PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Ford in January 2014

Our Vision

‘To be a leading, independent investigatory body,
a model to others, that makes a significant contribution
to safer, fairer custody and offender supervision’

This is the investigation report into the death of a man who died of lung disease on 24 January 2014 at HMP Ford. He was 51 years old. I offer my condolences to the man's family and friends.

The investigation was carried out by an investigator. A clinical reviewer reviewed the clinical care the man received at Ford. The prison cooperated fully with the investigation.

The man was sentenced to life imprisonment in 1993 and transferred to Ford in 2013. The man had been diagnosed with chronic obstructive pulmonary disease (COPD) many years before and, by the time he arrived at Ford, the disease had entered the severe stage.

The man was admitted to hospital a number of times as his health deteriorated. His last admission in December 2013 lasted three weeks and he was told that only palliative care was possible. Healthcare staff at the prison put in place end of life plans after discussion with the man. On 24 January, a prison officer found the man unresponsive in his room. In line with the man's wishes, he did not attempt resuscitation. Healthcare staff attended and a doctor verified his death.

The clinical reviewer is satisfied that the man's care in prison was equal to that he could have expected in the community. Although there does not appear to have been a formal care plan to manage his COPD, it is clear from the records his condition was well managed in line with national guidelines. I am satisfied that the man was well cared for at Ford.

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 **July 2014**

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SUMMARY

1. The man was sentenced to life imprisonment in 1993 and transferred to HMP Ford in 2013. He had spent time at a number of prisons and a secure mental health unit.

2. The man transferred from HMP Wymott to HMP Ford in May 2013. He had been diagnosed with chronic obstructive pulmonary disease (COPD) many years before and, by the time he arrived at Ford, his COPD had reached the severe stage.

3. Over the next eight months, the man was taken to hospital with COPD exacerbation many times. In June, he requested a do not resuscitate order. Healthcare staff discussed the implications of this with him and the order was put in place.

4. Between 25 December and 15 January 2014, the man was in hospital with COPD exacerbation. Hospital staff made it clear to him that there was no cure for his condition and he could only be treated palliatively. When he returned to prison an appropriate end of life plan was put in place, in liaison with a local hospice.

5. On the morning of 24 January, a prison officer found the man unresponsive in his room. In line with the man's wishes, he did not attempt resuscitation and a prison doctor verified the death.

6. We agree with the clinical reviewer that the man's care in prison was equal to that he could have expected in the community. He was well looked after at Ford and his COPD was managed in line with national guidance. Liaison with the man's next of kin, his friend, was good. We make no recommendations.

THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners at HMP Ford informing them of the investigation and inviting anyone with relevant information to contact her. No one responded.

8. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison record. She informed the Governor in writing of the preliminary findings of the investigation.

9. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.

10. We informed HM Coroner for Bournemouth and Poole Eastern District of the investigation, who provided the cause of death. We have sent the Coroner a copy of this investigation report.

11. One of the Ombudsman's family liaison officers contacted the man's friend, his nominated next of kin, to explain the investigation. He did not raise any concerns.

12. The man's friend received a copy of the draft report and indicated that he was satisfied with the findings.

13. The prison considered our draft report and raised one small factual inaccuracy (regarding an individual's name) which has been amended.

HMP FORD

14. HMP Ford is an open prison in West Sussex which holds approximately 500 men. NHS Sussex commissions healthcare services which are provided by Sussex Partnership NHS Foundation Trust. A prison healthcare centre is open on weekdays from 8.15am to 5.15pm (7.00pm on Wednesdays). West Sussex Out of Hours Service covers other times.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Ford was in August 2012. The Inspectorate found that nurses led on the management of patients with certain chronic conditions and doctors on others. Care plans were not routinely used for prisoners with complex health needs, although records showed there was appropriate review and follow-up.

Independent Monitoring Board

16. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that prisoners are treated fairly and decently. In its most recently published annual report for the year to October 2013, the IMB noted that 88 percent of offenders who attended the healthcare centre had rated the quality of service as good or very good.

Previous deaths at HMP Ford

17. The man was the first prisoner to die from natural causes at Ford in five years.

KEY EVENTS

18. The man was serving a life sentence and had spent time in a number of different prisons and a secure mental health unit. He had long standing chronic obstructive pulmonary disease (COPD). Although records do not show when he was first diagnosed with the condition, it is clear that he had had the disease for many years.

19. In October 2012, the man was in HMP Wymott when his COPD deteriorated significantly. He was admitted to hospital for treatment and considered to have end stage COPD. He returned to Wymott on 2 November. After being assessed as suitable for open conditions, he moved to HMP Ford on 30 April 2013. There had been discussion between Wymott and Ford about whether Ford had appropriate healthcare cover (Wymott has 24 hour nursing cover), but Ford agreed to accept him and healthcare staff at Wymott gave a comprehensive handover.

20. The man lived in an adapted single room on the ground floor of C wing, approximately thirty to forty yards from the healthcare unit. On 1 May, a nurse recorded that the man was severely disabled with COPD and that he used a self-propelled wheelchair and a nebuliser (which administers medication in the form of a mist inhaled into the lung.) He noted that the man was on a large amount of medication and referred him to the GP and the mental health team. The man declined advice about giving up smoking, although throughout his time in prison, he made a number of unsuccessful attempts to give up smoking and was frequently prescribed nicotine mouth sprays and patches to help.

21. In the early hours of 2 May, the man was admitted to hospital. He had been struggling to breathe even after using his nebuliser for two hours.

22. On 6 May, the man was discharged from hospital with a diagnosis of infective COPD. On 7 May, a nurse took him a dossett box (to store and organise medications) and noted that he was unable to clean his room. Arrangements were made for another prisoner to help him with his daily living tasks.

23. On 9 May, a prison GP reviewed the man's pain relief. The GP prescribed codeine and gabapentin to help relieve muscle pain. The GP noted that he needed an electric wheelchair. However he was never assessed for one, as each time an assessment was arranged he was in hospital. Records show he was able to move around his room and could use a self-propelled wheelchair.

24. On 14 May, healthcare staff gave the man a nebuliser machine after he had two asthma attacks.

25. On 17 May, a mental health nurse discussed the man's condition with him and the challenges of being in an open prison after 20 years of

closed prisons. She continued to see him frequently (usually every week or every other week) to discuss how he was feeling and to support him.

26. On 31 May, a nurse noted that the man was coughing up lung tissue, which was a normal symptom of his disease. He was admitted to hospital on 1 June with COPD exacerbation and a chest infection. He returned to Ford on 5 June.

27. On 6 June, the man's solicitors requested that the prison give him a do not attempt cardiopulmonary resuscitation (DNACPR) form, as he did not want any intervention if he had a cardiac or respiratory arrest. The mental health nurse and a prison GP discussed the implications with him and he signed the form on 20 June. Both healthcare and prison staff were made aware of this.

28. Prison staff called paramedics on 27 July as the man was having an asthma attack. He recovered without the need to be admitted to hospital, but was admitted four days later with breathing difficulties.

29. While in hospital, the man had a CT scan. A consultant respiratory physician told him that the scan showed that in the past he had had tuberculosis and he currently had emphysema (COPD) in the left upper lobe of his lung. The physician recommended changing his prescription to levoflaxacin (an antibiotic) as tests had shown he was resistant to amoxicillin. The physician also said that he should be encouraged to use his nebuliser and a spacer for his inhalers.

30. The hospital discharged the man on 2 August with a diagnosis of non-infective COPD. Records show that, on 8 August, a locum prison GP prescribed the levoflaxacin.

31. On 5 August, a nurse referred the man to the mental health team for review and a consultant psychiatrist and a senior house officer saw him on 29 August. There is nothing in the record to indicate he was in low mood about his health, but he appears to have been anxious about his move to open conditions. A nurse continued to see him frequently and records show he seems to have settled at Ford.

32. The man was admitted to hospital for one night on 12 August and discharged the next day with a diagnosis of COPD exacerbation. On 4 September, an ambulance was called when he had breathing difficulties. He recovered without the need to be admitted to hospital.

33. On 6 September, the man had a lung function test at hospital and an echocardiogram (a test which gives information about the structure of the heart). The results of the tests are not recorded in his prison medical record.

34. On 14 September, the man was admitted to hospital for two days with COPD exacerbation. On 17 September, records show that he was told that he might be suitable for a bullectomy (removal of a dilated air space in the lung) if he stopped smoking for three months. He was given a nicotine mouth spray to help, but started smoking again on 28 September. Records show that he often stopped smoking briefly and then started again.

35. On 1 October, the man was admitted to hospital with COPD exacerbation and returned to the prison the next day. A nurse spoke to him on 3 October and recorded that he was adamant that he did not want to be admitted to hospital again, but would accept treatment in the prison. However, he agreed to be admitted to hospital on a further six occasions and attended to by paramedics, or seen in an accident and emergency unit, four more times before he died.

36. The man's last admission to hospital was from 25 December to 15 January, during which he was treated for another COPD exacerbation. Hospital staff informed him that his condition was only suitable for palliative treatment.

37. On 10 January 2014, a nurse completed a referral to a hospice. A hospice doctor assessed him on 13 January while he was still in hospital. The doctor concluded that he was in the terminal phase of COPD and was fully informed of his condition. He considered him suitable for palliative care and arranged for a specialist nurse to visit him.

38. On 13 January, a nurse opened a 'Planning Future Care' document with the man. He stated he wanted to receive treatment until no more could be done for him. He reiterated he did not want to be resuscitated. He said his preferred place of death would be a hospice or the prison. On 16 January, the nurse began a nursing care plan which covered issues such as how to manage episodes of acute breathlessness, personal hygiene, pressure sore risk and his preferences about end of life care.

39. On 14 January, a prison family liaison officer was appointed. The officer visited him that day to discuss what he wanted to happen when he died. He did not have any contact with his family and named a friend who he wanted to be contacted by telephone in the event of either an emergency or his death.

40. On 17 January, the man was given additional pillows to help keep him comfortable and fortisip drinks were ordered. On 21 January, the specialist nurse visited him and noted he was managing quite well, but would benefit from a hospital bed and mattress. The bed and mattress were ordered that day but, unfortunately, did not arrive before he died.

41. The man had been on codeine and gabapentin to alleviate his pain. On 20 January, the codeine was replaced by 10mg of oral morphine twice a day. A prison GP reviewed his pain relief on 23 January and prescribed fentanyl patches (strong pain relief).

42. At about 10.02am on 24 January, an officer went to speak to the man about dismantling his bed in preparation for the new one arriving. He found him slumped forward in his wheelchair with his breathing mask still attached to his face. The officer tried to rouse him by calling his name and shaking his shoulder, but got no response. He noticed white fluid on his chin and yellow fluid around his feet. He called a prisoner for help and they both tried to sit him up and check for any obstruction to his airway.

43. The officer alerted a wing officer and radioed for assistance. Medical staff arrived shortly after. A prison GP verified that the man had died.

44. Notices informed prisoners and staff of the man's death and support was offered from other staff, the care team and the chaplaincy.

45. When the man died, the prison contacted his friend by telephone, in line with his wishes. The family liaison officer remained in contact with the man's friend, offered him a visit to the prison and kept him informed of arrangements.

46. The family liaison officer organised the funeral and the prison covered the costs. The funeral was held on 10 February and a number of prison staff and a prisoner friend of the man attended. A memorial service was held at Ford on 12 February. The man's friend told us that he had been very impressed with the family liaison team at the prison and in particular the family liaison officer.

47. The Coroner gave the cause of death as chronic obstructive pulmonary disease.

ISSUES

Clinical Care

48. The clinical reviewer says that the care the man received in prison was good and equal to the care he could have expected in the community. Although there was no formal care plan in relation to the management of his COPD, his care was in line with the National Institute for Health and Care Excellence (NICE) guidelines on the management of COPD. He was appropriately referred for specialist treatment when necessary and provided appropriate medication for the management of his respiration and pain. Palliative care was good and provided in liaison with hospice staff.

49. A do not attempt cardiopulmonary resuscitation order was put in place in line with the man's wishes and following discussion with him to ensure he fully understood its meaning and implications.

50. When the man was found on 24 January, no attempt to resuscitate him was made. We are satisfied that this was appropriate and as he had requested.

51. The man's nominated next of kin, his friend, said that they had discussed the care he received at Ford, and both of them were very impressed with the care and attention he had received. We make no recommendations.