Given his recent conduct in hospital, I also consider this to be reasonable.

86. Following the man's admission on the afternoon of 20 December, an escort chain only was authorised to be used in hospital. When he deteriorated the following morning, the duty governor gave permission for

the escort chain to be removed. Again, I consider this to be an appropriate use of restraints.

Return from hospital on 19 December 2010

87. The man was admitted to hospital on 19 December, via an emergency ambulance, after a large amount of blood was found in his catheter. At hospital, he was diagnosed with urinary sepsis (a bacterial infection of the blood) and was prescribed an antibiotic. He was discharged from hospital that afternoon. His discharge summary noted that no follow up was required.

88. The clinical reviewer notes as an “issue of concern” that the man was not admitted as an inpatient on 19 December, as he was “obviously very unwell, passing blood in his catheter with a falling blood haemoglobin level”. This decision was made by hospital staff and falls outside of the terms of reference of my investigation and the clinical review. However, I note the clinical reviewer’s comments that it may be necessary for other authorities to explore this further if they deem it appropriate.

Hospital admission on 20 December 2010

89. On the morning of 20 December, the man again passed a large amount of blood in his urine. He was examined by a prison doctor, who described him as “dehydrated and confused”. She subsequently tried to telephone outside hospital on three occasions to discuss his symptoms and potential admission to hospital. The telephone was not answered on either occasion. The clinical reviewer also notes this as an issue of concern for the hospital.

90. An ambulance was called to take the man to accident and emergency at around 2.00pm. The ambulance arrived at Swaleside around 45 minutes later, at 3.15pm. Although his condition was not critical at this time, the clinical reviewer notes this delay as an issue of concern.

CONCLUSION

91. The man's time at Swaleside was defined by his persistent refusal to take insulin or other medication, for a period of over two years. Despite this refusal, he remained reasonably well for most of the time and was able to manage his diabetes through adjustment to his diet. He was described as "cantankerous" and was sometimes abusive to staff. He also sometimes appeared paranoid and became more and more withdrawn. However, at no time did staff have doubts about the man's capacity to refuse treatment.

92. The clinical reviewer finds that the man received a high standard of clinical care at Swaleside. I am satisfied that staff did all they could to encourage him to engage with his treatment. However, I consider that the man's capacity to refuse treatment should have been formally assessed and recorded more regularly.

RECOMMENDATIONS

1. The head of healthcare should remind prison doctors and nurse practitioners to record the reasons for any changes to a patient's medication in the patient's medical record.

   Accepted – Notice to all healthcare staff reminding them of their responsibilities in accordance with local policy on core health record keeping. Including best practice guidance.

2. The head of healthcare should ensure that care plans are shared with all healthcare staff and that all actions are carried out as the care plan sets out.

   Accepted – Notice to healthcare staff to ensure that all care plan actions are communicated to the responsible person. Review of care plans are undertaken at least weekly by the primary nurse.

3. The head of healthcare should ensure that, when a prisoner is refusing treatment, consideration of their capacity to do so is formally recorded on a regular basis by staff of a variety of grades and disciplines. Consideration should be given as to whether psychiatric assessment should be made.

   Accepted – decisions involving consent to treatment include reference to the mental capacity act and this is included in the local policy on consent.