

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stephen Bladen, a prisoner at HMP Long Lartin, on 17 February 2021

A report by the Prisons and Probation Ombudsman

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 to identify how the organisations whose actions we oversee can improve their work in the future.

Mr Stephen Bladen died on 17 February 2021 in Pershore Community Hospital from diabetic ketoacidosis due to acute late-onset type 1 diabetes. He was 60 years old. I offer my condolences to Mr Bladen's family and friends.

This is an unusual case. Mr Bladen's diabetes was treatable but he refused medical intervention and died within a month of diagnosis. Mr Bladen completed an advance decision to refuse treatment (ADRT) and a prison GP confirmed that he was mentally competent to refuse treatment.

The clinical reviewer concluded that the clinical care Mr Bladen received at Long Lartin during the last month of his life was good and at least equivalent to that which he could have received in the community.

My investigation found, however, that some prison staff were wrongly advised that Mr Bladen's ADRT did not apply to them and were told to attempt resuscitation in the event he stopped breathing. Although this situation did not arise, we make a recommendation to ensure all staff understand what they must do.

We also make a national recommendation to bring prison guidance in line with current Resuscitation Council guidelines that establishments, such as prisons, should have a clearly understandable policy on attempting cardio-pulmonary resuscitation (CPR) when ADRT and do not attempt resuscitation (DNAR) orders are in place.

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

Sue McAllister CB
Prisons and Probation Ombudsman

March 2022

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Summary

Events

1. Mr Bladen was sentenced to 21 years in prison in 2015 and transferred to HMP Long Lartin in March 2019. He had no serious physical health issues until 18 January 2021 when tests showed he had developed severe type-1 diabetes and needed urgent hospital treatment.
2. On 21 January, Mr Bladen completed an advance decision to refuse treatment (ADRT). He specified that he did not want treatment for his diabetes, or to be resuscitated or given any pain relief to make him more comfortable at the end of his life. A prison GP concluded that Mr Bladen was mentally competent to refuse treatment and the prison healthcare provider's lawyers confirmed that his ADRT was legally valid.
3. Nurses visited Mr Bladen daily to offer treatment and he was supported by Prison Service suicide and self-harm monitoring procedures, known as ACCT. Multi-disciplinary meetings were held regularly to discuss his care.
4. Despite advice from clinical staff, a senior prison manager advised wing staff that they should attempt to resuscitate Mr Bladen even though this was against the terms of his ADRT.
5. On 11 February, Mr Bladen moved to the prison's inpatient unit. His condition deteriorated and on 16 February his ADRT came into force. The Deputy Governor was concerned that watching Mr Bladen die without pain relief would be unnecessarily distressing for staff and a bed was found for him in a local community hospital. Mr Bladen died there the following day.

Findings

6. The clinical reviewer concluded that the clinical care Mr Bladen received in the last month of his life was good and at least equivalent to that which he would have received in the community.
7. Prison staff were told, wrongly, that they should attempt to resuscitate Mr Bladen. Although this situation did not arise, we found that some staff were still confused about whether the terms of a prisoner's ADRT applied to them.
8. Current Prison Service guidance is not in line with Resuscitation Council guidance that establishments, such as prisons, that face CPR decisions where ADRT and DNAR orders are in place should have a policy that is readily available and understood by relevant staff.
9. The decision to monitor Mr Bladen under ACCT procedures was appropriate but with hindsight monitoring should have stopped when he moved to the inpatient unit. This is a learning opportunity for the prison.

Recommendations

- The Governor should ensure that all staff must respect the wishes of prisoners with valid advance decisions to refuse treatment (ADRT) and do not attempt resuscitation (DNAR) orders.
- The Director General of HMPPS should give guidance to all prisons on developing policies outlining the expectations for staff in CPR decisions in line with current Resuscitation Council guidance.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Long Lartin informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
11. The investigator obtained copies of relevant extracts from Mr Bladen's prison and medical records.
12. NHS England commissioned a clinical reviewer to review Mr Bladen's clinical care at the prison. Due to restrictions in place during the COVID-19 pandemic, the investigator and clinical reviewer interviewed seven members of staff by telephone in April 2021. The investigator spoke to two further staff, also by telephone, on her own.
13. We informed HM Coroner for Worcestershire of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
14. Our family liaison officer spoke to Mr Bladen's next of kin to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Mr Bladen's next of kin did not have any specific questions for us. We have sent them a copy of this report.

Background Information

HMP Long Lartin

15. HMP Long Lartin is a high security prison in the Vale of Evesham, Worcestershire. It holds up to 609 men across five main wings and two support wings. All prisoners are accommodated in single cells. The healthcare contract is held by Practice Plus Group (formerly Care UK).

HM Inspectorate of Prisons

16. The most recent inspection of HMP Long Lartin was in January 2018. Inspectors found relationships between staff and prisoners were confident and respectful. Healthcare was well led and there was an appropriate range of clinics and treatments. Partnership arrangements and communication between the prison and healthcare were underdeveloped. Inspectors were concerned by a continued failure to replace the automated night sanitation arrangements for prisoners on wings A to D. A capital bid to provide integral sanitation in these cells had been rejected by HMPPS.
17. HMIP also conducted a scrutiny visit (a shortened inspection due to the coronavirus pandemic) in February 2021. Inspectors found that healthcare waiting times were long and the allocation of urgent clinic appointments was not always based on risk. Prisoner access to healthcare services was not facilitated effectively which created risks to prisoners' health outcomes that were not adequately mitigated. Inspectors did find however, that good care had been maintained for prisoners with an existing social care package.

Independent Monitoring Board

18. 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 31 January 2020, the IMB noted that overall healthcare management was good. The Board said it would like to see more cooperation from prison managers. Attendance at monthly healthcare quality assessment meetings was poor and often resulted in meetings being cancelled.

Previous deaths at HMP Long Lartin

19. Mr Bladen is the ninth prisoner to die at Long Lartin since February 2019. Of the previous eight deaths, five were from natural causes. There has been one natural causes death since Mr Bladen died. We have not identified any similar issues between Mr Bladen's death and the previous deaths.

Advance Decision to Refuse Treatment (ADRT)

20. An ADRT is a decision to refuse specified treatment made in advance by a person who has capacity to do so. The decision only takes effect at a future time when that person lacks capacity to consent to, or refuse, the specified treatment. An ADRT:
 - can be made by someone over the age of 18 who has mental capacity;

- is a decision relating to refusal of specific treatment and may also include specific circumstances;
- can be verbal, but if it includes refusal of life sustaining treatment, it must be in the form of a written statement, signed and witnessed and including the words 'even if life is at risk'; and
- is legally binding if valid and applicable to the circumstances.

Mental capacity

21. Mental capacity is defined as the ability of an individual to understand the issues of a decision, retain that information, weigh up the facts and communicate their decision. Capacity must be assumed in all individuals unless there is a suspicion of an impairment or disturbance of mind or brain. In this situation, capacity for that decision must be tested. A person with capacity can make any decision they wish, even if others view that decision as illogical or unwise. Capacity is specific to the decision being made - therefore an individual can have capacity for one decision, but not another. If an individual lacks capacity for a specific decision, carers must make the decision in the person's best interest in line with the requirements of the Mental Capacity Act.

Assessment, Care in Custody and Teamwork

22. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multidisciplinary case reviews involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Diabetic ketoacidosis

23. Diabetic ketoacidosis (DKA) is a serious medical condition that can happen in people with diabetes if their body starts to run out of insulin. When this happens, harmful substances called ketones build up in the body, which can be life-threatening if it is not identified and treated quickly. DKA mainly affects people with type-1 diabetes. DKA is an emergency and needs to be treated in hospital immediately.

Key Events

24. Mr Stephen Bladen was remanded into custody on 7 August charged with multiple sexual offences against children. On 21 December 2015, he was sentenced to 21 years in prison. Mr Bladen maintained he was innocent of the offences for which he had been sentenced, but because of their nature he was unable to have contact with his children. On 1 March 2019, Mr Bladen transferred to HMP Long Lartin.
25. Mr Bladen had a history of back pain following spinal surgery and high blood pressure. He was mostly non-compliant with prescribed medication for his blood pressure, blaming the condition on inadequate pain relief and saying that he suffered unpleasant side effects from the medication. He refused to attend a significant number of appointments to discuss this condition. Throughout his sentence he refused food for several short periods in protest at his conviction.
26. Mr Bladen was managed under Prison Service suicide and self-harm monitoring procedures, known as ACCT, on several occasions during his time in prison including on four occasions at Long Lartin prior to his diagnosis of diabetes. In April 2020, Mr Bladen headbutted a wall after being told he had to move to the COVID-19 isolation wing.

Diagnosis of diabetes and refusal of treatment

27. On 18 January 2021, Mr Bladen asked to see a GP because he was thirsty and urinating frequently. A nurse noted during triage that he was dehydrated, and his blood sugar was too high for the machine to calculate. A prison GP ordered blood tests. The results showed that Mr Bladen had severe diabetes and needed urgent hospital treatment. Mr Bladen refused to go to hospital and refused to sign a disclaimer taking responsibility for his decision.
28. On 20 January, a nurse told Mr Bladen that, without treatment, he would go into a diabetic coma and die. Mr Bladen repeated that he did not want treatment. She advised him to complete an advance decision to refuse treatment (ADRT). When he expressed an interest in this, she provided him with the relevant forms and outlined the necessary legal process.
29. Mr Bladen completed the ADRT forms the next day and a nurse scanned and sent them to Practice Plus Group's legal department on 22 January.
30. On 25 January, Mr Bladen refused examination and a blood test, but told a nurse that he was feeling worse. She tried to persuade him to go to hospital or to be admitted to the prison's inpatient unit, but Mr Bladen said he preferred to stay on A wing. She began Prison Service suicide and self-harm monitoring procedures (known as ACCT) because she deemed his behaviour to be a form of self-harm.
31. That afternoon, a nurse explained to Mr Bladen the non-fatal consequences of diabetic ketoacidosis such as falls, stroke and heart attacks and that he might sustain irreversible physical and mental damage by refusing treatment at this stage. She told him again about the life-threatening nature of his current condition and gave him some more information that she had printed out. She said she wanted him to have as much information as possible to inform his

decision. Mr Bladen maintained that he did not want treatment and that he understood the consequences of his refusal.

32. A nurse explained that his ADRT would come into force once he became unconscious and that in the meantime nurses would visit him daily to offer him treatment and ask if he had changed his mind. She completed routine observations which showed that Mr Bladen had significant ketosis (a condition associated with uncontrolled type-1 diabetes).
33. On 26 January, medical staff, a Custodial Manager (CM) and several other A wing staff attended a multi-disciplinary meeting. They discussed Mr Bladen's reasons for refusing treatment. The CM and the officers were concerned that they would not know if Mr Bladen was in a coma or simply asleep. Someone - we are not sure who - suggested that the officers should ask for legal advice about how Mr Bladen's ADRT impacted on their duty of care to him. This does not appear to have been pursued. It was agreed that ACCT monitoring would continue in order to provide Mr Bladen with structured support and a record of interactions with him. He would remain on A wing, as he wished, in order to retain his support network. A GP said he would assess Mr Bladen's mental capacity, and a consultant forensic psychiatrist agreed to review Mr Bladen's mental health.
34. Mr Bladen's ACCT assessment and first case review took place shortly afterwards. Mr Bladen raised a number of non-medical issues relating to his sentence and access to his children during the assessment but refused the CM's offer to work through these issues during the review.
35. That afternoon, the GP reviewed Mr Bladen's mental capacity with a nurse. The CM was also present. The GP said that he was satisfied Mr Bladen had capacity to make decisions about his treatment. Mr Bladen agreed to take his ADRT form away and give further consideration to his wishes. He also asked the GP to speak to his wife to see what she thought.
36. The GP telephoned Mr Bladen's wife the same afternoon. She told him that she wanted her husband to accept treatment, but she suspected that he wanted to make this conditional on her re-opening a social services case for him to have access to his children. Mr Bladen's wife said she would not agree to this under any circumstances.
37. The GP and nurse encouraged Mr Bladen to think again about his decision not to have treatment and he agreed to go to hospital. He was admitted for insulin treatment but discharged himself the next day against medical advice. Mr Bladen accepted insulin from prison nurses on 28 and 29 January. He made it clear to the nurse that he was only accepting treatment while his ADRT was being validated.
38. On 29 January, other prisoners complained that Mr Bladen was coughing. Officers moved him to Perrie Blue wing (for prisoners in quarantine and waiting for COVID-19 test results) and a swab sample was taken. Shortly afterwards Mr Bladen was found standing on a chair with a noose around his neck in protest at the move. The then Head of Safer Custody decided to move him to a safer cell

(a cell with reduced ligature points) on Perrie Blue on constant observation, pending an ACCT review the next morning.

39. On 30 January, Mr Bladen refused insulin in protest at being in a safer cell. A nurse attended his ACCT review that morning. It was agreed that Mr Bladen should move to a standard cell but remain on Perrie Blue pending his COVID-19 test result. Constant observation was stopped and replaced by five observations an hour. Mr Bladen returned to A wing when his sample tested negative.
40. On 1 February, a nurse received confirmation from Practice Plus Group's lawyers that Mr Bladen's ADRT was valid. She gave a copy to Mr Bladen and a copy to the wing supervising officer to share with a CM. She emailed Mr Bladen's ADRT to all healthcare staff so they could familiarise themselves with the terms. She also printed copies to give to staff at daily handovers. She told Mr Bladen that nurses would continue to visit him daily to review his condition and ask him if he wanted treatment.
41. Mr Bladen's ADRT confirmed that he did not want any treatment in the event of an emergency where paramedics would usually be called. He also said that he did not want:
 - cardio-pulmonary resuscitation;
 - mechanical or artificial ventilation;
 - clinically assisted nutrition or hydration;
 - medical treatment to alleviate pain and distress or to provide comfort;
 - any medical treatment to treat a life-threatening infection; or
 - treatment for rehydration in the event of a collapse.
42. From 2 February, Mr Bladen refused to attend the healthcare centre and so nurses went to his cell every day to ask him if he had changed his mind and to offer him treatment.
43. On 2 February, a CM emailed a prison manager for advice on what prison officers should do if Mr Bladen required emergency treatment. The manager replied that prison staff should "stick to what we know". He said that, if paramedics and Practice Plus Group decided not to provide treatment in the light of the ADRT, that was their prerogative, but his view was that prison officers should follow their usual procedures in an emergency set out in Prison Service Instructions (PSIs) and then hand over to prison nurses and paramedics when they arrived. The manager added that he thought it impractical to explain the legalities of an ADRT and when it applied to every officer at Long Lartin, particularly when it had been entirely overseen by a private healthcare provider. (The manager left the Prison Service before interviews took place and was not interviewed. The CM provided us with the relevant email exchange.)
44. At an ACCT review the same day, Mr Bladen's observations were reduced to four an hour. Mr Bladen asked for them to be reduced to one an hour and left the review in protest when his request was denied.

45. Also, on 2 February, a multi-disciplinary meeting between prison and healthcare staff confirmed that Mr Bladen's ADRT was in place. An appointment with the consultant forensic psychiatrist was made for 8 February.
46. On 4 February, Mr Bladen refused to attend an ACCT review. On 8 February he refused to attend his appointment with the psychiatrist. He told nurses he felt weak with kidney pain but said that he did not want any treatment.
47. Mr Bladen refused to attend the next ACCT review on 6 February, so wing staff went to his cell. He told them he was not feeling very well but was not going to harm himself beyond refusing treatment. Observations were reduced to twice an hour. Mr Bladen refused to attend the next ACCT review on 10 February and observations remained the same.
48. On 10 February, a multi-disciplinary healthcare team meeting discussed the fact that wing staff were finding it difficult to maintain observations on Mr Bladen and his refusal to attend the healthcare centre or see nurses meant that it was difficult to continually assess whether he had changed his mind about treatment. A nurse noted that prison staff had been advised to attempt to resuscitate Mr Bladen until healthcare staff intervened. She said she had explained that Mr Bladen's ADRT was legally binding, and his wishes should be respected. The meeting concluded that Mr Bladen should be moved to the inpatient unit to better manage and monitor him.
49. A nurse attended a multi-disciplinary meeting with the prison on 11 February and Mr Bladen was moved to the inpatient unit the same day.
50. At an ACCT review on 12 February, held on the inpatient unit, Mr Bladen complained that he did not need extra monitoring. A CM wrote on the record, "I reminded Mr Bladen several times that the Prison Service has not accepted Mr Bladen's ADRT and staff will follow procedures in the PSI. I informed Mr Bladen that while he was refusing treatment, he will be subject to the ACCT process". Mr Bladen said that he would no longer speak to officers.
51. Mr Bladen's health deteriorated daily but he remained adamant that he did not want treatment.
52. On 13 February, Mr Bladen made an additional statement in his ADRT to clarify that he did not wish to receive insulin or any treatment if he went into a diabetic coma. Mr Bladen was reported to be weak and dizzy and vomited frequently. Over the next two days he accepted milk and treatment for mouth ulcers but reaffirmed that he did not want treatment for his diabetes.
53. On 15 February, the Practice Plus Group's lawyers confirmed the validity of Mr Bladen's additional statement.

16 and 17 February

54. At 9.45am on 16 February, a nurse and prison GP saw Mr Bladen. He was groaning in pain but refused treatment. The GP prescribed medication used for terminal care, in case Mr Bladen changed his mind and asked for pain relief later.

55. A conference call with a prison manager, senior members of Practice Plus Group and their lawyers, a nurse and other healthcare staff took place at 1.00pm. The meeting discussed whether Mr Bladen should have a do not attempt resuscitation (DNAR) order but concluded it was unnecessary because Mr Bladen's ADRT specified that he did not want any treatment that prolonged life.
56. The meeting discussed that prison officers had been advised to try to resuscitate Mr Bladen against the wishes expressed in his ADRT. The prison manager said he would revisit this advice with another manager.
57. Staff reviewed Mr Bladen and decided that he was no longer able understand information about his condition. He was groaning and breathing heavily and did not respond to them. His ADRT came into effect and his care plan was updated to try to ensure he had a comfortable and dignified death.
58. At 3.54pm, the consultant psychiatrist visited Mr Bladen but he was too unwell to participate in an assessment. The psychiatrist said he reviewed Mr Bladen's medical records and was satisfied that he had been seen by two psychiatrists and a number of other mental health professionals in the past and that there was no evidence that Mr Bladen had a mental illness that would invalidate his ADRT.
59. The Deputy Governor said a prison manager asked him for advice about Mr Bladen that afternoon. He said he was surprised to learn that Mr Bladen was close to death and immediately went to see him. Mr Bladen was in a standard healthcare cell and appeared to be in some pain. Nurses told him that they had decided not to move Mr Bladen to the end of life suite because they were concerned it would cause him further pain.
60. The Deputy Governor said he did not think a standard cell was appropriate and he asked for Mr Bladen to be moved should an opportunity present itself. He said he understood the terms of Mr Bladen's ADRT and was worried that it would be increasingly distressing for all staff to watch Mr Bladen die slowly and in pain. He decided that it was in everyone's best interests for Mr Bladen to be moved to hospital and asked a prison GP to find a suitable bed for him.
61. At about 6.00pm, Mr Bladen was moved to the prison's end of life suite. His door was kept open to allow nurses to check him every 30 minutes.
62. Just before 7.00pm, a nurse received confirmation that there was a bed available for Mr Bladen at Pershore Hospital. Mr Bladen was taken to Pershore Hospital by ambulance at about 9.00pm. No restraints were applied. Two officers remained with Mr Bladen, but the Deputy Governor agreed that they should not be in the same room.
63. At 8.30pm on 17 February, it was confirmed that Mr Bladen had died.

Contact with Mr Bladen's family

64. The prison appointed an officer as the prison's family liaison officer on 16 February when it became clear that Mr Bladen was near the end of his life. She kept in regular telephone contact with Mr Bladen's next of kin from then until after he died. Given the distance between the prison and the next of kin's home and the risk of publicity in the light of Mr Bladen's offences, local police informed Mr

Bladen's next of kin that he had died. The prison contributed to the cost of Mr Bladen's funeral in line with national guidance.

Support for prisoners and staff

65. The healthcare staff interviewed said they found it very difficult to watch Mr Bladen deteriorate knowing that they were unable to offer him any medical treatment to make him more comfortable. They all reported that they had felt well supported by managers and colleagues after Mr Bladen died.
66. The prison posted notices informing other prisoners of Mr Bladen's death, and to offer support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Bladen's death.

Post-mortem report

67. The pathologist concluded that Mr Bladen died from diabetic ketoacidosis due to acute late onset type 1 diabetes.

Findings

Clinical care

68. The clinical reviewer concluded that the clinical care given to Mr Bladen in relation to his diabetes was of a good standard and at least equivalent to that he would have received in the community. There is significant evidence of good communication and multi-disciplinary working, and the staff interviewed were clearly distressed that they were unable to ease Mr Bladen's suffering towards the end of his life.
69. Late onset acute type-1 diabetes is rare, and the clinical reviewer concluded that there was nothing in Mr Bladen's medical record to suggest that he was in the process of developing it before his diagnosis on 18 January 2021. After diagnosis, Mr Bladen was given appropriate advice and offered treatment daily.
70. Mr Bladen's ADRT was completed in accordance with the requirements of the Dying Well in Custody framework. We have seen Practice Plus Group's ADRT policy and it is in line with this framework. We are satisfied that the management of Mr Bladen's ADRT by clinical staff was appropriate and followed national and local guidelines.

Incorrect advice given to staff about CPR

71. A valid ADRT is legally binding and must be adhered to. Chapter 10 of Prison Service Instruction (PSI) 64/2011 makes clear that prison staff should respect both ADRTs and do not attempt resuscitation (DNAR) orders and that this information should be recorded, shared and be accessible to all prison staff.
72. We did not interview one prison manager because he had left the Prison Service, so we do not know why he thought ADRTs did not apply to prison staff or why it was unfeasible to make staff aware that Mr Bladen should not be resuscitated. We do not think, from our interview with the Deputy Governor and our investigations into previous deaths at Long Lartin, that there is a wider misunderstanding of advance decisions among prison managers. However, there was clearly residual confusion among some prison staff as a result of this manager's incorrect advice. We therefore recommend that:

The Governor should ensure that all staff understand that they must respect the wishes of prisoners with valid advance decisions to refuse treatment (ADRT) and do not attempt resuscitation (DNAR) orders.

73. The latest guidance from the Resuscitation Council on ADRT and DNAR orders says that:

“All establishments that face decisions about attempting cardiopulmonary resuscitation (CPR), including hospitals, general practices, care homes, hospices and ambulance services, should have a policy about CPR decisions [when an ADRT or DNAR is in place]. These policies must be readily available and understood by all relevant staff.”

74. PSI 64/2011 says that prison staff must respect ADRT and DNAR orders. However, it pre-dates the latest Resuscitation Council guidance and does not

stipulate that prisons should have a policy about CPR decisions when ADRT and DNAR orders are in force, although it says that the healthcare provider should have such a policy for healthcare staff. In Long Lartin's case, Practice Plus Group has its own policy but the prison does not. If the prison had had a policy, the confusion about whether officers were bound by Mr Bladen's ADRT might not have arisen. We are aware that some prisons already have policies outlining the expectations for staff in CPR decisions and in the light of the aging prison population we consider that it would be sensible for all prisons to have them, especially as it might simply be a case of them extending the healthcare provider's policy to include operational staff. We make the following recommendation:

The Director General of HMPPS should give guidance to all prisons on developing policies outlining the expectations for staff in CPR decisions in line with current Resuscitation Council guidance.

Use of ACCT monitoring

75. A decision to refuse treatment is not considered in law to be a form of self-harm. However, PSI 64/2011 suggests that ACCT may provide a useful way of recording the care offered to prisoners who refuse food and fluids (which is akin to refusing treatment) and facilitate the sharing of information. Consideration of ACCT monitoring is also suggested in Practice Plus Group's Advance Decisions policy.
76. We consider it was reasonable for a nurse to begin ACCT procedures on 25 January and for a multi-disciplinary meeting the next day to agree that monitoring would continue in order to provide Mr Bladen with structured support and a record of interaction with him while he remained on A wing. ACCT procedures would have started anyway on 29 January after Mr Bladen put a noose round his neck and threatened to jump off a chair.
77. With the benefit of hindsight, we consider that ACCT monitoring should have stopped when Mr Bladen moved to the inpatient unit on 11 February. Mr Bladen's health was deteriorating, and he clearly found observations intrusive. At a review on 12 February, he asked for monitoring to be stopped. A CM told him that he would remain on an ACCT as long as he continued to refuse treatment. We recognise that the CM, and all the staff involved in Mr Bladen's care, were doing their best to look after him. However, Mr Bladen was not on an ACCT to try to reduce his risk of self-harm or change his mind about accepting treatment, and the main reason for opening the ACCT (for support and to maintain contact while on the standard wing) was made redundant by his move to the inpatient unit. This was an unusual situation, and we make no recommendation, but the prison can learn from this should a similar situation arise in the future. We make no recommendation.

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