PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the death of a man at outside hospital in April 2012 while a prisoner at HMP Parc

Report by the Prisons and Probation Ombudsman for England and Wales

January 2013

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This is the report of an investigation into the death of a man. He was 75 years old when he died in outside hospital in April 2012. He had a number of chronic conditions and had been refusing to take food for some weeks. The post-mortem report showed that he died of a pulmonary embolism (a clot in the vessel taking blood to the heart). This was not associated with his food refusal. I offer my condolences to the man's family and friends.

The investigation was carried out by one of my investigators. Healthcare Inspectorate Wales carried out a review of the man's clinical care. HMP Parc cooperated fully with the investigation.

The man was remanded to HMP Parc on 22 February 2012. He had not been in prison before. He maintained his innocence of the offences he was charged with. In protest, he had been refusing to eat since before he arrived in Parc. He also refused almost all medication and treatment. Prison staff tried to persuade him to eat and to accept treatment, but he continued to refuse. In early April, he agreed to go to hospital and remained there until he died later that month.

The man's refusal to take food and most medication, together with his underlying ill-health, posed significant challenges to Parc. The prison managed these challenges with care and compassion, and sensitively respected his wishes. His food and medication refusal was appropriately managed. He was kept well informed of the risks he was taking. His capacity to make decisions was properly and regularly reviewed. His health was monitored and he was frequently offered treatment, which he refused. The man made his intention to die very clear, but ultimately he died from natural causes which could not have been foreseen or prevented. I am satisfied that staff at Parc provided very good care for the man which was at least equivalent to that which he could have expected 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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **January 2013**

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SUMMARY

1. The man was born in June 1936. He was 75 years old when he died in hospital in April 2012. He had no previous criminal convictions, but had been charged with a number of offences, committed over a period of time, against members of his family. He had been remanded on bail since March 2011 and was due to stand trial on 11 June 2012. Until his arrest, he had no previous history of mental illness or of harming himself, but while he was on police bail he made three attempts to take his own life and spent four days in a psychiatric hospital. He was remanded into custody on 22 February 2012 and taken to HMP Parc.

2. On arrival at Parc, staff noted the man's recent suicide attempts, and he was monitored under the Prison Service process for supporting prisoners at risk of harming themselves. He was located in the safer custody unit, a separate unit at Parc to provide intensive support and care to prisoners.

3. Because of the man's food refusal, he was in continual contact with healthcare and assessed by healthcare staff daily. Prison managers held frequent case conferences to discuss his care involving the prison's Director and the G4S national Head of Healthcare, as well as staff responsible for his day-to-day care. Prison staff continually tried to persuade him to eat and to take his medication, but he refused to eat and would only accept pain-relieving medication or medication to reduce the risk of a stroke.

4. Healthcare staff regularly assessed the man's capacity to make his own decisions about eating and medical treatment. At no point was there any reason to suspect that he had lost capacity. He was also referred to a consultant psychiatrist, who found no evidence of mental illness or dementia.

5. On 2 April, the man's health declined and he was admitted to hospital. Tests confirmed that he had cancerous cells in his bowel for which he refused treatment.

6. The man had been out of contact with his immediate family since before his imprisonment. However, as his health deteriorated, the prison chaplain liaised between the man and his family who visited him before he died.

7. The man died on a morning in April. The post-mortem report showed that he died of a pulmonary embolism, further to deep vein thrombosis and ischaemic and hypertensive heart diseases and carcinoma of the stomach. This was not related to his on-going refusal to eat.

8. We do not make any recommendations.

THE INVESTIGATION PROCESS

9. The Ombudsman's office was informed of the man's death on 29 April 2012. The investigator issued notices to staff and prisoners informing them of the investigation and inviting anyone with relevant information to contact him. No further information was received.

10. The investigator spoke to the duty manager on 30 April and visited HMP Parc on 3 May. He met the Director and the Deputy Controller (Contracts for privately managed prisons are monitored on site by a Ministry of Justice appointed controller). He visited relevant areas of the prison, including the healthcare centre, and spoke to staff and prisoners who knew the man.

11. The investigator obtained copies of the man's prison record and prison medical record. Healthcare Inspectorate Wales (HIW) conducted a clinical review of the man's care and treatment while in custody. The clinical review was received by the Ombudsman on 8 October 2012. The investigator gave feedback to the Director at Parc during the investigation.

12. HM Coroner was informed of the investigation and a copy of the post-mortem report was requested. After consultation with this office, the Coroner decided to hold the inquest into the man's death before this report was published. A verdict of natural causes was returned. A copy of this investigation report will be sent to the Coroner for his information.

13. One of the Ombudsman's family liaison officers contacted one of the man's sons to explain the purpose of our investigation and offered him the chance to raise any concerns about his father's care at Parc. The man's son said that his family were content with the level of care their father received, which he described as excellent. His family had found contact with the chaplain helpful and had no specific issues they wanted the investigation to address. They did not have any comments in relation to the draft report.

14. The investigation has assessed the main issues involved in the man's care including his diagnosis and treatment, managing his food refusal, liaison with his family, his location and security arrangements, and whether appropriate care was provided.

HMP PARC

15. HMP & YOI Parc opened in 1997, and is run by the private company G4S. It holds up to 1474 convicted male juvenile, young adult and adult prisoners on remand or convicted.

16. Since October 2010, G4S has provided 24 hour primary general and mental healthcare services at Parc. The healthcare centre has a 14 bed unit for older prisoners with increased health needs (known as U block) and six emergency care beds for patients with acute physical or mental health needs. General practice sessions are provided by a local surgery. The doctors offer 14 sessions per week, as well as out of hours cover.

Prison Service guidance on food refusal

17. Guidance to staff on prisoners who refuse food is contained in Prison Service Instruction (PSI) 64/2011. The instruction states:

> "Some prisoners may decide to refuse food and/or fluids, or medical treatment for a variety of reasons. These decisions will be valid provided that the prisoner is deemed to have the mental capacity to make the decision. Mental capacity can only be assessed by a healthcare professional."

18. The PSI notes that the decision to refuse food is not considered in law to be a form of self-harm. Regarding prisoners having the mental capacity to make such a decision, the instruction states:

> "The Mental Capacity Act 2005 provides clear guidance that any individual has the legal right to refuse any treatment including food and/or fluid or resuscitation if they are mentally capable. The Act states that a person is assumed to have capacity unless it is established that they lack capacity and must not be considered unable to make a decision merely because they make an unwise decision."

Her Majesty's Inspectorate of Prisons (HMIP)

19. HMIP last published report on Parc is of an inspection in September 2010. The report found that prisoners were mostly positive about their relationships with staff. However, the report identified there was little work specifically targeting older prisoners, and found that healthcare services were not delivered to an acceptable standard, with poor management of chronic conditions. The inspection took place before G4S took over the provision of healthcare services.

Independent Monitoring Board (IMB)

20. Each prison in England and Wales has an Independent Monitoring Board, made up of unpaid volunteers from the local community who monitor day-to-day life in the prison to help ensure that proper standards of care and decency are maintained. The last report published by the IMB for Parc, covering the period March 2011 – February 2012, noted that the prison was a well-run and safe prison. Some problems with prisoners being made aware of medical appointments were noted.

Previous deaths at HMP Parc

21. In the three years up to the man's death, this office has investigated five deaths from natural causes at HMP Parc. There have since been a further two. There are no similarities between those deaths and that of this man.

ISSUES

The man's diagnosis

22. The man had suffered from poor health prior to his imprisonment. Past medical problems included bladder cancer, an irregular heartbeat, hypertension (high blood pressure), heart disease and emphysema. He had had a quadruple heart bypass and a pacemaker fitted.

23. When the man arrived at Parc on 22 February 2012, prison staff noted that he had recently tried to kill himself and that he had already been refusing food for two days. His reception health screen recorded his past health conditions and that he frequently suffered chest pain, became short of breath when walking, and had poor circulation. He said that he had an operation to remove a cancerous tumour from his bladder in the past and had had chemotherapy. However he had not attended his last oncology appointment on 8 February.

24. Records that arrived at the prison with the man showed that he had a "serious intent on suicide". He was placed on special supportive measures, known as Assessment, Care in Custody and Teamwork (ACCT) and a care plan was opened. This remained in place until the man died.

25. One of the prison doctors assessed the man on 23 February. They discussed his suicide attempts. While on police bail he had tried to take his life several times by tampering with the gas fire at his home, attaching a hose to the exhaust pipe of his car and by taking an overdose. He said that he no longer intended to take his life by such means, but would continue to refuse food. Following this, despite the efforts of staff, he refused food and almost all medical treatment. He consistently stated his wish to die.

26. As his health declined, the man finally agreed to go to hospital on 2 April. The hospital carried out a number of tests and, on 24 April, he told the prison chaplain that he had been told by hospital staff that he had cancerous cells in his bowel and would need surgery. He refused surgery and all treatment. The man died four days later,

27. The post-mortem report showed that the man died of a pulmonary embolism, further to deep vein thrombosis and ischaemic and hypertensive heart disease and carcinoma of the stomach. There is no suggestion that the man's food refusal was the cause of his death. The clinical reviewers note that he did not have any symptoms to suggest a pulmonary embolism while he was in prison.

Informing the man about his condition and treatment

28. Prison staff ensured that the man was aware of how his decision would affect his health. On 25 February, a doctor explained the risks in not taking his medication, which included stroke and heart attack. The man said that he understood. He stopped taking most of his medication, but continued to take warfarin (a blood-thinning medication) because he did not want to have a stroke. He declined any further medical assistance, including vitamins and health drinks. The following day, when the risks of not taking medication were explained again, he said to the doctor "I am here to die, this is my intention and that is what I am here to do, the sooner I pass away the better".

29. On 9 March, a prison doctor had a detailed discussion with the man, explaining how his food refusal would affect his health. The man repeated that he wanted to die but was willing to accept medication for pain relief. On 26 March, the doctor advised him that if he continued to refuse food, he would have approximately two weeks to live. He continued to decline food.

30. Frequent case conferences were held to discuss the man's care, involving the Director and the G4S national Head of Healthcare. On 27 March, it was agreed that he should be made fully aware of what would happen to his body if he continued to refuse food. On 28 March, the doctor explained this in detail to him.

31. On 29 March, the man started to vomit and cough up blood. The doctor told him this was likely to be bleeding in his stomach caused by not eating. The man asked what would happen if he did not eat, and the doctor said that he could have a larger bleed, which would kill him. The man said that it was his intention to die and declined further treatment.

32. On 31 March, a prison doctor offered to have the man taken to hospital for tests to find the cause of his internal bleeding. He declined. The doctor asked him why he prolonged his suffering by drinking while refusing to eat, and the man said he did not like the thought of dehydrating.

33. The man agreed to go to hospital on 2 April. On 18 April, he was told by hospital staff that further tests were needed on a suspected tumour in his stomach. On 24 April, he told the prison chaplain that cancerous cells had been found in his bowel, but that he had refused an operation or any treatment.

34. The medical records contain frequent assessments of the man's capacity to decide not to eat or accept treatment. He was assessed by a member of the Mental Health In-reach team and a consultant

psychiatrist on 5 and 7 March. They concluded that he displayed no symptoms of mental illness and remained rational and orientated. The consultant psychiatrist assessed him again on 12 March, and found he had capacity and there was no evidence of mental illness. A consultant old age psychiatrist agreed that there was no evidence of dementia. The consultant psychiatrist assessed him again on 28 March and, on 1 April, the prison doctor noted that, in refusing to go to hospital, the man was still of sound mind to make that decision. While in hospital on 4 April, a psychiatrist assessed the man and confirmed that he was making informed decisions about his care.

35. The advisability of the man making an advance directive[1] about his future treatment should he lose mental capacity was fully discussed with him. Throughout his imprisonment, he made it clear that he did not want treatment to prolong his life. He told a prison doctor that, should he lose capacity to make his wishes known, he did not wish to receive medication or to be fed. Nor did he want to be resuscitated should the need arise. The doctor advised him to arrange a formal advance directive with his solicitor, but he chose not to do this. He reiterated to the doctor that he did not want treatment or resuscitation. He did not wish to receive active medical treatment but would accept easing of pain and symptoms. He said that if he lost consciousness he wanted to go to hospital. This is well documented in his medical record.

36. The clinical reviewers were satisfied, as are we, that the man was kept well informed of the consequences and risks of not taking food and medication. His mental capacity was assessed frequently.

The man's medical appointments and treatment

37. The man was in frequent contact with healthcare services. However he refused to accept medical treatment which would prolong his life. A note on his medical record on 24 February shows that he was refusing all medication.

38. On 26 February, the man told a prison doctor that he had had chest and abdominal pain. The doctor suggested an electrocardiogram (ECG)[2] and blood tests. The man declined, saying that he would only accept medication to relieve pain. On 27 February, he asked for his prescribed inhalers and said that he was willing to be referred to hospital cardiology and urology services. Healthcare made appropriate referrals but the dates for the appointments had not been received before he was admitted to hospital on 2 April.

[1] The Mental Capacity Act 2005 allows for a person wishes to make their wishes known is advance if they wish refuse medical treatment in the future (when they may not have mental capacity to refuse).
[2] A test to detect heart irregularities

39. On 28 February, a prison doctor saw the man who described some brief chest pain, but refused an examination or any treatment. A letter was sent to the hospital to request a check on his pacemaker.

40. On 1 April, the man continued to refuse his medication and told a prison doctor that he was unable to drink much. The doctor offered to have him taken to hospital, but he refused.

41. After the man had agreed to go to hospital on 2 April, the prison chaplain visited him the following day. He told her that he was willing to receive treatment, but had no intention of starting to take food again. He received medication to reduce the production of acid in his stomach, but no other treatment. The hospital indicated that if he continued to refuse treatment then he would be returned to prison.

42. While in prison, the man was assessed several times a day by healthcare staff, including prison doctors. A prison doctor told the clinical reviewers that the man refused to go to the healthcare centre. The only interventions he was willing to accept were to relieve pain. The clinical reviewers note that he was given numerous healthcare appointments that he did not attend. Prison staff appropriately obtained his medical records from his community doctor. There was good communication between prison and hospital staff when the man was there. We are satisfied that liaison with outside health agencies was pursued appropriately by prison healthcare staff and that the man was given every opportunity to receive appropriate treatment for his health conditions.

The man's pain relief and medication

43. Because of his ongoing contact with medical staff, the man's medication was frequently discussed with him. Although he refused most medication, he accepted pain relief. At various times he was prescribed dihydrocodeine (pain relief), metoclopramide (to relieve nausea) and, as he became more unwell, morphine.

44. On 27 February, the man told a prison doctor that he had been refusing warfarin as it was making him sick. The doctor discussed alternative medication to prevent a stroke. The man agreed to have daily injections of clexane (a blood thinning medication).

45. On 10 March, a second mattress was provided for the man's comfort in view of his weight loss. The next day he was given mouthwash and skin cream. When he told a nurse that he was having difficulty drinking water because of the taste, she gave him flavoured water and arranged to get some fruit squash for him. On 26 March, the man was given morphine to help with his pain.

46. The clinical reviewers write that the man was prescribed medication when he complained of pain, nausea or vomiting. When he could no

longer tolerate warfarin his medication was changed and regularly monitored. He was seen promptly and issues were addressed appropriately as they arose. When he complained of chest pains, he was examined properly and treated appropriately, even though he declined the offered tests. He was prescribed skin cream, stronger painkillers when required, and medication to stop him from being sick. His stomach medication was changed when necessary. We are satisfied that his pain relief and medication were properly considered.

Liaison with the man's family

47. At the time of his imprisonment, the only family contact the man retained was with his sister-in-law. Soon after he arrived at Parc, staff contacted her and she visited him on 6 March. The prison chaplain gave the man's sister-in-law her contact details for future use.

48. On 26 March, the man asked if he could have a visit from his wife. The prison chaplain contacted the man's wife and she initially agreed. However, later that evening she received a telephone call from one of the man's sons to say that his family wanted no further contact, even in the event of the man's health deteriorating. His wife confirmed that she agreed with this and the man was told of his family's decision.

49. On 30 March, the man's son telephoned the prison chaplain to say they had reconsidered the situation. His sons agreed to consider visiting their father. The chaplain said that she would discuss this with the man and asked if his family would like to visit the prison to meet those responsible for their father's care. A visit was arranged for the afternoon of 2 April. On 31 March, the prison chaplain told the man that his sons had asked about the possibility of visiting and the man agreed to a visit.

50. A case conference was held on 2 April, before his family's visit. The Witness Care Team and the Crown Prosecution Service agreed that there was no objection to the man seeing them. The man agreed to see one of his sons. Later that day, after members of the man's family had met senior managers responsible for his care, one of his sons went to visit him.

51. On 4 April, the man asked if one of his sons could visit him in hospital. His sons discussed this with his family and they decided against any further visits. In the meantime the man changed his mind about a visit. His family asked that they should be contacted only if there was a severe deterioration in the man's condition.

52. On 21 April, the prison chaplain telephoned one of the man's sons. She explained that his father's health had deteriorated significantly and that doctors were investigating the possibility of a tumour. On 24 April, she contacted his family again to report that he had refused to be treated for cancer. The next day, on the advice of hospital staff, one of

his sons was told that his father's condition had declined considerably. The man's wife, sons, daughter and son-in-law then visited him and discussed his condition with the doctor responsible for his care. After the visit, the prison chaplain agreed that if the man died when his family were not present, she would inform them by telephone. The man's wife visited him on 26 April. The following day she telephoned for an update on his condition.

53. The man died at 9.38pm on an evening in April. His family were not there and the prison chaplain informed one of the man's sons by telephone as agreed. The man's family attended the hospital and the chaplain met them there to offer support and guidance.

54. On 29 April, the prison chaplain and the Head of Performance Management visited the man's family. They asked the chaplain to officiate at his funeral, to which she agreed.

55. The man's family told the Ombudsman's family liaison officer that they had found the contact with the prison chaplain helpful. We are satisfied that the chaplain maintained effective contact with the man's family throughout the later stages of his life and provided good and sensitive support in very difficult circumstances.

The man's location

56. When he arrived at Parc, the man was allocated a cell in the safer custody unit, where staff were able to provide better support than on a normal prison wing. A member of the mental health team saw him on 28 February and advised that he should be moved to the Older Persons' Unit in U block. This was discussed in a case conference on 1 March. It was agreed that he should move to one of the healthcare beds on U block to allow ready access for healthcare staff. He was given a cell covered by CCTV to help monitor him.

57. On 26 March, the man asked about the possibility of moving to hospital. It was explained that he would not be admitted to hospital as there was no treatment that could be offered. The man's location was discussed at a case conference the next day. It was agreed that his current location was suitable.

58. On 28 March, the man said that he wanted to go to hospital for re-hydration, but this was not considered necessary at that stage. He then told one of the doctors that he was willing to go to hospital so that he could begin to accept food again. This would mean that he would be fed through a tube from the nose into the stomach. The prison's deputy controller and a member from the IMB met the man to ensure that he was aware of what he was agreeing to. He then told them he was not ending his food refusal. Nevertheless, he was taken to outside hospital where he refused to accept any treatment. He was brought back to the prison at 1.40am on 29 March.

59. A case conference was held later that morning. It was agreed that palliative care[3] could be provided in the prison if needed. The man said he wanted to go to hospital if he lost consciousness. A hospital bed and a ripple mattress (to prevent bedsores) was provided. As it was too large for the man's cell it was placed in a cell in the safer custody unit, but he refused to move. He said he was familiar with U block and did not want to move even though this meant not having the hospital bed. He asked for a more comfortable chair which was provided.

60. On 2 April, the man agreed to go to hospital and was taken to outside hospital at 4.00pm. He was admitted, but refused treatment or examination. A prison doctor spoke to his consultant in the hospital about arrangements for the man's possible return to prison. His cell in U block was adjusted to house the hospital bed with the ripple mattress. However, the man did not return to the prison before he died.

61. The clinical reviewers note that appropriate decisions were made about the most suitable location for the man. He was offered the option to go to hospital several times, but he only accepted once and withdrew his acceptance of treatment after a few hours so was brought back to prison. He was offered a move in the prison so he could use a special airflow bed, but he refused. Once he went to hospital, staff in the prison continued to liaise with hospital staff to ensure that they were prepared to provide care should he return. We are satisfied that the man's location was given proper consideration during his time in prison.

Restraints, security and bed watch

62. When prisoners are taken to outside hospital, they are assessed as to the level of security that is required. The man was taken to hospital twice. He went on 28 March, only remaining for a few hours. The prison have been unable to find the security assessment made for this visit, although other documentation shows that as well as being escorted by prison officers, he was handcuffed.

63. The man returned to prison after only a few hours. At the case conference the following day it was agreed that if he needed to return to hospital, he would not require any physical restraints.

64. When the man agreed to go to hospital on 2 April, a security assessment was conducted. He was to be accompanied by two members of staff. Because of his age and health, and in line with the

[3] Palliative care is provided when patients will not recover, but are receiving treatment to reduce the severity of their symptoms.

earlier agreement, it was agreed that physical restraints were not necessary. This remained the case when his security was reassessed on 5 April and he was not subject to physical restraint for the rest of his time in hospital.

65. It is unfortunate that the prison has been unable to find a copy of the risk assessment for the man's hospital visit on 28 March. It seems unlikely that restraints were needed, but it is encouraging to see that when he returned to the prison the man's future security requirements were considered in advance, even though a risk assessment would be needed at the time. This was a good arrangement and we are satisfied that appropriate decisions were then made not to use restraints.

Palliative care plans

66. 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.

67. The man's health deteriorated over a period of time, and his care was continually considered by medical staff and reviewed in frequent case conferences. His medical record on 25 February, three days after his arrival in Parc, shows that a management plan had been put in place that covered observations, mental health review, psychiatric input and ongoing review. The following day a prison doctor produced a comprehensive plan to try to prevent the man from developing angina due to his erratic pulse.

68. At a case conference on 29 March, staff confirmed that, if required, the man could be provided with palliative care in the prison by healthcare staff. The cell in the safer custody unit that staff offered him was specifically set up for palliative care. The man, however, refused to move there.

69. A prison doctor told the investigator that the man was not always clear about what he wanted. It was therefore important that information was available to staff so that management plans followed to ensure appropriate care.

70. A formal palliative care plan or end of life pathway was never started for the man at the prison. However, the clinical reviewers note that good management plans were made to deal with his food refusal and refusal to accept active medical treatment. These were fully discussed with him and well documented in his medical record. We are satisfied that all the elements of an appropriate care plan were in place and that he was well cared for and well informed during his time at Parc. His

last weeks of life were spent in hospital when end of life care became the hospital’s responsibility.

CONCLUSION

71. The gentleman was an elderly man who came into prison with a history of poor health and having already been refusing food for two days. He continued to refuse food and only accepted limited medication to relieve pain or reduce the likelihood of a stroke.

72. Staff at the prison clearly explained the likely effects of his actions and regularly ensured that he retained the mental capacity to make the decision to keep refusing to eat. They did what they could to maintain his comfort. The man was very clear that he intended to die. In the event, it was not his food refusal which killed him but an unconnected pulmonary embolism.

73. The clinical reviewers state that the care received by the man in HMP Parc was properly coordinated, well thought out and timely. They note that the quality was exemplary and, in some respects, probably better than that which could have been provided in the community.

74. We agree that the man received good treatment at Parc and was treated with care and compassion.