Investigation into the circumstances surrounding the death of a man at HMP Woodhill on 7 May 2009

Report by the Prisons and Probation Ombudsman for England and Wales

April 2010

This is the report of an investigation into the death of a man at HMP Woodhill on 7 May 2009. He was aged 45, had arrived at Woodhill on 16 June 2008 after being at HMP Whitemoor since September 2001. I offer my sincere condolences to all those touched by his passing.

He had a history of asthma and respiratory infections which led to a consultant diagnosing him as suffering from Chronic Obstructive Pulmonary Disease (COPD) in July 2004. (COPD is a disease that restricts the airflow to the lungs.) His breathlessness increased in severity over the following years and he could not move far without the support of oxygen therapy. He continued to smoke heavily throughout his life.

In late 2004 he started to suffer Transient Ischaemic Attacks (TIAs, often called mini-strokes). It was thought that these might be related to his COPD and the interaction between oxygen saturation levels in the blood and the brain. However, the TIAs were never fully investigated because he refused to allow any health interventions, including assessment of the cause of his TIAs.

The man wrote a letter in September 2004 setting out his wishes in a living will format. This was witnessed and a copy sent to his solicitors as proof of his intent. On 25 November 2005, he signed an Advance Directive and, after some time, he was formally assessed as having capacity to refuse life saving treatment.

Throughout the following years, the man's TIAs developed into regular seizures. He continued to suffer from COPD and to smoke heavily. His seizures became more frequent and the effects lasted longer. On 7 May 2009, following two earlier seizures that day, he suffered a third seizure. Staff sat with him whilst he recovered but, in accordance with his wishes, they did not actively intervene other than to ensure that oxygen therapy was provided via a face mask. He slipped into unconsciousness and ceased breathing at approximately 7.15pm. A doctor and nurses attended and pronounced him dead at 7.20pm.

An Investigator conducted the investigation on my behalf. I thank the Governor of Woodhill, and his staff for their co-operation and assistance; in particular, I would like to mention the staff of Safer Custody Group. In addition, a review of the man's medical care in prison was carried out on behalf of Milton Keynes Primary Care Trust. I must apologise for the delay in issuing this report.

I find that Prison Service staff at Woodhill managed the man in an entirely proper and dignified manner, complying fully with his wishes not to be resuscitated or have any life saving interventions. I ask the Governors of HMP Whitemoor and Woodhill to share with their staff my favourable comments on the way they honoured the wishes of a man who clearly knew how he wanted his life to end.

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.

Stephen Shaw
Prisons and Probation Ombudsman **April 2010**

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SUMMARY

The man first arrived in prison on 13 December 1999 having been charged with kidnap, false imprisonment and murder. He was found guilty and sentenced to life imprisonment on 9 November 2000. He was sent to HMP Belmarsh and moved to HMP Whitemoor on 7 September 2001.

On his arrival in prison he was found to be a heavy smoker and an asthmatic who frequently suffered from chest infections. Over the years these chest infections left him with Chronic Obstructive Pulmonary Disease (COPD) which led him to struggle for breath whenever he exerted himself. Slowly his COPD got worse so that he needed almost constant oxygen to be provided via a face mask. He became incapacitated and required a wheelchair to move about. A special bed was provided and he often slept in a chair because he found it impossible to lie down.

He also developed Transient Ischaemic Attacks (TIAs), probably because his blood oxygen levels were affected and his brain was not receiving sufficient oxygen. The seizures he suffered as a result of the TIAs gradually became more frequent and their effects lasted longer.

At Whitemoor, he started refusing appointments for investigation of his TIAs at outside hospital. He went further by refusing to allow himself to be taken to outside hospitals in emergency situations when he had seizures. He would often discharge himself from the prison in-patient unit if he had been admitted following a seizure. This eventually led to him writing an Advance Directive or living will that reflected his wish not to receive life saving treatment. The Directive included instructions not to actively resuscitate him in the event of a cardiac arrest. Several attempts were made to change his mind, including by psychiatrists who were tasked with assessing his capacity to make such decisions. At the conclusion of these assessments, he had a well publicised list of instructions on what he would accept - and what he would not - by way of treatment and intervention.

On 16 June 2008, he was transferred to HMP Woodhill with their full knowledge that an Advance Directive and a Do Not Attempt Resuscitation order were in place. Despite continued attempts by doctors and nurses to persuade him to change his mind about these interventions, he remained resolute in his decision.

On 7 May 2009, the man was being supported by two prisoners throughout the day. They were joined by two prison staff at approximately 6.00pm. A senior nurse called in to check on him at about this time and also witnessed him having a third episode of seizures. He began to settle and recover from the seizures, and by approximately 7.00pm he was quiet and appeared to be sleeping. At approximately 7.10pm, the staff observing him realised that he was not breathing and they summoned assistance. A nurse arrived, followed by a doctor and other healthcare staff. After checking him for any vital signs, they concluded that he had passed away quietly in his sleep, much in line with his wishes. The man was certified dead at approximately 7.20pm.

THE INVESTIGATION PROCESS

1. The investigator visited Woodhill and spoke to staff who had come into contact with the man during his time there. Notices were posted to staff and prisoners about the investigation, inviting them to contribute if they wished. The investigator interviewed eight members of staff and four prisoners. He also interviewed a friend of the man, who had written to this office saying he had information relating to the circumstances of the man's death.

2. The investigator studied all relevant prison records relating to the man. These included his main prison record, medical records, and statements made by staff. The investigator also visited the unit where he was housed when he died.

3. A member of staff from Milton Keynes Primary Care Trust carried out a review of the man's clinical care whilst he was at Woodhill. I am grateful to her for undertaking this review. My investigator discussed aspects of his treatment in particular relating to the Advance Directive and Do Not Resuscitate instructions with staff from Milton Keynes Primary Care Trust.

4. My investigator contacted HM Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. Upon completion, my report will be sent to the Coroner to assist in his enquiries into the man's death.

5. The Family Liaison Officer (FLO), spoke to his nephew, and arranged that she and the investigator would visit him at his home. During a visit on 18 September he raised the following matters:

   He was concerned that the man had not been moved to a lower category prison, or one closer to his family, before he died. He had been waiting a long time for the move and his nephew thought that a suitable prison had been identified.

   He was concerned that the man had to wait a long time for some of his medical equipment.

   Finally, he was concerned that the man's Advance Directive required a doctor to be present at the time of his death, and it was his belief that no doctor was present.

6. I hope this report goes some way to answering those questions for his nephew.

Advance Directive and Mental Capacity Act, 2005

7. An Advance Directive is a document giving instructions specified by the patient as to what healthcare interventions and actions should be carried out if they become ill and unable to make decisions for themself. The man supplemented this directive with a 'Do Not Attempt Resuscitation' (DNAR) instruction which meant that he did not want anyone to revive him or provide life saving treatment, under certain specified conditions. He was of the view that his medical condition, chronic obstructive pulmonary disease (COPD), and the seizures he suffered, might leave him in a vegetative state if resuscitation were attempted and only partially successful. He was adamant that he did not want this to happen to him.

8. The Mental Capacity Act 2005 sets out the circumstances governing the status and legal validity of an Advance Directive. The Act makes it clear who can take decisions, in which situations, and how they should go about this. It enables people to plan ahead for a time when they may lose capacity. The Act is underpinned by a set of five key principles, three of which are particularly pertinent to his circumstances:

    - A presumption of capacity - every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise;
    - The right for individuals to be supported to make their own decisions - people must be given all appropriate help before anyone concludes that they cannot make their own decisions;
    - Individuals must retain the right to make what might be seen as eccentric or unwise decisions.

9. The Act sets out a single clear test for assessing whether a person lacks capacity to take a particular decision at a particular time. It is a "decision-specific" test. No one can be labelled 'incapable' as a result of a particular medical condition or diagnosis. The Act makes it clear that a lack of capacity cannot be established merely by reference to a person's age, appearance, or any condition or aspect of a person's behaviour which might lead others to make unjustified assumptions about capacity.

10. A person is thought to be unable to make a decision for him/herself if unable:

    (a) to understand the information relevant to the decision,
    (b) to retain that information,
    (c) to use or weigh that information as part of the process of making the decision, or
    (d) to communicate the decision (whether by talking, using sign language or any other means).

11. The Act says a person is not to be regarded as unable to understand the information relevant to a decision if he is able to understand an explanation of it given to him in a way that is appropriate to his circumstances (using simple language, visual aids or any other means). The fact that someone is able to

retain the information relevant to a decision for a short period only does not prevent them from being regarded as able to make the decision. Finally, the information relevant to a decision includes information about the reasonably foreseeable consequences of:

(a) deciding one way or another, or
(b) failing to make the decision.

12. The Mental Capacity Act also covers advance decisions to refuse treatment. It says that people may make a decision in advance to refuse treatment should they lose capacity in the future. It is made clear in the Act that an advance decision will have no application to any treatment that a doctor considers necessary to sustain life unless strict formalities have been complied with. These are that the decision must be in writing, signed and witnessed. In addition, there must be an express statement that the decision stands “even if life is at risk”.

Chronic Obstructive Pulmonary Disease (COPD)

13. Chronic Obstructive Pulmonary Disease (COPD) is an 'umbrella' term for people with chronic bronchitis, emphysema, or both. COPD is usually caused by smoking and results in the airflow to the lungs being restricted. Symptoms include a cough and breathlessness. The most important treatment is to stop smoking. Inhalers are commonly used to ease symptoms. Other treatments such as steroids, antibiotics and oxygen medicines are sometimes prescribed in more severe cases, or during a flare-up of symptoms.

HMP WOODHILL

14. HMP Woodhill is a local prison, purpose built to high security prison standards in the early 1990s. It is rated as performing well (level 3 out of four levels) against the performance rating criteria set by the Prison Service, and has been at this level since before the man died. It holds some category A prisoners (the highest level of security) as well as some of the most disruptive prisoners in the system in the close supervision centre. He was a category B prisoner (Category B prisoners are lower security prisoners than Category A, but they still require high levels of security such as high walls and locked doors around the prison).

15. An inspection by HM Chief Inspector of Prisons, Dame Anne Owers, in 2005 led to a description of the prison as 'depressing and disappointing'. However, following a subsequent inspection in 2007, Dame Anne found 'a very different prison'. Safety at Woodhill was said to have 'improved considerably, with extremely good reception and first night procedures'.

16. Before his death there had been seven deaths from natural causes at Woodhill since I became responsible for all investigations into deaths in prison custody in 2004. Aside from the issue of poorly maintained health records, there are no significant similarities between this report and those resulting from earlier investigations I have conducted at Woodhill.

17. Milton Keynes Primary Care Trust is responsible for commissioning healthcare at Woodhill. The provider arm of the PCT provides a nursing healthcare team based in the prison, a Mental Health In-Reach Team, and x-ray, dental, pharmacy and podiatry services. Milton Keynes PCT also commissions a number of other agencies to provide healthcare services at Woodhill including:

    - Resuscitate Medical Services Limited, who provide general medical services.
    - The Seagrave Trust, who provide substance misuse services, and
    - Howcroft and Selly, who provide ophthalmic services.

    In addition, Woodhill provides some additional staff who support the functions of the healthcare department.

KEY FINDINGS

18. The man first arrived at HMP Pentonville on remand on 13 December 1999 having been charged with kidnap, false imprisonment and murder. He was found guilty after a trial and sentenced to life imprisonment.

19. He started his sentence at HMP Belmarsh but was moved to HMP Whitemoor on 7 September 2001. He remained there until June 2008 when he was transferred to HMP Woodhill.

20. When he first arrived at Whitemoor, he was identified as not having any medical problems, although he was referred to the urologist by the prison doctor (Prison Doctor A) on 15 October for a cyst that had developed while he was at Belmarsh. He was assessed by healthcare staff in reception as not needing any help as regards his mental health, and that he was not suicidal or at risk of harming himself. He was also noted to be a heavy smoker, asthmatic, overweight and in need of increased exercise.

21. On 8 January 2002, he cut himself with a razor blade. He was admitted to the healthcare centre on continuous observation and a F2052SH document was opened. (F2052SH was the Prison Service's then system for supporting and monitoring prisoners in crisis. This has been superseded by the ACCT process. An Assessment, Care in Custody and Teamwork (ACCT) document is now used as a tool for keeping prisoners safe.)

22. It is not clear from the records how long he was in healthcare. It appears that he was referred to a psychologist for help with flashbacks resulting from abuse he had received when he was young, and he asked if he could be transferred to HMP Dovegate's therapeutic community. The F2052SH was closed on 2 March.

23. The man again felt that he might harm himself on 11 October as he had read a newspaper article about his case and his impending appeal. This worried him and he asked staff to take away his razor blades and to keep an eye on him. Staff on his wing started an F2052SH form and kept closer observation. The F2052SH was closed on 14 October.

24. In November 2002 he was seen by the visiting urologist regarding a cyst on his testicles. There is no detail about this consultation in the clinical record aside from a letter from the man to the Prison Doctor A. In that letter he says that the urologist was intending to arrange for him to have an operation. It is also evident from a letter sent by a visiting doctor in July 2004 to a specialist chest physician at the local Hospital that he had been experiencing increasing problems with chest infections and asthma over an 18 month period. However, there is little other information in his clinical record about these problems.

25. On 6 February 2004, he went to the local Hospital for surgery on the cyst. When he arrived, he refused to undergo an operation as he objected to being restrained in handcuffs until the point when he was unconscious and sedated. His consultant urologist, discharged him from his list.

26. The man had a chest infection on 4 July 2004 that required his admission to the in-patient unit of the prison healthcare centre. When he had first had problems breathing that day, prison staff called for an ambulance to take him outside to a hospital. He had refused to go and signed a disclaimer to that effect. The paramedics who attended and assessed him also noted on their patient report form that he had refused to go to hospital with them and that he was aware of the consequences of his actions.

27. He was seen at the local Hospital on 3 August by a consultant in respiratory medicine. Who prescribed a course of steroids to help his breathing (a steroid works by reducing inflammation) and asked that he return to his clinic three weeks later. It is not clear that he actually returned to the consultants clinic on or around 24 August. On 10 September he was admitted to the local Hospital because of shortness of breath and a swelling to his calf (lower leg). It was thought that he might have a deep vein thrombosis (DVT – a blood clot in the veins in the legs) or a pulmonary embolism (a blockage of the main artery of the lung or one of its branches by a substance that has travelled from elsewhere in the body through the bloodstream). This turned out not to be the problem, but the man discharged himself from hospital without having a final diagnosis. For the first time his medical condition was referred to as COPD (Chronic Obstructive Pulmonary Disease).

28. On 16 September, he was admitted to the prison in-patient unit where he continued to be monitored for shortness of breath, possible chest infection, COPD and a potential embolism. He was put onto a fluid balance regime (which means the amount of fluid he took in was measured against the amount of fluid he passed out). He had frequent blood tests to measure how well his blood clotted as part of his treatment was to receive a drug that thinned his blood (to reduce any embolism present or the risk of an embolism forming).

29. On 23 September, he formally instigated a Living Will document. He set out in letter form and on a templated document his wishes about what he would and would not accept by way of treatment or help for his medical problems. This was witnessed by the Chairman of the Independent Monitoring Board (IMB). (Each prison has an Independent Monitoring Board. IMB members are independent and unpaid. They monitor day-to-day life in the prison and ensure that proper standards of care and decency are maintained. The IMB produces an annual report on the prison.) He also wrote a letter to the Governor of Whitemoor, a copy of which was to be stored in his clinical record. In that letter he said:

> 'One of my main reasons for requesting my solicitor … to obtain and retain a copy of a living will, is to afford me a dignified death and to regain a level of control over how my health is managed. The living will will also prevent the prison from enforcing its duty of care upon my body even if I am no longer in a position to verbalise my requests/wishes and should also serve to protect the prison's healthcare department from any form of negligence in that duty of care as this will was completed and signed as witnessed by the chairman of the establishment's Independent Monitoring Board and is countersigned to that effect.'

30. He wanted to return to his own living unit in early October, but was advised that he needed to stay in the prison hospital. He was insistent, and staff at Whitemoor considered asking the governor to issue him with an order to remain in the hospital. He told staff that if this happened, he would refuse all treatment, including oxygen via a bottle. He could not be persuaded to stay, and on 6 October he discharged himself back to C wing.

31. A consultant forensic psychiatrist, went to C Wing on 7 October 2004 to see the man. She had been asked to assess whether he had capacity to make the decisions he had been making recently (the inference being that he might have a mental impairment to decision making). He refused to see the consultant forensic psychiatrist and she was unable to say for sure whether he had capacity to make his own decisions.

32. The next entry in his clinical record is by a visiting doctor, who reviewed the man's medical condition on 26 October. He noted that he wanted to return to his wing (so presumably he had been re-admitted to the in-patient unit) and that he should be referred to the local Hospital for further tests. He recommended continuing him on anti-coagulant medicine (to stop his blood clots) until the multidisciplinary team (MDT) considered his care at a meeting the following day.

33. The MDT met on 27 October but the record is incomplete as to their decisions. It would appear that he remained on the in-patient unit.

34. On 1 November, the visiting doctor again saw him and listed his medical problems as COPD. He queried whether the man had also suffered transient ischaemic attacks (TIAs – which are mini-strokes) or was suffering with hypoxia (a lack of oxygen in his system). The visiting doctor wanted to check the progress of the referral to the consultant of respiratory medicine he had previously seen at the local hospital for the man's blood clotting test results.

35. Later that day, the visiting doctor was asked to see him again as he was vomiting and feeling dizzy. The doctor diagnosed that he was suffering from labyrinthitis (an inner ear infection that causes dizziness and vomiting). He prescribed medication to ease the symptoms. When the man was seen by the visiting doctor again on 5 November, he was feeling no better.

36. The doctor saw him again on 10 November and made no mention of the labyrinthitis, but concluded that he had probably been having TIAs. Entries in the clinical record of 18 November and 2 December say that the man reported that the TIAs were getting more frequent, occurring at least weekly. On 4 December, he was witnessed having one of the TIAs. He was seen shaking and the right side of his body was weak. He also reported losing track of about one hour of time.

37. He saw, a consultant psychiatrist, on 9 December and had a very full and frank discussion about his thoughts and feelings. The consultant psychiatrist made eight pages of notes, but in the end had to finish her session with him without reaching a firm decision whether he had capacity to make his living will decision.

She did record amongst those notes that he understood what was wrong with him:

> 'I have chronic obstructive airway disease … no known cure … attacks the respiratory system and that has four levels. I have level four emphysema … end state emphysema … I understand this to be at the end of the illness … the fatal end. Coupled with that … TIAs … like tiny strokes that cause me to lose consciousness. I am obviously incapacitated by both. This illness … eventually I will drown in my own body fluid. I understand they can drain the lung and cut bits out here and there and use surgery to remove blood clots. My greatest concern is not that I am dying … it is that I am afforded a certain level of dignity that I would not have if I was taken out of here to the hospital. I can not think of a set of circumstances that would make me change my mind e.g. if in the community.'

38. When the consultant psychiatrist returned to complete her assessment on 16 December, he refused to see her.

39. Healthcare staff saw him a number of times throughout the rest of that year and in January 2005, usually about his feelings of sickness and the fact that he was not eating. It was recorded that he had lost a lot of weight, but this was not quantified. On 24 January, he had a TIA which left him with right sided weakness and slurred speech. He went to the healthcare centre for tests and observation, but would not stay. He returned to his cell on C wing and was visited by nursing staff throughout the day. He recovered and by the end of the day he was back to his usual self, saying that he was feeling a lot better.

40. There are several entries in his clinical record about him having shortness of breath and pain in his calves (the lower legs) – a possible DVT – throughout April. On each occasion he was offered further care by being admitted to the healthcare unit, but on each occasion he declined.

41. On 17 May, he was worried about pain he was having in his chest or lungs and was concerned that, if he needed help during the night, he might not be able to ask for it. He therefore agreed to be admitted to the healthcare centre. He felt much better by 19 May and discharged himself, against the advice of Prison Doctor A.

42. Nurse 1 was asked to see him on 4 June because he was complaining of feeling breathless and wheezing when he breathed. When the nurse arrived at his cell he found him sitting in his chair, with oxygen being given to him via a nasal tube. He was smoking. The man said he did not need any urgent assistance, but wanted to see Prison Doctor A after the weekend. When Prison Doctor A saw him he found that he was quite well, although he did have some wheezing noises from his lungs when he breathed. On 8 June, he was admitted to the healthcare centre for observation after feeling unwell during the previous 24 hours. On 13 June, he was discharged back to his wing.

43. When Prison Doctor A saw him on 10 July, he was having breathing difficulties but refused to be admitted to the healthcare centre. He was again short of breath on 8 and 13 September but once again refused to be admitted to healthcare.

44. On 20, 22 and 23 September, he had a number of ‘falls’ in his cell. On each occasion staff called for nurses to come and see him. The nurses found him to be in various states of recovery when they saw him: from not able to get up off the floor himself, to being alert and aware of his surroundings. On each occasion he refused to be admitted to healthcare. He was also seen and assessed by doctors on a number of occasions. It is unclear from the records how many falls he actually had, but there appear to have been at least three separate episodes of falling over and losing consciousness.

45. The man’s clinical record also has a number of entries regarding the validity of his living will from September 2005. It appears from the entries that staff felt it could not be valid as he had refused to co-operate with the psychiatric assessment of his capacity and competency to make a living will.

46. On 29 September, a consultant forensic psychiatrist, interviewed and assessed him regarding his living will. She wrote:

> ‘He has capacity. His living will and expressed wishes should be followed. He understands the risks of his decision. He wishes to be given pain relief and oxygen. He has agreed with this paragraph.’

47. Nurse 2 was asked to see him in his cell on 5 October. She was accompanied by two senior prison staff. The man told staff that he had changed his mind about going to hospital for treatment of his TIAs. Nurse 2 asked him if he would go to hospital and stay for the duration of any treatment offered to him. He said that he would. The nurse agreed to ask Prison Doctor A to see him the following day.

48. On 6 October, the man saw Prison Doctor A and re-affirmed his willingness for the cause of his TIAs to be investigated. Prison Doctor A wrote an urgent referral letter to the local hospital. However, the ,man wrote to Prison Doctor A again on 9 October, indicating that he had changed his mind once more and did not now want active treatment. He wrote that his legal team had advised him not to go ahead with treatment.

49. On 22 October two nurses were asked to see the man in his cell as he felt that he was about to have another fit. As they were assessing him, he began to fit violently and lost consciousness. The fit lasted for about eight to ten minutes. As he settled down and relaxed, the nurses were able to put him on his bed in the recovery position. He remained unresponsive for about 30 - 40 minutes and his observations at the time were: pulse 138 (fast,) blood pressure 122 over 54 (a little low), and temperature 37.4 (normal). An ambulance had been called and he remained confused and incoherent throughout the nurses’ assessment. The paramedics decided to take him to hospital for further investigations. When officers made to put handcuffs on him, he protested about going out to hospital and eventually refused, signing a disclaimer to that effect. He did, however,

agree to go to the prison’s in-patient unit to be observed over lunchtime and see the doctor there.

50. The doctor who saw him that day wrote that he thought the man’s fits were related to vascular problems and he would need a scan to find out where the problems were. However, ‘The man remained adamant that he will not go out for further investigations.’

51. On 25 November, he signed a new Advance Directive or living will. This set out his express wish not to be resuscitated in the event he should become unconscious or unable to communicate his wishes. The directive added that the man would be content to receive food, water, prescribed pain relief, oxygen and first aid for any injuries he might suffer in a fall, whilst he was conscious and able to communicate. The Advance Directive was typed, signed by him and witnessed by a nurse.

52. The Head of Healthcare at Whitemoor, wrote to the man’s solicitors on 22 December following a number of letters from them complaining about his treatment. In her letter they said:

> ‘I am sorry that he has regarded any actions taken as resuscitation. I can find no record in his IMR [Inmate Medical Record] that any active resuscitation procedures were performed. I am of the belief that although he was brought to the Healthcare Department on one occasion there was no active resuscitation procedures performed. Oxygen was administered, but it is my understanding of his Directive that he still wishes to receive this form of treatment. He was kept comfortable on a trolley until he regained some consciousness, enough to assist his transfer to a bed in the interests of his comfort, and then when fully conscious was taken back to his cell on the wing.’

53. A Senior Officer from C wing asked the Mental Health In-Reach Team (MHIRT) to see the man on 1 February 2006 as he was feeling low in mood, partly because of his physical condition. He was seen on 9 and 16 March when he disclosed a number of issues that were causing him distress. After these sessions, ,an assistant psychologist with the MHIRT, wrote to the Head of Healthcare at Whitemoor. She said the MHIRT were concerned that all his worries might have been impacting on his mental health and affecting the validity of his living will. They asked for him to be re-assessed as to his capacity to decline active treatment.

54. The consultant forensic psychiatrist saw him on C wing on 20 April 2006. She reported to the Head of Healthcare that he was confused why she had been asked to see him. He thought the consultant forensic psychiatrist was there to help with his mental health concerns, not to judge capacity again. He feared that she was there to ‘nut him off’ and questioned her impartiality as she worked for the prison authorities. She told him that she would see him again if he wished to assess his capacity or his mental health needs or both, but she made it clear that he must consent to these assessments. On 5 July, Prison Doctor A wrote

another referral letter to the consultant forensic psychiatrist, asking her to assess the man's capacity to make an Advance Directive.

55. On 10 July, the man wrote to the consultant forensic psychiatrist and said:

> 'I have been advised by Prison Doctor A that I have apparently agreed, during one of our sessions, to go to outside hospital. As I am unable to recall such a conversation I do not feel it would be practical or beneficial to either of us for me to continue seeing you.'

56. HMP Whitemoor kept a running nursing log of visits to his cell between 2004 and 2007. There are literally hundreds of entries recording times when nursing staff looked in, or were asked to visit him in his cell. Often this was following one of his TIAs, but sometimes it was simply to check he had no problems that he wished to bring to the attention of healthcare staff. When nursing staff offered some form of treatment, he would usually decline. But at other times he would accept help. There does not appear to have been any pattern to the man's refusals of offers of help.

57. On 1 January 2007, an Officer saw that the man was coughing up blood, but he did not wish healthcare staff to attend to him. On 1 February, he was breathless and asked to be seen by Prison Doctor A. On 17 February, C wing staff called healthcare staff to see the man. When they arrived he was sitting in his chair, no more short of breath than usual, without his oxygen mask on. He said he had had 'one of his turns' and declined any further intervention. On 18 February, staff again asked nurses to see him. This time when they arrived he was slipping in and out of consciousness. His pulse was 108 beats per minute (fast) and was very weak. After 15 minutes he became more lucid and said that he was having more and more of these 'turns'. The same happened on 19 February. On both occasions he declined to go to healthcare.

58. When he was seen by a nurse on 26 March following one of his seizures, the nurse (who cannot be identified from the record) advised that he should increase the amount of oxygen he was taking. His response was that this would 'get in the way of my cigarettes'. Prison Doctor A recorded that he was smoking about 40 - 50 cigarettes a day when he saw him on 6 July.

59. The man was moved from Whitemoor to HMP Woodhill on 16 June 2008. On his arrival at Woodhill he was admitted to the in-patient unit and assessed by Prison Doctor B there. He recorded as follows:

- The man had COPD and was on two litres of oxygen for 15 hours of the day.
- He also had chronic back pain.
- He had suffered from depression for the past year and had cut the artery in his right arm in 2000.
- He was incontinent of urine.
- He suffered seizures (TIAs) which lasted between 15 and 90 minutes.
- He did not have a history of epilepsy.

- He had signed a Living Will and a Do Not Resuscitate (DNR) order on 25 November 2005 and a later version 29 December 2006.
- He did not want any referral to hospital or hospital admission at any time.
- He denied any mental illness, thoughts of self harm or suicide.

60. The man remained in the in-patient unit at Woodhill until 26 June when he was moved to a cell on house unit 4B. Prison Doctor B had written details of the DNR and Living Will in his clinical notes. These were confirmed by the man in a letter dated 2 July that was used by the Governor in charge of healthcare, and set out formally what was expected of staff in a range of different circumstances. The Governor's instructions informed staff that:

    'If the man should stop breathing or his heart stops beating he will NOT be resuscitated using artificial ventilation ('mouth-to-mouth' or using breathing equipment) or have attempts to re-start his heart (defibrillation or CPR). Staff may put him in the recovery position and attempt to make him comfortable.

    'He has made an Advance Decision to Refuse Treatment which sets out his wishes more specifically in relation to medical treatment, which includes being given oxygen therapy, food, hydration, pain management and first aid for injuries unrelated to his chronic condition.

    'In order to adhere to his wishes and plan his future care, the following must be adhered to, if he is found unresponsive or unconscious:

    1) Contact Healthcare Hotel 1/Hotel 5 via urgent message.
    2) Healthcare staff, including a doctor if available, will attend and assess his condition.
    3) If he is found to be not breathing, he will NOT be resuscitated. If the doctor has not yet attended, s/he will be called in to assess him.
    4) If he is breathing but is unresponsive, then he will be given oxygen but no other treatment and a doctor will review him.
    5) If he is responsive and is able to talk to us, then we will follow his instructions regarding what treatment he would like to receive.
    6) An ambulance may be called in line with normal procedures. However, treatment by paramedics will only commence on the instruction of the senior nurse or doctor at the scene. The Paramedics must be made aware of both the **DNAR** and **Advance Directive**.'

61. Following seizures on 12 August and again on 18 August, he was moved temporarily to the in-patient unit. He returned to his cell shortly after he had recovered from the seizures.

62. On 29 August, the man complained of an enlarged scrotum. He was seen by Prison Doctor C, and advised that he would need an ultrasound investigation and appointment with the urology department at the local hospital. He agreed to that referral. However, on 14 September, he wrote a letter to healthcare staff stating that he had been pressurised into agreeing to the urology and ultrasound appointment. At his request, the appointments were cancelled.

63. Prison Doctor C saw the man on 11 November and it was agreed that he should be referred for an ultrasound again, in case his enlarged testes were cancerous. The man's ultrasound appointment was on 18 November. The test results were disclosed on 23 December. He was told that he did not have cancer but did have a large bilateral hydrocele (this is a collection of fluid in the scrotum and is completely harmless – it needs no treatment usually).

64. On 9 March 2009, Prison Doctor B saw the man while he was having a seizure. Prison Doctor B monitored him throughout this seizure and asked if he would go to hospital. At 2.25pm he declined, but at 2.50pm he agreed to an ambulance being called. The ambulance arrived at 3.00pm but at 3.10pm he refused to go with the paramedics to hospital. At 3.15pm he consented but at 3.30pm he withdrew consent and this time signed a disclaimer for the paramedics. He also refused to be admitted to the prison's in-patient unit. Prison Doctor B recorded in his clinical record that he had signed a DNAR order on 8 July 2008 with a review scheduled for January 2009.

65. The man together with Governor of Woodhill, a nurse and Woodhill's, Head of Healthcare, reviewed his Advance Directive on 17 March 2009. The only change was that, instead of reviewing it after every time healthcare were called to see him, they would review the document if there was a major change to his circumstances and at six monthly intervals.

66. On 7 May at 4.20pm, Prison Doctor B was asked to review the man who had been having seizures during the day. Two nurses had seen him earlier and made sure he was receiving oxygen via a mask. Prison Doctor B found him to be conscious, but slightly confused with slurred speech. He checked his vital signs and recorded them as blood pressure 97/60 (low), pulse 146 (fast), temperature 35.7 (normal), and blood sugar 5.7 (normal). The man's chest was clear (no signs of any infection). Prison Doctor B then recorded the man's vital signs seven further times over the next hour. His blood pressure showed improvement over that time, although his pulse remained fast at 133 beats per minute at 5.10pm. Prison Doctor B left the man shortly after 5.10pm as he did not want any further medical intervention.

67. Throughout the day, as was usual when he had fits, a fellow prisoner would sit with him while he recovered. This was to offer assistance, such as a drink, and to help the man orientate himself as he would often be confused following a seizure. On this particular day, from early afternoon, two fellow inmates were sitting with him. They were joined by a principle and a senior officer at approximately 6.00pm.

68. At approximately 6.15pm, Nurse 3 visited his cell at Prison Doctor B's request. He found that the man was having another seizure. He was breathing without difficulty, sitting in his chair. When he started to recover, The nurse asked him if he wanted any assistance, but he did not respond. Some time between 6.30pm and 6.45pm, his two fellow inmates were asked to go back to their cells as all other prisoners were being locked up for the night. Nurse 3 was called away from the cell at approximately 7.00pm to an incident elsewhere in the prison. The

man's seizure had ended and he was left breathing without difficulty while the principle and senior officer were in attendance.

69. Shortly after Nurse 3 left his cell, the principle and senior officer became aware that he was no longer breathing. They both checked him for signs of life or some response to their calls but there was none. The principle officer left the cell in search of the nurse who was working on the unit, Nurse 4.

70. Nurse 4 arrived at the man's cell but was unable to find a pulse or any blood pressure. He called on the radio for a doctor to attend the cell. At this point Nurse 3 returned, followed shortly afterwards by a senior officer who brought emergency equipment. There was no attempt to use the equipment, but it was brought in case it was needed.

71. Prision Doctor B arrived and checked for signs of life but was unable to find any. He confirmed that the man had died at 7.20pm. The prison's contingency plans for a death in custody were then put in place. The cell was locked, and police and Coroner's office were informed. Staff wrote out their statements and held a hot de-brief. Care and welfare services were offered to all staff who were involved with his care. The two prisoners who had last been with him were told that he had died. The chaplain came to the cell and said prayers for the man.

ISSUES

72. An instruction to Woodhill staff, developed over time in line with the man's wishes, was issued on 6 July 2008 and amended on 19 March 2009. It set out his wishes as follows:

- 'If he is found unresponsive or unconscious contact Healthcare Hotel 1/ duty manager via urgent message.
- Healthcare staff, including a doctor if available, will attend and assess his condition.
- If he is found to be not breathing, he will **NOT** be resuscitated. If the doctor has not yet attended, s/he will be called in to assess the man.
- If he is breathing but is unresponsive, then he will be given oxygen but no other treatment and a doctor will review him.
- If he is responsive and is able to talk to us, then we will follow his instructions regarding what treatment he would like to receive.
- An ambulance may be called in line with normal procedures. However, treatment by paramedics will only commence on the instruction of the senior nurse or doctor at the scene. The paramedics must be made aware of both the DNAR and Advance Directive.'

73. This is largely in line with the instruction completed by HMP Whitemoor before the man arrived at Woodhill. There was a need to review these instructions and it had been agreed that this should be following an incident, a change in his condition or every six months. There should have been a review of the Advance Directive (AD) and Do Not Attempt Resuscitation (DNAR) in January 2009, but this did not happen until two months later. In the event, the delay had no adverse impact on the care he received.

74. The man used his solicitors to reinforce his AD and DNAR wishes. He freely discussed the matter with staff and prisoners who wanted to know why he had chosen this path. He said he did not want to be left in a vegetative state following one of his many seizures or a failed resuscitation attempt. He was fearful of being totally dependent on others for his every need. He said he did not want to die, but was explicit about receiving no interventions to prolong his life. He was fully aware that compliance with his wishes might well hasten his death.

75. He was full of praise for staff at Whitemoor and Woodhill, as can be seen from two letters to *Inside Time*, a newspaper for prisoners, .In a letter about disability services at Woodhill he wrote:

> 'Much of the credit has to go to the 'foot soldiers' and I would like to thank all those that have instigated these improvements, especially those that have had to meet us head on in some, shall we say, less than dignified situations. They have made a difficult situation much more tolerable.'

In a letter about Whitemoor staff he wrote in 2005:

> 'The reality is that there really are people who joined the Prison Service believing they could make a difference. I know this to be true, because I've met them right here in Whitemoor … and at all levels too.'
>
> ' … I find myself saying time and time again not that I was 'being looked after', but that I was being ***cared for***. Can you imagine how that feels?'

76. Staff at both Whitemoor and Woodhill honoured his wishes and they should be commended for doing so. It was particularly difficult for those staff involved at the time of his death. The resilience they showed in following his instructions to take no action were completely at variance with the professional standards to which they normally work.

    The Governors of HMP Whitemoor and HMP Woodhill should commend their staff for adhering to Do Not Attempt Resuscitation orders and Advance Directive instructions instigated by the man.

77. The Clinical Review says that some of the clinical record entries are poor. Some entries were illegible, unsigned or did not include the person's name, while others were not in chronological order. By and large, his medical notes are comprehensively written, with just a few exceptions. However, I reiterate the clinical reviewer's recommendation that record keeping should be improved.

    The Healthcare Manager should develop an action plan to ensure that record keeping practice is of a standard consistently in line with Milton Keynes PCT's Record Keeping Policy and other professional standards.

78. During the man's time at Whitemoor, there were a number of attempts to judge his capacity to make an Advance Directive. He was seen by a consultant psychologist specifically to judge his mental capacity on 7 October 2004, 9 December 2004 and 20 April 2006, but she was unable to make a categorical judgement about his mental capacity at these assessments. A consultant forensic psychologist saw him on 29 September 2005 and did feel able to say that he had full capacity to make an Advance Directive.

79. The man would often change his mind about agreeing to hospital admissions (for example paragraphs 50, 51 and 58 above), but he held true to his underlying refusal to accept any life saving interventions. He seems to have occasionally agreed to further tests, but these were usually to investigate the cause of his TIAs or regarding his testicular cysts. I think his explicit wishes regarding the interventions he would allow were always honoured by prison staff, much to their credit. I appreciate that it was part of their function to test his resolve by frequently asking if he had changed his mind, and do not think they abused that position. I note that he wrote to his legal advisors on at least one occasion because he felt that the prison authorities had overstepped the mark (see paragraph 54), but the head of healthcare's response is equally clear that staff had not attempted resuscitation at any time. Her response appears to have been

accepted by him and his solicitors as there is no further correspondence on the matter in the files.

80. The family's three main concerns were that there should have been a doctor present when he died, that some of his medical equipment took a long time to be installed, and that he should have been moved closer to Wales during the latter part of his sentence before his death.

81. My investigator explained to the man's nephew, at their meeting on 18 September 2009 that, although there was no doctor present at the actual moment of the man's death, he had been seen by a doctor a short time before. Together with the fact that he was not alone when he died, and staff who knew and cared for him were present, this was a comfort to his nephew.

82. The man's letters in *Inside Time* indicate to me that he understood the lengthy process that prisons have to go through to have adapted cells or extra equipment installed for disabled prisoners. He was a man who made certain that his concerns were heard, and would not simply take 'no' for an answer. From the interview transcripts and the views offered by staff and fellow prisoners, I am confident that he would have made his feelings known if he had thought there had been undue delay in providing him with medical equipment.

CONCLUSION

83. At the time of the man's remand in custody in 1999, he was a heavy smoker who suffered from asthma and was overweight. Over the next ten years he developed breathing difficulties that became progressively worse, restricting his mobility and the oxygen that reached his brain. This oxygen shortage led to transient ischaemic attacks that also worsened and induced seizures. The seizures became ever more frequent and strong so that he took correspondingly longer to recover from them.

84. The man declined any investigations of the cause of those TIAs and seizures. Furthermore, he declined any sort of active medical intervention. He went one stage further by engaging solicitors and writing instructions that he should not be resuscitated if he became unconscious. He did not want to run the risk of being left in a vegetative state following a seizure or failed resuscitation attempt.

85. It is clear to me that he knew his own mind in this matter. Everyone who spoke of him liked him and respected his wishes. In the end, he passed away exactly as he had requested. He slipped into unconsciousness, was not resuscitated and died with dignity.

RECOMMENDATIONS

The Prison Service have accepted both the following recommendations and have commented in respect of each as follows:

The Governors of HMP Whitemoor and HMP Woodhill should commend their staff for adhering to Do Not Attempt Resuscitation orders and Advance Directive instructions instigated by the man.

> The Governor of HMP Woodhill has commended staff for their care of him and their adherence to the DNAR order and Advanced Directive instructions (by personal letter after his death).
>
> Staff will be reminded of the commendation as part of the Staff Information Notice which is to be issued detailing the findings and recommendations of the Prison and Probation Ombudsman investigation into the death of the man.
>
> The governor of HMP Whitemoor has commended all staff for their work with him whilst in custody at Whitemoor.

The Healthcare Manager should develop an action plan to ensure that record keeping practice is of a standard consistently in line with Milton Keynes PCT's Record Keeping Policy and other professional standards.

> The Electronic Patient Record System was introduced in November 2009. This has ensured that there is a greater accessibility to a single record which can be reviewed by all departments contemporaneously.
>
> Advice has been sought from different departments in relation to governance issues surrounding electronic record systems and this will be incorporated into a new Electronic Patient Records Policy. The scheduled completion for this is by the end of April 2010.