

**Prisons &
Probation**

Ombudsman
Independent Investigations

Investigation into the death of Mr William Law a prisoner at HMP & YOI Moorland on 17 May 2015

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr William Law died of respiratory failure and chronic obstructive pulmonary disease while a prisoner at HMP Moorland on 17 May 2015. He was 82 years old. I offer my condolences to Mr Law's family and friends.

I am satisfied that Mr Law received a generally good standard of care at Moorland. Healthcare staff managed his chronic illnesses well and reviewed him frequently. A prisoner helper supported him effectively with daily tasks. Staff treated Mr Law with care and respect. However, in the weeks before he died, it appears that Mr Law began to give up eating and drinking and not enough was done to monitor and address this. Mr Law's end of life care would have been improved with a formal care plan, including ensuring he received adequate nutrition and hydration.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

December 2015

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Summary

Events

1. In 2011, Mr William Law was sentenced to ten years in prison. He had been at HMP Moorland since January 2013.
2. Mr Law suffered from high blood pressure and chronic obstructive pulmonary disease (COPD). Healthcare staff noted his low body weight when he arrived at Moorland. Nurses and prison GPs monitored Mr Law's chronic conditions frequently. A prisoner helper supported Mr Law with daily living tasks.
3. In October 2014, a prison GP prescribed a nutritional supplement because Mr Law had a poor appetite. In March 2015, staff became concerned about Mr Law's physical and mental health. Mr Law was very underweight and his prisoner helper told healthcare staff that he was not drinking his nutritional supplements or eating his meals.
4. On 2 May, a nurse noted that Mr Law was frail, pale and thin. He was still not eating and no one had been able to persuade him to eat. The next day, he was unwell. His clinical observations were poor and a nurse sent him to hospital as she thought he was dehydrated, had malnutrition and had an underlying infection.
5. The hospital admitted Mr Law and treated him for advanced COPD. Despite an initial improvement, his condition declined and he continued to eat and drink very little. Hospital staff nursed him palliatively and Mr Law died in hospital on 17 May.

Findings

6. The clinical reviewer found that healthcare staff managed Mr Law's chronic illnesses very well. They reviewed him frequently and monitored his conditions well. A prisoner helper gave him good support with day to day living tasks. However, we are concerned that healthcare staff did not implement a coordinated care plan to monitor and manage Mr Law's care and nutrition.

Recommendation

- The Head of Healthcare should ensure that prisoners with chronic and complex conditions have appropriate care plans and a recognised screening tool is used to monitor those who might be at risk of malnutrition.

The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Moorland informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
8. The investigator obtained copies of relevant extracts from Mr Law's prison and medical records.
9. NHS England commissioned a clinical reviewer to review Mr Law's clinical care at the prison.
10. We informed HM Coroner for South Yorkshire East of the investigation who gave us the cause of death. We have sent the coroner a copy of this report.
11. One of the Ombudsman's family liaison officers contacted Mr Law's granddaughter, his next of kin, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Law's granddaughter asked the following:
 - Why prison staff had not noticed and addressed the fact that Mr Law was clearly unwell, had lost weight and was not eating his meals?
 - Why was she given conflicting information about whether Mr Law was unconscious or not when taken to hospital?
 - Why did the prison inform her aunt that Mr Law was in hospital when she was Mr Law's listed next of kin?
12. Mr Law's granddaughter received a copy of the initial report. She identified one factual inaccuracy which has been amended.
13. The initial report was shared with the Prison Service. They identified one factual inaccuracy which has been amended. The action plan has been added as an annex to this report.

Background Information

HMP & YOI Moorland

14. HMP & YOI Moorland in South Yorkshire holds up to 1,000 men. Nottinghamshire Healthcare NHS Trust runs healthcare services at the prison, including primary care, mental health and substance misuse services. The prison does not have an inpatient facility or full-time nursing cover.

HM Inspectorate of Prisons

15. The most recent inspection of Moorland was in December 2012. Inspectors reported that the overall quality of health services had improved since the previous inspection. There was a wide range of clinics as part of a wing based service. Inspectors noted that an initiative with prisoner healthcare representatives on the wings was working well and there was proactive support for older prisoners and those with disabilities.

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to February 2014, the IMB reported that all wings had an allocated nurse to give out treatments and assess applications to see the doctor. Prisoner healthcare representatives met monthly with the nurse to address any issues and foster health promotion. The IMB considered that prison officers worked extremely well with healthcare staff to provide an excellent coordinated quality of care for terminally ill prisoners.

Previous deaths at HMP Moorland

17. Mr Law was the fourth prisoner at Moorland to die of natural causes since 2013. There were no significant similarities with the circumstances of the previous deaths.

Key Events

18. On 17 March 2011, Mr William Law was sentenced to ten years in prison. In April, he moved to HMP Moorland from HMP Lincoln. In September 2012, Mr Law moved to HMP Whatton and returned to Moorland on 17 January 2013.
19. Mr Law had a history of poor health, including high blood pressure and chronic obstructive pulmonary disease (COPD – the name for a collection of lung diseases such as chronic bronchitis and emphysema). Prison GPs prescribed an inhaler to ease his COPD symptoms and medication to reduce and stabilise his blood pressure. Mr Law’s height was recorded as 167.6 cm (5’6”) and his weight was 52.8kg (8st 4lb), which was low.
20. Healthcare staff at Moorland saw Mr Laws frequently to monitor his COPD and blood pressure. Mr Law had a single cell and another prisoner was employed as his “buddy.” (Buddies are prisoners trained to help older prisoners and those with disabilities with day-to-day living tasks.) Mr Law’s buddy collected his meals for him, helped him get to the shower and toilet and reminded him to take his medication.
21. On 21 October 2014, a prison GP noted that Mr Law was frail and had a poor appetite. He weighed 50.8kg. Mr Law had been prescribed milkshake drinks to improve his nutrition but did not like them. The GP therefore prescribed fortisip, another nutritional drink, to see if he preferred that. Over the next six months, Mr Law received his prescribed medication but there is nothing significant in the record. His weight was not recorded during this time.
22. On 29 March 2015, a nurse went to see Mr Law in his cell, as officers had been concerned about his physical and mental health. The nurse referred Mr Law for dementia screening. On 17 April, a prison GP screened Mr Law and the results were normal.
23. On 16 April, Mr Law moved to a double cell, which he shared with his buddy. Later that day, the buddy and the prisoner wing representative told a pharmacy technician that Mr Law was not taking his medication. The buddy said Mr Law had to be encouraged to take a shower and did not mix with other prisoners. The pharmacy technician arranged for a nurse to review Mr Law.
24. On 17 April, a nurse discussed Mr Law’s medication with him and the buddy. Mr Law could not explain why he had not been taking his medication and the buddy agreed to let healthcare staff know if Mr Law did not take it.
25. On 28 April, a prison GP went to see Mr Law in his cell and noted he was getting better support now he shared a cell with his buddy. He prescribed fortisip again and noted that Mr Law was still very underweight. Mr Law’s weight was recorded as 48.6kg (7st 9lb). On 30 April, a nurse went to see Mr Law. The buddy was there and told her that Mr Law would not drink the fortisip and ate only a few biscuits during the day.

26. At 2.15pm on 2 May, a nurse went to see Mr Law in his cell and noted he was rocking back and forth on his bed and had a vacant look on his face. He had not taken any fortisip and had thrown his lunch away. The nurse arranged for a colleague to review Mr Law again the next day.
27. At 10.57am on 3 May, a nurse went to see Mr Law and noted he appeared frail, pale and thin. Mr Law's buddy told the nurse he could not persuade Mr Law to eat. He said that Mr Law had not eaten anything for several days and had only taken a few sips of blackcurrant juice.
28. At 2.15pm, two nurses went back to check Mr Law again. The nurses took his clinical observations and noted his oxygen saturation level was very low at 68 per cent. The nurses administered oxygen which improved his saturation levels temporarily. One of the nurses was concerned about Mr Law's poor nutrition and that he was dehydrated. She thought he was suffering from an underlying infection and arranged an ambulance to take him to outside hospital. Two officers accompanied Mr Law but did not use restraints.
29. Mr Law was admitted to hospital. Doctors diagnosed advanced COPD and treated him with antibiotics and oxygen therapy. Initially, Mr Law's condition improved but he was reluctant to get out of bed and continued to eat or drink very little. On 17 May, Mr Law's condition deteriorated and hospital staff began palliative care. Mr Law died in hospital at 10.05pm on 17 May. His granddaughter was with him at the time.

Contact with Mr Law's family

30. Mr Law had named his granddaughter as his next of kin. However, the telephone numbers listed for her in his prison record were unobtainable, so prison staff were unable to contact her to let her know he had been admitted to hospital. Officers found some correspondence from his sister in his cell, with her telephone number. On 4 May, a custodial manager telephoned Mr Law's sister and told her he was in hospital. Mr Law's sister then contacted his granddaughter to let her know.
31. The Offender Management Unit hub manager acted as the prison's family liaison officer. She spoke to Mr Law's granddaughter later on 4 May. She offered support and arranged for Mr Law's granddaughter to visit him in hospital.
32. After Mr Law died, the family liaison officer remained in contact with his granddaughter. Mr Law's funeral was on 10 June and the prison contributed to the costs in line with national instructions.

Support for prisoners and staff

33. After Mr Law's death, the prison's care team offered staff support.
34. The prison posted notices informing staff and prisoners of Mr Law's death, and offering support. Officers spoke individually to Mr Law's buddy and offered him

support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Law's death.

Cause of death

35. The coroner concluded that the cause of death was respiratory failure and chronic obstructive pulmonary disease.

Findings

Clinical Care

36. Mr Law was a frail, elderly man who suffered from COPD and high blood pressure. The clinical reviewer noted that, during the last year of his life, he mostly saw the same prison GP and nurses, who monitored and treated his chronic conditions well and gave good continuity of care.
37. The clinical reviewer concluded that Mr Law was generally well cared for at Moorland. Healthcare and prison staff treated him with care and respect and the support he received from his prisoner buddy further enhanced his care. We are satisfied that the standard of care Mr Law received for his chronic conditions was equivalent to that he could have expected to receive in the community.

Mr Law's nutrition

38. Healthcare staff noted Mr Law's low weight when he arrived at Moorland. In October 2014, a prison GP prescribed a nutritional supplement but, over the next six months, there is no record that anyone considered Mr Law's nutrition further. On 28 April 2015, a prison GP prescribed a nutritional supplement again, but it appears that Mr Law was reluctant to take it. Nurses saw Mr Law every day from 30 April to 3 May and noted that he was not eating but no one implemented a care plan to monitor this or used a validated screening tool for malnutrition. When nurses sent Mr Law to hospital on 3 May, they considered he was malnourished and suffering from dehydration.
39. The clinical reviewer considered that healthcare staff should have implemented a formal care plan to meet his care and nutritional needs, particularly when it was apparent that Mr Law had stopped eating and drinking, shortly before his hospital admission. We make the following recommendation:

The Head of Healthcare should ensure that prisoners with chronic and complex conditions have appropriate care plans and a recognised screening tool is used to monitor those who might be at risk of malnutrition.

Family Liaison

40. When Mr Law went to hospital on 3 May, the prison tried to contact his granddaughter, his next of kin, but the details he had given were out of date, and there was no record of any contact between them since 2013. As a result, the prison contacted Mr Law's sister. We are satisfied this was appropriate.
41. Mr Law's granddaughter said a member of prison staff gave her inaccurate information about his condition when he went to hospital. We have been unable to find any record of this, and we have been unable to interview a key member of staff because of long term absence. However, we note the need to ensure that families of seriously ill prisoners are given accurate information.

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