

**Investigation into the circumstances surrounding the
death of a man at the Samuel Johnson hospital whilst in
the custody of HMP Stafford
in January 2009**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

March 2010

This is the report of an investigation into the death of a man who died at the Samuel Johnson hospital, whilst in the custody of HMP Stafford on 17 January 2009. Shortly after he arrived at the prison in September 2008, he had made a decision to refuse to eat.

I would like to extend my condolences to the man's family and to all those affected by his death.

An Investigator from my office was appointed to carry out my inquiries into the circumstances of the man's death. In addition, a clinical review was commissioned from South Staffordshire Primary Care Trust who appointed the Clinical Reviewer to lead the review panel. I am grateful for their contribution to the investigation.

I am also grateful for the assistance provided by the Governor of Stafford, and his staff. In particular, I thank the prison's liaison officer for his help.

The man had refused food on an earlier occasion whilst at HMP Birmingham, but had started to eat again prior to his transfer to Stafford. However, very soon after his transfer he chose to refuse all food (and, for a time, all fluids) in protest against his move and what he saw as his wrongful conviction. He arranged for his solicitor to draw up an Advance Directive to this effect.

This report reflects upon sad and traumatic events for all those involved. Both staff and prisoners could see what was happening to the man but were unable, legally, to intervene. The best that staff could do was to manage the situation and make the man as comfortable as possible. It is a credit to the Governor and his staff that they managed to achieve this with compassion and professionalism.

Indeed, it is heartening to report on a prison whose staff showed commitment and dedication, who kept clear and concise records of their actions, and who sought legal and medical advice at every opportunity. It is unusual for one of my investigations not to lead to any recommendations, but I do not believe Stafford could have done any more for the man. I would be grateful if the Governor could share that thought and my comments in paragraph 132 of this report with his entire staff team. (The clinical review has made seven recommendations, two of which I have formally endorsed.)

I must apologise for the delay in issuing this report. This was due to wider work pressures within my office.

Jane Webb
Acting Prisons and Probation Ombudsman
January 2010

CONTENTS

Summary	4
The Investigation Process	5
Mental Capacity Act 2005 and Advance Directive	6
HMP Stafford	8
Key Findings	10
Issues	27
Recommendations	29

SUMMARY

On 8 September 2008, the man was transferred to HMP Stafford from HMP Birmingham where he had started serving an indeterminate sentence. Five days later, the man told staff that he was “on hunger strike” as he was innocent of the charges of which he had been convicted. An ACCT form (the Prison Service’s process for supporting and monitoring prisoners at risk of self harm) was opened the same day. The man remained on an open ACCT until he died on 17 January 2009.

Staff at Stafford assessed the man daily, through ACCT and medical reviews, and recorded their discussions and decisions. They checked with the man every day whether he would reconsider and resume eating. Although on a few occasions he said he would think about his decision and let them know if he changed his mind, in the main he remained steadfast and told staff he intended to take his own life in this way.

On 2 October, the man met with his solicitor to discuss drawing up an Advance Directive to refuse medical treatment. He signed the document the next day. Staff in both healthcare and on the wing, as well as the chaplaincy and the Independent Monitoring Board, spoke to the man at length about his decision and its implications. Healthcare staff also checked on a daily basis that the man was of sound mind and wanted to maintain his course of action, and that the terms of the Advance Directive remained in force. Those who cared for the man and staff and prisoners who had contact with him were advised what an Advance Directive meant and what they were able to do for him under its terms.

The man’s health deteriorated and, on 10 October, he was admitted to an outside hospital where he stayed until 16 November when he returned to Stafford. The man’s health had improved slightly and he began to take fluids.

During December 2008, the man’s health began to deteriorate again. Staff continued to assess and monitor him, and asked him each day whether he wanted to reverse his decision. He said he did not.

On 15 January 2009, the man was again admitted to hospital. At 9.05pm, he told a doctor at the hospital that he had changed his mind and wanted to survive. However, 30 minutes later he told the same doctor that his wishes remained unchanged and he wanted to die. He also said that in the event of his heart stopping he did not want to be resuscitated.

The man drifted in and out of consciousness most of the next day, and by the morning on 17 January was unresponsive. At 11.07am, the hospital sister checked on him and found that he had died. This was confirmed by a doctor at 11.50am.

I do not make any recommendations of my own as I have found the care afforded to the man to have been very good. I believe that a hugely difficult situation was handled professionally and compassionately. However, the clinical review makes a total of seven recommendations, mainly surrounding the management of end of life care for prisoners.

THE INVESTIGATION PROCESS

1. An Investigator from my office was appointed to conduct this investigation. She visited HMP Stafford on 22 January 2009 to see the cell where the man died, to meet with staff, and to collect all prison documentation. Because of the volume of paperwork, some of it was couriered to my office after her visit.
2. Notices were issued to both prisoners and staff inviting anyone who had information regarding the man's death to make themselves known to the investigator. No further witnesses came forward.
3. The Investigator visited Stafford again on 7 and 8 April and 6 May to carry out taped interviews with staff.
4. One of my Family Liaison Officers, contacted the man's brother to explain the role of the Prisons and Probation Ombudsman and to offer him the opportunity to participate in the investigation. The man's brother noted that when the man first went to outside hospital he was handcuffed, which he thought was surprising as he was so frail. However, he said this was more of an observation than a concern. He also praised staff at the prison and how they had treated his brother. In particular, he wanted to mention the Safer Custody Co-ordinator who he said had done a lot for his brother.
5. The Investigator met with the Chair of the Independent Monitoring Board (IMB) at Stafford, on 6 May. She apologised for not having met with him on her first visit to the prison. The Chair of IMB confirmed that he had attended a number of case conferences about the man and had visited him both on the wing and in hospital. He also said that the IMB had been impressed by the actions of staff who had shown dedication and professionalism.
6. South Staffordshire PCT was commissioned to conduct a clinical review, and appointed the Head of Integrated Governance as the Clinical Reviewer. She convened a panel to evaluate her findings.

MENTAL CAPACITY ACT 2005 AND ADVANCE DIRECTIVE

7. The Mental Capacity Act 2005 provides a statutory framework to empower and protect vulnerable people who are able to make their own decisions. It makes clear who can take decisions, in which situations, and how they should go about this.
8. The Act establishes a set of key principles and provides a checklist to be used in ascertaining a person's best interests. It deals with liability for actions in connection with the care or treatment of a person who lacks the capacity to consent to what is done.
9. An Advance Directive is a statement of instruction about how a person wants to be treated in the future should they lose the capacity to make informed decisions about their own care. Adults with capacity have the right to refuse food, fluid and treatment, both at the time it is offered, and in the future using an Advance Directive. If treatment is forced, it is a breach of the patient's right to life, self determination and liberty. It can also be considered a criminal offence to treat someone against their informed will.
10. The man had to have the capacity to make an Advance Directive in order for it to be legally valid and implemented by staff. The presumption in law is that a patient who wants to make a directive has the capacity to do so, unless it can be proven otherwise.
11. A person lacks capacity if they have a mental health condition that causes them to be unable to make a decision to consent to, or refuse, treatment. The man was assessed by a number of healthcare professionals who determined that he did not have a mental health condition precluding him from making such a decision.
12. There are three stages to assess whether someone has capacity. The patient must be able to understand information relevant to their decision, be able to retain that information, and be able to weigh that information in the balance in order to make their decision.
13. The key characteristics of an Advance Directive under the Mental Capacity Act include:
 - That the decision and statement must be verified in writing
 - A person can change or completely withdraw the advance decision if he has the capacity to do so
 - The withdrawal or partial withdrawal does not need to be in writing
 - An alteration of an Advance Directive does not need to be in writing, unless it applies to an Advance Directive refusing life sustaining treatment, in which case formalities will need to be satisfied in order for it to apply.
14. It is very rare that prisoners die as a result of refusing food. I understand that only four other prisoners have died in this way in the last 15 years. Prison Service guidance says that prisoners refuse food either as a means of protest or

as a result of a serious mental disorder. The man told staff at a very early stage that he wanted to die through food refusal as a protest against his wrongful conviction.

15. On 24 September 2008, the Governor of Stafford, spoke to the Head of Operations and Nursing at the PCT about his concerns regarding the man's actions. The Head of Operations and Nursing at the PCT made a note of their conversation and sought legal advice to give assurances that the action being taken was appropriate. The principles relating to a person's capacity were reiterated. All of us have the right to make decisions that others might think are unwise. A person who makes a decision that others think is unwise should not automatically be labelled as lacking the capacity to make a decision. The prison needed to regularly reaffirm the man's capacity and document that they had done this, preferably on a daily basis. They also needed to ensure that the man was fully aware of the consequences of his actions, with particular regard to understanding the eventual outcome and mode of death. There was a discussion about the man drawing up an Advance Directive and what this would entail.
16. It was agreed that the man's mental capacity would be assessed and recorded daily and a senior manager would attend all case conferences. Staff would be made aware of the Mental Capacity Act and its consequences, and would be reminded of the need for detailed and rigorous record keeping. The Head of Operations and Nursing at the PCT and the Governor of Stafford agreed to discuss the man on a weekly basis, if not more frequently.
17. The man signed an Advance Directive to refuse treatment on 3 October 2008. The directive said that he had made a decision to refuse food and was aware that this would lead to his death. It also said that he had made the decision of his own free will, and that he had been examined by a psychiatrist and discussed his decision with medical and legal staff, and it was accepted that he had the mental capacity to make the decision to refuse food.

The effects of malnutrition

18. Malnutrition affects every system causing vulnerability to infection, poor wound healing, impaired organ function, muscle weakness, depression and apathy. Starvation is also accompanied by changes in metabolism which lead to changes such as deficiencies of specific vitamins and trace elements, low insulin concentrations and a partial switch from carbohydrate metabolism to ketone metabolism to provide energy.

Re-feeding syndrome

19. Re-feeding syndrome can be life threatening for a starving person. Giving too much food or fluid to a malnourished person can cause problems such as cardiac failure, acute circulatory fluid overload and liver dysfunction. When a person has had little or no food for a long period, initiation of feeding must be cautious, providing generous quantities of minerals and vitamins. A patient is thought to be at high risk of re-feeding syndrome if they have had little or no nutritional intake for more than ten days. This was the case for the man.

HMP STAFFORD

20. HMP Stafford was built in 1794. It holds 741 category C prisoners in seven wings and a segregation unit. A, B and D wings house mainstream prisoners, C wing is the induction wing and G wing is a stand alone wing that accommodates prisoners identified as ready for release on temporary licence or transfer to a category D prison. E and F wings are known as The Crescent and house vulnerable prisoners. F wing is also an induction wing. There is no inpatient healthcare facility at Stafford.
21. In 2003, Stafford dedicated half its capacity to vulnerable prisoners and sex offenders and a regime based on the delivery of offending behaviour programmes.

Her Majesty's Chief Inspector of Prisons

22. Stafford was most recently inspected by HM Inspectorate of Prisons in an unannounced short follow-up inspection in June 2009. In her report, the Chief Inspector, said:

“HMP Stafford had continued to make progress and was now performing reasonably well in all areas.

“Stafford was not an unsafe prison, and procedures to support vulnerable prisoners had improved ...

“The suicide prevention co-ordinator post was full-time, compared to only 18 hours a week at the last inspection. During absences, the work was covered by residential staff or the violence reduction co-ordinator.”

Independent Monitoring Board (IMB)

23. An IMB is appointed to each prison by the Secretary of State for Justice. Its members are wholly independent of the Prison Service and the prison's management team. Each IMB is required to produce an annual report to the Secretary of State about the prison, highlighting good practice and areas of concern.
24. The IMB is kept informed about events in the prison through a weekly newsletter and a monthly diary presented at its meetings. Board members also receive the minutes of team meetings, staff briefings, Head of Function reports, and other documentation which together provide a broad view of any new initiatives or problems.
25. The latest report from the Stafford IMB covers the period May 2008 to April 2009. The IMB said:
- “There have been two deaths in custody, one of which was in hospital from natural causes. The other involved a prisoner who, during his stay at Stafford during the period 8 September 2008 to 16 January 2009,

refused to take food but subsisted only on hot tea (with milk and sugar). The Board monitored the situation closely and witnessed distressing and harrowing circumstances. The Board admired greatly the concern and compassion shown by prison officers, healthcare and chaplaincy staff. Of particular significance has been the Board's admiration of the Safer Custody Co-ordinator's commitment and dedication towards this prisoner."

26. The Chair of the IMB at Stafford, visited the man after being told about him by the prison's Safer Custody Co-ordinator. IMB members also attended case conferences held by the prison, and on one occasion visited the man in hospital. He told the Board he was being well treated by staff at both Stafford and in the hospital, and said he was satisfied with the support and care he had received.

27. The IMB were much impressed with the care and respect shown by staff. In a letter dated 20 March 2009 shared with my investigator by the Chair of the IMB, the Board said:

"At each of the Board's monthly meetings, the Governing Governor gave a detailed report on the man's condition and kept members fully informed of the extensive measures being taken to care for the prisoner in these difficult and intense circumstances. Board members witnessed, at first hand, not only the incredible amount of time spent by a wide range of all levels of staff within the prison, but also the extensive lengths to which some prison officers and healthcare staff went to make the man as comfortable as possible."

Assessment, Care in Custody and Teamwork (ACCT)

28. ACCT is a care-planning system whereby staff can work together to provide individual care to prisoners identified as being at risk of harming themselves or of suicide. Any member of staff can open an ACCT on a prisoner, and scheduled meetings are held to monitor and review the prisoner's care and progress.

Suicide and self harm policy

29. Stafford issued the latest edition of its suicide and self harm policy in June 2008. The document gives advice on the ACCT process, assessments, reviews and response to emergencies. The overarching statement says:

"HMP Stafford has a duty of care to all prisoners. We aim to reduce the risk of suicide and self harm by providing a safe environment in which people can live and work."

30. The Head of Safer Custody is a governor grade and, as noted above, the Safer Custody Co-ordinator is a senior officer. The core membership of the safer custody team comprises representatives from healthcare, education, chaplaincy, race equality, IMB, Samaritans, Listeners and wing staff. The team meets monthly.

KEY FINDINGS

31. The man was initially remanded to HMP Birmingham on 21 December 2007, charged with a serious sexual offence. In September 2008, he was sentenced at a local Crown Court to an indeterminate sentence, with a recommendation that he serve a minimum of six years.
32. The man had a history of harming himself. He had tried to hang himself in 2004 when he was in prison on a previous sentence, and banged his head on the cell wall at Birmingham in 2007. He also began to refuse food at Birmingham, but started to eat again. Whilst at Birmingham an ACCT was opened and the man was a Rule 45 prisoner (a prisoner segregated for their own protection). According to notes made by staff at Birmingham, the man caused no problems, worked well, and was polite and respectful to staff.
33. On 8 September 2008, the man transferred to Stafford. On reception, he was seen by healthcare staff who recorded normal readings on general health questions. At that time, he was recorded as being five feet six inches in height and weighing 57kg. The screening recorded a past history of mental health and suicide issues, but noted that these were “resolved” in 2007. The man said he was angry at the injustice of false allegations.
34. Five days later at 11.00am on Saturday 13 September, a Senior Officer (SO), attended the healthcare treatment room and said that the man had told her he was “on hunger strike” as he was innocent of the charges against him. It was suggested that he should be assessed by healthcare, but the SO said he refused to engage with them. Later that day, the SO said she had spoken again to the man who said that he was drinking small amounts of fluid. However, he was protesting against his sentence and said he had been on hunger strike at Birmingham and intended to do so again. He was also protesting about being transferred from Birmingham to Stafford.
35. An ACCT was opened for the man at 3.00pm as he was refusing to eat or drink and refusing to be seen by healthcare. The man told staff he was on hunger strike because he had not wanted to be transferred to Stafford. He also said he had not eaten since Monday tea time, and that he had refused food for three months at Birmingham because he was protesting his innocence but had been eating prior to his transfer to Stafford. Staff agreed that the man should be observed three times per night and have three conversations with staff during the day, until the next review. It was also agreed that he should remain on normal location for the time being, and that his meals should be taken to him and left in his cell. The next review was set for 16 September.
36. A Nurse visited the man in his cell later that day. She recorded that he was polite and pleasant towards her and that he confirmed that he had taken small amounts of fluid. The man said that he had already been informed of the consequences of his actions (refusing food) whilst he was at Birmingham, but said that he was making a fully informed decision in protest (although he did not disclose the reason for his protest). The Nurse carried out checks of the man’s pulse, tongue and breath, which all appeared to be normal. He declined any further

intervention, but did agree to reconsider his food refusal and displayed no further ideation of harming himself.

37. On 14 September, the man refused to see the Nurse he had previously seen and was observed eating sandwiches. However, the next day he stated he was not eating and only drinking small amounts and was unhappy at being transferred to Stafford. The man also said that he was not suicidal but did not want any treatment if he became seriously ill.
38. There was an ACCT review on 16 September. The man maintained that he would not eat as he was protesting his innocence. He said he was unwilling to accept any help and that there was no chance of an appeal. It was noted in his medical record that he was “communicative but unconvincing”. It was agreed to continue to monitor him closely and to observe him at meal times. The man was told that he could contact a member of healthcare at any time if he wanted to talk. He had only one drink that day and appeared semi-dehydrated. The next ACCT review was planned for 23 September.
39. The man refused to see anyone from healthcare the next day. However, on 18 September the Nurse that had previously cared for him went to see him in his cell. He was lying on his bed and seemed reluctant to converse. He told the Nurse that he had started work at the prison, that passing urine had begun to feel painful, and that he was continuing to refuse food but was taking two cups of tea a day. The Nurse attempted to speak to the man about changing his mind, but he politely declined.
40. The next day, the Head of Healthcare, noted in the medical records that the man needed a psychiatric assessment. However, she noted later that day that he had refused any mental health assessment. Two days later he was seen again in his cell by the Head of Healthcare. He declined any healthcare intervention despite being advised of the potential consequences of refusing to eat. The man confirmed he had had two cups of tea but had not eaten anything.
41. Healthcare conducted a review on 22 September. The man maintained that he was not eating as he had been wrongfully convicted. He told staff that he had seen traces of blood in his urine for the past couple of days. He denied feeling low, depressed or suicidal, and re-iterated that he did not want to receive any treatment. The nurse again explained the risk of death or the harm he could cause to himself by not eating.
42. The second ACCT review was held on the same day (a day earlier than planned). This was attended by a governor, the Safer Custody Co-ordinator, and the Head of Healthcare. It was noted that during the review the man appeared relaxed and determined. He again said he intended to end his life by refusing all food, and apologised for the distress this would cause. The man was told that his health would be monitored closely, and he replied that he would refuse any tests and all medication. The next ACCT review was arranged for 25 September.

43. However, in fact the next review was held on 24 September. The Head of Operations and Nursing from the Primary Care Trust (PCT) also attended. Staff spoke in depth to the man about the history of his food refusal, his previous mental health problems and the reasons for his current refusal of healthcare intervention. The man continued to refuse to allow healthcare staff to test his urine, check his observations, or carry out a mental health assessment. The man explained in detail that he understood the consequences of his actions. He said he was not suffering from any current mental illness or thought disorder, and appeared to have the mental capacity to make decisions regarding his treatment. Again, the man stated his intention to die as a result of refusing food.
44. A plan was formulated during the meeting. The Head of Operations and Nursing agreed to discuss the man's case with the PCT's legal advisor. Healthcare agreed to speak with the In-Reach psychiatrist to see whether a mental health assessment was possible. The man was to be moved to a cell on the ground floor of the wing and he could no longer attend work for health and safety reasons. It was agreed that he would have access to the prison library, that healthcare staff would continue to visit and offer assistance daily, and a daily case review would be held. A Senior Officer agreed he would talk further with the man.
45. Another case conference was held simultaneously with an ACCT review the next day. The ACCT document noted that the man was unwilling to engage and remained persistent in his views. He admitted that if he stood up quickly he "sees stars". He was asked to consider contacting his family. His medical record on the same day said that he appeared bright and orientated, and somewhat argumentative. The man said he was not depressed and was not experiencing any auditory or visual hallucinations. He declined to give a urine sample to assess the presence of ketones. (Ketones are produced when fat is broken down. They can be harmful to the body.) He also declined to be weighed. The man was talkative and said he was quite happy to die through lack of food. The complications caused by starvation were discussed, but the man said he would cross that bridge when he came to it.
46. A further review for the man was held the following day, although no nursing staff were available to attend. (However, it was noted in his medical record that he continued to decline all medical intervention.) At the review, the man was advised that if he continued to refuse to eat he would have to be taken to outside hospital. He remained adamant that he did not want any medical help, although he agreed to speak to healthcare on a daily basis. He was offered exercise and showers on the wing whenever he wanted them, and arrangements were made for him to attend the library and chapel. The man gave the Safer Custody Co-ordinator a contact telephone number to inform his brother of the situation. The man was told that if he required anything to keep him active, such as attending education or quiz books, he only had to ask. A further review was arranged for the next day.
47. On 27 September, it was noted that the man was alert, coherent, ambulant and co-operative, and gave appropriate answers to questions. He continued to deny any thoughts of suicide or harming himself and did not display any anxiety.

Healthcare noted that they could not detect any ketones on the man's breath, despite 18 days of fasting. He said that he was continuing to refuse food but was drinking a pint of black tea a day. Healthcare noted their impressions of the man: that his memory appeared to be intact, his cognitive functions appeared normal, and that he fully understood the implications of his actions. The man appeared to be enjoying the attention of the reviews and seemed disappointed that this one was briefer than on previous occasions. He was reminded that he could speak to any member of staff at any time. The man agreed to be weighed daily, although he continued to refuse to give a urine sample. He said he felt slight discomfort when urinating.

48. Another review was carried out the next day. Once again the man stated his intentions and refused any medical intervention, but he agreed to be weighed and have his blood pressure taken. The man mentioned that he had been in touch with a solicitor regarding a possible appeal against his conviction. He was also seen by healthcare and it was noted in his medical records that he was adamant he would not complete his sentence and would not eat. He was reminded about the damage not eating would do to his organs, and that even if he did change his mind he might have to cope with the damage he had already done. It was recommended that he should be seen by the visiting psychiatrist for a mental health assessment.
49. The next review was carried out on 29 September. At this review the man told staff his vision was becoming blurred at times. He agreed that medical observations such as ECG and ketones tests could be carried out. Later that day the man was seen by an In-reach nurse (part of a team who help prisoners with serious mental health problems), who again explained the risks of food refusal. It was noted that he appeared of sound mind, fully orientated, engaged in good rapport, and held eye contact. He again expressed his intention to die. It was advised that the man should be located in a safer cell and that he should be transferred to the local hospital if he lost consciousness.
50. Later that day, the man was moved to a safer cell but he was unhappy with this. Staff also placed him on a constant watch overnight. He refused all medical tests as he felt that, after agreeing to tests earlier in the day, he was being punished by being located in a safer cell. The man said he would not harm himself in any other way, so was allowed to keep his normal clothes and belongings with him.
51. The next day, the man agreed to take sugar in his tea, although he still would not eat anything. He agreed to medical checks to monitor any decline in his health. For this reason, he was allowed to move back to his previous cell, with an agreement that he would be observed five times an hour. The Safer Custody Co-ordinator continued trying to contact the man's brother, as well as a solicitor as the man intended to write a living will. The man was happy with this and agreed to see a psychiatrist as soon as it could be arranged. There was also a note to say that a Doctor had seen the man and concluded there was no need for him to be on a constant watch, and that a protein drink was available should he wish to end his hunger strike.

52. Also on 30 September, healthcare checked the man's blood pressure, pulse, weight, and blood glucose, and carried out an Echocardiogram (ECG). The man discussed the necessity of a living will with the Head of Healthcare and that this should be drafted in the presence of a solicitor. The man remained adamant that he was prepared to die and understood that this could entail a slow and painful death. The Head of Healthcare noted that the man had demonstrated that he understood the consequences of his actions and had the mental capacity to make his decision at this time. The man was again told that, if he changed his mind, healthcare would be happy to provide intervention.
53. Staff were instructed that they must not give the man any food straightaway if he changed his mind and chose to eat, but that a protein build-up drink would be provided in the first instance before seeking advice about the re-introduction of food. The Head of Healthcare also asked for a further opinion from a psychiatrist and the man confirmed that he was happy for this to take place.
54. On 1 October, the man was happier that he was back on the wing and asked for some library books in large print. A visit from his solicitor was arranged for 3 October. It was noted that the Safer Custody Co-ordinator was still trying to contact the man's brother. He had all food removed from his cell to prevent him from eating too quickly should he change his mind, but he was aware that a protein drink was available. The Head of Healthcare again assessed the man to be of sound mind and able to make his decision. Members of the chaplaincy saw the man on a regular basis and he was grateful for their support.
55. The next day it was noted in the medical records that the man would alert staff if he was in discomfort or felt unwell. He said he was not sure if he would accept medical treatment if he was in any pain. The Head of Healthcare asked why he had chosen this course of action and he replied that he had tried cutting himself and attempted hanging before, and did not want to experience them again.
56. Also on 2 October, the man was seen by the first Nurse who cared for him from healthcare and another mental health nurse. They noted in the medical record that the man was pleasant and appropriate throughout the interview. They discussed the reasons for his food refusal. The man told them that he had seen a psychiatrist in 1975 and had been admitted to hospital for a week with depression. His next contact with a psychiatrist was in 1995 whilst he was in prison. The man said he had no contact with any family members apart from a brother, whom he had written to. The nurses concluded at the end of the meeting that there was no evidence of any mental illness. The man was also assessed by a forensic psychiatrist that day. The psychiatrist also concluded that he had no current underlying mental illness.
57. Later that day, the man met with his solicitor and the Safer Custody Co-ordinator. The Head of Healthcare and the Nurse from Healthcare were in attendance. The solicitor was content for the man to make an Advance Directive regarding decisions about his treatment and care, and agreed to draw up a legal document.

58. At the ACCT review the next day, the man was told that his sister had died. He was shocked, although he had not seen her for 20 years. He was also told that the Safer Custody Co-ordinator had made contact with his brother and that the man should write to him. His brother would then decide on any further contact. It was suggested that two Listeners would spend time and talk with the man and that the visits from chaplains would continue. It was noted in the medical records that the man had told his solicitor that he would accept pain relief if needed, and that his solicitor agreed to look through the case file again to check whether there were any grounds on which the man could appeal against his sentence.
59. An Advance Directive to refuse medical treatment was signed by the man and his solicitor on 3 October. The document said that the man had made the decision to refuse food and was aware this would lead to his death. It said that the man made this decision entirely of his own free will, and that he understood what his actions would lead to. It also said that the man had been examined by prison psychiatric staff and it was accepted that he had the mental capacity to refuse food. Finally, the document said that, in the event that (because of his decision to refuse food) the man lacked the mental capacity to make decisions concerning the treatment, his solicitor should be contacted.
60. The ACCT review the next day noted that the man intended to pursue his course of action, no matter what the outcome of his appeal. He told staff his vision “comes and goes” but he felt “ok” at present. The next day the man complained of slight dizziness.
61. On 6 October, the man told staff that he was becoming distressed during the night as he was being woken up by the number of observations. It was agreed to drop the level of observations from five per hour to hourly if the man consented to an increase in his medical checks so that his condition could be better monitored. The man was offered the services of the Samaritans, but he declined. The Head of Healthcare noted that the man appeared lucid and fully aware of his actions and that he had “capacity” under the terms of the Mental Capacity Act to make his decisions.
62. The following day, during the ACCT review the man said that he had had a good night’s sleep and was grateful that the frequency of observations had been reduced. He also said that he had not noticed any change in his health, apart from his eyesight. The man said that he was adamant that he wished to continue with his hunger strike, and could not be persuaded otherwise. Again it was noted in the medical records that the man was fully aware of the consequences of his actions, but had the necessary mental capacity.
63. Also on 7 October, a management plan for the man was circulated to staff. It gave details of what they should do in an emergency and what action to take if the man was admitted to outside hospital.
64. On 8 October, during the ACCT review the man was asked whether he had changed his mind about refusing to eat. He replied that he had not. He added that he had no problems on the wing and was grateful for the way in which he was being looked after. The man requested a radio for his cell so he could listen

to music. Further information recorded in the medical records said that he was still enjoying reading. If he wanted to attend the library by himself he was able to use a wheelchair. It was also noted that when the man wanted to take a shower a male member of healthcare staff would assist him, as he felt so weak. During the ACCT review, he was able to fully converse with staff, clearly stating his wish to remain on hunger strike. Healthcare took his observations and noted his blood pressure, pulse, weight and Body Mass Index (BMI).

65. Later that day the man was examined by a prison doctor. The prison doctor noted in the medical records that the man was not dehydrated, that he was drinking liquids, and felt "normal but weak".
66. During an ACCT review held the next day, the man said that he had felt weak after taking a shower and had stomach pains. It was agreed that his medical observations would be carried out daily at 8.00am to enable healthcare to better monitor his condition. The man agreed to speak to a chaplain regarding funeral arrangements, and he was told he would be given a radio, as requested, later that day. It was noted in the medical records that there was no change in the man's condition and that he was feeling weak with some tightness to his chest. He also had some pain radiating into his neck. The man was drinking, but still refusing food.
67. The man wrote a letter to the prison on 9 October. He said that he wanted to clarify his reasons for the course of action he was taking. His treatment by healthcare staff at Stafford had been "first rate and very professional at all times". He also wanted to thank staff for the care and compassion they had shown him. The man recorded special thanks to the Safer Custody Co-ordinator for his help, including making contact with his brother and solicitor. He wrote, "no-one could have helped more". The man said he was serving a sentence for a crime he had not committed and that he had been "set up". His actions were to highlight the unfairness and inequality of the justice system and that he had not been given a fair trial. The man ended the letter by apologising for the distress that his actions would cause staff and that "no-one could have treated me any better or with more compassion and I thank them all from the bottom of my heart".
68. In the medical records on 10 October, it was noted that the man appeared very thin and frail. His observations were taken but he refused to allow any bloods to be taken. He was given the opportunity to discuss any issues or problems, but declined. Later that day he was prescribed soluble aspirin in case he was in any pain. Healthcare also discussed with the Safer Custody Co-ordinator that the man was becoming very unsteady when walking around the wing, and should now use a wheelchair for his own safety. It was agreed that every assistance would be given to the man to keep him safe in his cell.
69. Also on 10 October, the man said during the ACCT review that he was feeling better, but his medical observations suggested otherwise. Healthcare was of the opinion that he was struggling and "could be using his liver to sustain life". Despite this, the man said he would not change his mind and told staff that he had completed the arrangements for his funeral with a member of the chaplaincy and had passed these on to the Safer Custody Co-ordinator. He asked for a

simple service to be held at the local crematorium, with a prayer which he would leave to the member of the Chaplaincy he had spoken to and the hymn *All Things Bright and Beautiful*. They discussed whether the man wanted to arrange a telephone call or visit from his brother, but he said he would rather wait until he received a reply to the letter he had written to his brother. It was also noted in the ACCT review that the man was close to organ failure and it had been decided to take him to an outside hospital. Additional information in the medical records said that, due to the poor state of his health, it had been decided to admit the man to hospital for observations. It was arranged for him to be transferred to Stafford Hospital by non-emergency ambulance within the next two hours.

70. The same member of the Chaplaincy team visited the man frequently during his time in prison and whilst he was in outside hospital. They spoke about his family, the consequences of his actions, and whether he might change his mind about what he proposed to do.
71. Healthcare again checked with the man that he understood the consequences of his food refusal, and the Head of Healthcare remained satisfied that the man had the mental capacity to continue to refuse treatment. Later that day, the man was admitted to Tamworth Hospital. (Whilst in hospital the man was subject to security arrangements which meant he was handcuffed and had two prison officers escorting him.)
72. A notice was issued to all prisoners on 11 October. It told them that the man had become very ill and been taken to hospital. If anyone was upset or distressed by what had happened they should speak to their personal officer or ask to talk to a Listener.
73. An ACCT review was held at the hospital the next day. The man remained adamant that he wished to continue with his food refusal and protested his innocence.
74. Another review was held in the hospital the next day. Again, the man maintained he would continue to refuse food. He told staff he felt fairly well, apart from some pain in his back.
75. On 13 October, the man was transferred to the Samuel Johnson Hospital in Lichfield. This was considered to be a more appropriate setting, providing a side room where he could be cared for. During an ACCT review held at the hospital, the man said he would continue to refuse food as this was a better option than trying to appeal against his conviction. He said he had been sick and that his back was still hurting. Aside from this, he seemed in generally good spirits and was fairly talkative. The Head of Healthcare noted in the medical records that she would visit the man to discuss his treatment and the Advance Directive.
76. The Head of Healthcare visited the man at the hospital on 14 October. She noted that he appeared bright and alert and continued to fully understand the consequences of his actions. She also noted that hospital staff were concerned that they were unable to carry out any extra interventions other than observations, as the man was still refusing treatment. He was taking tea with milk and sugar, in addition

to water, but still no food. After the visit, the Head of Healthcare met with ward staff and the unit manager. The Prison Healthcare Manager for the area was also in attendance. The Head of Healthcare told the hospital staff that they would be kept informed of any decisions regarding the man's care.

77. At an ACCT review held later that day, the man asked whether his brother had replied to his letter. The Head of Healthcare agreed to check this for him. At the review the next day, the Head of Healthcare gave the man the letter from his brother. I understand he found the contents to be quite dismissive and unsympathetic towards his actions, although the man said this was the response he had expected. He said he would have a think about the letter and decide whether to write back or ask for a visit.

78. On 16 October, during an ACCT review, the man reiterated that he wanted the terms of the Advance Directive to be followed. The next day he said he was now refusing liquids as well as food, because he wanted to "quicken up the process" due to his brother's letter (although staff believed this could also be because he wanted a transfer back to prison). On 18 October, the Head of Healthcare told the man that he could no longer leave the ward for a cigarette break. He was unhappy about this as he saw it as a form of punishment.

79. The next day, the man received a visit from his brother whilst at the hospital. The man said he was glad to have been able to see him and to "say goodbye". His brother tried to persuade the man to give up his hunger strike but was unsuccessful. Apart from during the visit, he spent most of the day sleeping. He took fluids again ahead of his brother's visit, but afterwards he refused to drink anything. The next day, during the ACCT review, it was reported that the man had asked for a can of Fanta and an ice cream as "it reminded him of his childhood". Initially this was refused as ward staff were concerned that this would have a negative effect on his health. However, it was noted in the medical records that he ate two spoonfuls of ice-cream at 5.30pm and said that he "wanted a treat before he died".

80. Also on 17 October, the man was assessed by a Consultant Gastroenterologist and GP, on request of the PCT. The Consultant Gastroenterologist assessed that the man was of sound mind and had full mental capacity. He was able to make his own decisions and to insist that that the Advance Directive was followed.

81. Healthcare received information from the bed watch staff on 22 October to say that the man had attempted to take a sip of water which had made him vomit. Ward staff asked whether he wished to end his food and fluid refusal, but he said that he did not. The man again asked for some ice-cream, but ward staff remained concerned and refused his request.

82. The Head of Healthcare and another nurse from healthcare, visited the man in hospital the next day. She noted that he remained bright and alert and was laughing and joking with staff. There was no evidence to suggest his mental health had deteriorated. The man continued to crave ice-cream, but accepted that he could not have any as he vomited after every mouthful. He refused to transfer to Stafford Hospital for re-feeding and continued to say he would refuse

food and fluids until he died. The man also re-iterated that he did not want any treatment to prolong his life, should he become unconscious. Both the Head of Healthcare and the Nurse from Healthcare agreed that the man had the mental capacity to make this decision.

83. For the next few days, staff continued to carry out ACCT reviews in the hospital and things remained unchanged. The man's brother visited him again on 26 October, and their time together appeared to go well. The man drank half of a cup of tea and said that he felt very tired and was having trouble with his hearing.
84. A note in the medical records at 9.55am on 27 October by the Senior Officer who had previously talked with the man before his cell move said, "Information received that the man has been transferred to EAU SDGH [Emergency Admission Unit] following his withdrawal of the Advance Directive. I have been informed that he now wants to eat and drink. I shall visit EAU this PM." The SO went to the hospital and attempted to communicate with the man, but he appeared confused and unable to recollect whether he had asked to finish his food refusal. The SO decided to contact the man's solicitor to inform him that, in his opinion, the man did not have the mental capacity to make a decision now. However, the solicitor was not available. A security decision was also made to remove the man's handcuffs as he was so frail and it was assessed that he did not pose a risk.
85. The SO spoke to bed watch staff who had been with the man. They said that at approximately 9.00am the man had told a member of nursing staff at the Samuel Johnson Hospital that he wished to start eating and drinking again. He had changed his mind and did not want to die. When the SO saw the man, he was on an emergency trolley in a hospital bay and was on a potassium drip. The SO noticed that the man had lost a considerable amount of weight and appeared weak, confused and disorientated. He was unable to recall his name, date of birth, or the date. The SO asked the man if he would like to eat, and he replied "yes", but was unable to explain why he had changed his mind. The man accepted a drink of water through a straw. The SO attempted to contact the man's solicitor three times that day. He managed to speak to the solicitor's secretary, but the secretary was also unable to contact the solicitor.
86. However, at 10.30am the next morning, the Safer Custody Co-ordinator contacted the SO that had a good relationship with the man and had previously explained his cell move and said that the man was refusing all food and fluids again and wanted to continue with the food refusal. The drip had been removed. The SO again tried to speak to the man's solicitor, but could not contact him. Eventually, at 4.00pm, the solicitor rang one of the prison governors, and said he would visit the man the following day.
87. The same SO, the Prison Healthcare Manager, the Head of Operations and Nursing at the PCT and a Nurse from the prison visited the man at 6.20pm that evening. This time the man seemed orientated and his cognitive functions were intact. During a conversation, the man seemed unsure about what he wanted to do and said he did not know whether he wanted to live or die. He accepted 150 millilitres of water and told the SO he would think about "his destiny" and inform

him of his decision the next day. The staff present concluded that the man had the mental capacity to make a decision.

88. The next day at 10.00am, the Safer Custody Co-ordinator informed the SO that the man had decided to continue with the food refusal. The SO visited the man later that afternoon. He appeared bright and alert and orientated. The SO noted that the man had the mental capacity to make decisions. The man told the SO that he wanted to continue with his food refusal and that he would not change his mind.
89. By 30 October, the man was sitting up in bed and taking fluids. The doctor at the hospital said he was considering returning the man to HMP Stafford. The man told staff that he would make a decision about whether he wanted to live or die after he saw his brother.
90. On 31 October, the man signed a form after a discussion with a doctor at the hospital as he had been craving ice-cream. The man signed to say that he fully understood that by consuming ice-cream he would be at risk of death from re-feeding syndrome.
91. During an ACCT review on 3 November, staff had a lengthy discussion with the man about whether he wanted to live or die. The man said he was unsure what he wanted to do and wished to speak to his solicitor and his brother (his solicitor does not appear to have visited him in hospital). The man asked if he could have a cigarette, but was told that it was hospital policy that smoking was not allowed within the grounds.
92. The SO that had previously been instructed to discuss with the man about his cell change, the Safer Custody Co-ordinator and a Governor visited the man later that afternoon. The SO told him that his ambivalence regarding his wish to die placed his Advance Directive at serious risk. The man then said he would decline fluids again if he did not speak to his brother that day. The Safer Custody Co-ordinator agreed to contact his brother, but warned the man that he might not wish to visit him.
93. Healthcare received a message from bed watch staff on 5 November to say that the man was still taking fluids, and was waiting for another visit from his brother before making a decision. At an ACCT review later that day, the man told a Community Psychiatric Nurse that he would make a decision in 48 hours. He said he had made a definite decision not to eat, but that he would consider whether he wanted to take fluids. He said he had no family "to go out to" and would definitely not change his mind about refusing food. He told staff he was not in any pain, and still needed to see his solicitor. For the next few days there was no change in the man's condition, apart from his sleeping more. He continued to stand by his decision.
94. The Community Psychiatric Nurse wrote to the Head of Healthcare about her visit to the man the day before. She wrote that the man seemed to fully understand who she was and the reason for her visit. He was fully orientated in time and place and person and answered all of her questions appropriately and coherently,

maintaining eye contact throughout. The man denied experiencing any psychotic symptoms and there was no evidence to suggest otherwise. He denied feeling low in mood and said he was not depressed. The Community Psychiatric Nurse discussed his decision not to eat and he confirmed that he wished to end his life and the way he had chosen to do so. The man seemed to fully understand the implications of his decision and that not eating or drinking would ultimately lead to his death. The Community Psychiatric Nurse said that throughout her conversation with the man she could find no evidence of mental illness. She agreed to continue to monitor his mental health and arranged to visit him again on 10 November.

95. The man received a visit from his brother on 9 November. When asked by staff the next day whether he had made a decision about taking fluids, he said he had told his brother that he intended to stop drinking from the following Wednesday morning. When asked why this was, the man replied it was to give his brother time to contact his solicitor and to clarify that the Advance Directive was still valid. The man again refused to reconsider his decision and said he wanted to “hurry up” the process.
96. The Community Psychiatric Nurse visited the man as arranged on 10 November to further assess his mental health. He told her that he was still refusing all food, but accepting cups of tea. The man told the Community Psychiatric Nurse he had made a decision to stop taking all fluids from the next evening. He appeared to fully understand the implications of his decision and reiterated that he understood this would lead to his death as was his wish. The Community Psychiatric Nurse again said she could find no evidence of any mental illness and therefore it was inappropriate to continue to visit him. However, the Community Psychiatric Nurse remained willing to support colleagues at the prison with their management of the man. The Community Psychiatric Nurse also said that, if the man’s mental health deteriorated, he should be re-referred for another assessment.
97. Notes in the medical record for 13 November show that the man did not receive a visit from his solicitor as planned, and had stopped drinking in the early hours of Wednesday morning. He was sleeping for much of the time. There was little change the following day.
98. On 16 November, the man returned to Stafford. He was settled into a safe cell by an officer who was to keep constant watch on him.
99. At an ACCT review later that day, the man said that whilst he remained adamant that he would not eat he would take a cup of tea with sugar. He appeared alert and responsive, although weak and frail. All staff were informed about the procedure should the man decide to start eating again, and told that food needed to be provided in a controlled way.
100. For the next few days, the man continued to take fluids, but did not eat. Healthcare staff carried out daily observations to monitor his health. At no time did the man express any wish to reverse his decision.

101. At an ACCT review on 20 November, the man expressed some doubts about his wish to die as his relationship with his brother had improved. He was told he could change his mind at any time. However, the man then said he definitely wanted to die and that his Advance Directive was to stand. It was agreed that he had the mental capacity to make his decision. Over the next couple of days the man continued to feel weak and dizzy, but remained alert and bright, re-iterating his intention to die and that his Advance Directive should stand.
102. On 25 November, the man said he felt quite ill. His lowest weight was recorded since he had begun refusing food. The man said his vision was blurry and he was feeling dizzy. He said his Advance Directive must stand.
103. On 29 November, the man stated during the ACCT review that he felt “rough” and that his eyesight was failing. He felt unsteady on his feet but was able to get around. The situation remained unchanged for the next few days.
104. During the ACCT review on 5 December, the man appeared very emotional and tearful. He said he had not slept well. He had drunk two cups of tea and asked whether he could have an alternative. It was suggested that he might like to try some nutritional drinks, but he responded that he might do as long as they did not prolong his life. Staff discussed with the man how he would raise an alarm in his cell if he needed assistance. It was agreed to purchase a personal alarm for him to use. It was noted that the man appeared low in mood, but adamant in his decision and not at all confused or lacking mental capacity.
105. Later that day the Head of Healthcare visited the man in his cell. He had spoken to a chaplain and seemed tearful. However, he re-iterated his wish not to eat. The Head of Healthcare assessed that he had the mental capacity to make this decision, but noticed that his physical health was deteriorating. The Head of Healthcare warned the man that a specialist opinion would now need to be sought if he wanted to begin eating again.
106. During an ACCT review on 8 December, the man complained of “jumpy” vision and stomach pains. The review took place in his cell as he was too weak to attend the office. He said that staff were looking after him well and that there was nothing he wanted or needed. His blood pressure and weight were recorded as being very low.
107. On 12 December at an ACCT review, the man said he felt “up and down” and that he was unsure whether to continue his course of action and was “waivering”. He was aware that his condition was deteriorating and that he needed to make a decision very soon.
108. The next day during the ACCT review, the man was asked why he had ordered peanuts and chocolate. He replied that it was a treat for Christmas. He was told that the order had not been processed as he would be unable to eat them. The man was asked whether he would like to be admitted to hospital to start being nourished, but he declined, saying that his Advance Directive remained in

force. It was noted that his blood pressure was now critically low and his observations were increased to five times an hour.

109. On 14 December, the man told staff present at the ACCT review that he felt worse, although his observations had shown a marked improvement and his blood pressure and weight had increased. The man said he was still able to get around his cell and was happy with the level of care he was receiving. Although he said he was still considering his decision, he declined to be transferred to hospital to be re-fed and said that the Advance Directive remained in force. The following day, the man complained of chest pains but his decision remained unchanged.
110. During the next few days the man's health deteriorated and he became weaker. He told staff he just wanted it over with and to die. Throughout this time it was the opinion of healthcare staff that he retained mental capacity. On 22 December, he was given his personal alarm should he need to call for help when he was in his cell.
111. The man continued to become steadily weaker and began to vomit after taking fluids. He was told by healthcare staff that his body was now rejecting fluids. Despite this he remained adamant the Advance Directive should stand.
112. During an ACCT review on 30 December, the man seemed extremely weak and had difficulty speaking. He said that he was finding it hard to drink and had abdominal pains. He said he thought he had now made his final decision and "there was no turning back". Healthcare said they were looking at types of pain relief that could be administered. Later that day the man spoke to a member of healthcare. He said he was fifty-fifty about his decision not to eat, and would tell them his decision the next morning. However, he said he did not want to go to hospital to be re-fed.
113. The next day he told staff he had had a "weak moment" the day before and definitely did not want to change his mind. His Advance Directive remained in force. Healthcare agreed that the man had the mental capacity to make this decision.
114. The man's brother visited him on 3 January 2009. The next day the man became quite emotional during the ACCT review, and said he had spent the night thinking about his decision following his brother's visit. He added that he would make his "final decision" tomorrow, but for now nothing had changed. The next day the man confirmed that, despite thinking it through, he remained committed to his course of action and was determined to "see it through".
115. During an ACCT review on 9 January, the man requested sweets and lemon tea, although he said he had not changed his mind. Healthcare agreed to check this out for him. He said he felt cold all of the time and was given extra blankets. Healthcare were unable to obtain accurate readings from the man's observations, but believed that was because he was being sick after every drink and becoming very dehydrated. The following day healthcare staff could not find a pulse and found it difficult to read his blood pressure.

116. The next day, the man seemed to have become much worse. He had redness inside his mouth, and on his tongue and cheek. His pulse was fluctuating and his breathing had become difficult and laboured. Although he appeared to have difficulty holding a conversation, he remained lucid and continued to say he was adamant about his decision.
117. By 13 January, the man was unable to sit or stand up without assistance. He seemed disorientated and confused. Healthcare assessed that he was not yet at the stage where he needed to be admitted to hospital, but they would review the situation that afternoon. During observations that afternoon healthcare noted that the man was sitting out of bed drinking a cup of tea and smoking a cigarette. They agreed to review the situation the next morning.
118. The SO that had visited him in prison and discussed his cell move with him previous to him going into hospital and the Head of Operations and Nursing at the PCT saw the man in his cell the next morning at 7.40am. He continued to be orientated and recognised familiar faces and the implications of his actions. The man was made aware that a hospital bed was available to him but, when asked what he wanted to do, shrugged his shoulders and replied "I'm not bothered". It was the opinion of the SO and the Head of Operations and Nursing that the man was not yet at the stage where he needed to be admitted to hospital, but they agreed to review the situation again that afternoon. Later that day, the man was given a bed bath, and his clothes and bed sheets were changed. He was assessed continually throughout the day. The SO saw him again at 11.45pm. He noted that the man seemed alert.
119. The next day during the ACCT review, the man seemed tired and less communicative. He had greater difficulty moving around unaided. He was told that the Governor had spoken to the Head of Operations and Nursing and arranged for him to be admitted to hospital. The man was transferred to Samuel Johnson Hospital at 1.15pm that day.
120. At 9.05pm on 15 January, a hospital doctor assessed the man. He noted that the man had told him that he wanted to survive and to be fed. The doctor asked him to repeat this twice and he affirmed this. The doctor wrote that, given this exchange, the man should be moved to another hospital where "proper monitoring" could be carried out. However, 30 minutes later, the same doctor re-visited the man. He asked him what he wanted the hospital to do in the event of his heart stopping, and whether he would wish to be resuscitated. The man replied that he did not. The doctor said this was an odd response given their earlier conversation when the man said he wanted to survive, and he said this was not the case. The doctor discussed this with the Head of Operations and Nursing and it was agreed that further psychiatric evaluation was necessary.
121. On 16 January, another ACCT review was held. During the review the man was drifting in and out of consciousness. He was asked a number of questions about where he was, but could not answer any that required a level of cognition. When asked about his Advance Directive, the man gave no

response. All staff present agreed that he did not currently have mental capacity, but that the Advance Directive remained active at that time. It was agreed that the man would continue to be offered fluids. In addition, a further assessment of the man's mental capacity, care and treatment would be held the next morning. He spent most of the day asleep. A note by a member of nursing staff at midnight said that the man's health appeared to have deteriorated and he now appeared to be terminally ill.

122. At 9.20am, another ACCT review was held. The man was totally unresponsive at this stage, a marked deterioration was noted, and he was taking no fluids. The man's brother and solicitor were informed, but his brother said he did not wish to visit. The Advance Directive remained in force.
123. The following day at approximately 6.00am, a nurse woke the man to ask whether he needed any pain relief. He said he did not. About 15 minutes later staff changed his bed sheets as they were slightly wet. By 7.00am, the man was not at all responsive and was lying in bed with his eyes open and occasionally groaning.
124. At 11.07am, the hospital sister checked the man and said that he had died. Staff at Stafford were immediately informed by the bed watch staff. At 11.50am, death was confirmed by a doctor. A police officer from Lichfield was in attendance. An hour later, the man was taken to Cannock Mortuary. Two prison staff followed in their car. Once at the mortuary the officers handed over the man to the undertaker.
125. A de-brief was held immediately after the man died for all those involved in his care and management. Senior management at the prison were aware that caring for the man had been emotionally challenging and that many staff had taken on extra responsibility. The Safer Custody Co-ordinator, for example, had built up a relationship with the man and liaised with his brother and solicitor on his behalf. The SO that had been told to discuss his cell move with him previously had visited the man both at the prison and at the hospital even when he was not rostered on duty or had finished work for the day.
126. A critical incident de-brief was held some time afterwards but, although it was advertised and staff were invited to attend, it was not generally well attended. (Staff told my investigator they all felt well supported, so they may not have felt the need to attend a further de-brief.) All staff were also reminded of the availability of the Care Team.
127. A notice was circulated to prisoners to inform them of the man's death. They were reminded that they could speak to their personal officer, a member of the chaplaincy, a Listener, or someone from the Samaritans.
128. A Governor was appointed the prison's Liaison Officer. Another Governor was initially appointed as the prison's Family Liaison Officer. The man's brother was very grateful for the care given to his brother and himself by the prison. The prison offered to contribute towards the funeral arrangements in accordance

with Prison Service Order 2710. All the man's possessions were listed and forwarded to his solicitor.

129. A post-mortem was held on 22 January 2009 at 7.45am. The cause of death was noted as inanition (starvation).
130. The man's funeral was held on 17 February and conducted by the member of Chaplaincy the man had contact with. It was attended by his brother and sister, two friends, a member of the chaplaincy, the Prisons Family Liaison Officer and the Safer Custody Co-ordinator.

ISSUES

Care of the man

131. I have a high regard for the work and judgements of Independent Monitoring Boards, and in paragraph 27 above, I have quoted from a letter dated 20 March 2009 from the Stafford IMB. The Board refer to:

“the incredible amount of time spent by a wide range of all levels of staff within the prison, but also the extensive lengths to which some prison officers and healthcare staff went to make the man as comfortable as possible.”

The support given to the man was “delivered unfailingly with extraordinary compassion and understanding by all concerned.” Particular praise should go to the Safer Custody Co-ordinator whose “commitment to his role was outstanding and far beyond the normal call of duty”.

132. I would like to identify myself with the Board’s comments. My investigator was also very impressed by the level of care and dedication shown by staff. I would be grateful if the Governor could share those views with the entire staff team. He should also consider whether the Safer Custody Co-ordinator and the SO who discussed his cell move with him should be formally commended for their actions.

Handcuffs

133. The man’s brother has commented that he was surprised that his brother was handcuffed when he was first admitted to outside hospital, as he was very weak. The decision to remove the handcuffs was made on 27 October 2008 after a risk assessment was made by the Security Department. The initial risk assessment concluded that the man should be handcuffed when he first arrived at the hospital.

134. Many of my investigation reports comment on excessive risk aversion in the use of physical restraints when very sick prisoners are transferred to hospital. In this case, I am content that both the initial risk assessment and the subsequent decision to remove handcuffs were properly arrived at.

Clinical Review recommendations

135. The clinical reviewer makes seven recommendations concerning the man’s healthcare whilst at Stafford. Five concern protocols on the case management of cases of food refusal and re-feeding, the prison’s physical environment, prison in-patient facilities in the West Midlands, counselling and support for staff caring for patients refusing treatments, and the role of in-reach community health services in the support of prisoners requiring end of life care. I have not felt competent to offer a view on those recommendations, but trust they will be carefully considered.

136. A further recommendation is that prison healthcare should seek a medical opinion before sending prisoners to Accident and Emergency in outside hospital. I endorse this recommendation (which I have slightly re-worded).

Other than in 999 situations, prison healthcare should seek an outside medical opinion wherever possible prior to sending prisoners to Accident and Emergency.

137. The clinical review also recommends that additional staff should be trained to provide end of life care for prisoners. Again, I endorse the recommendation (which once more I have slightly re-drafted).

As part of the strategy to develop end of life care for prisoners, additional staff training be considered.

CONCLUSION

138. These were sad and distressing events for staff at Stafford and all those involved in the care of the man. My investigation has revealed that he received exceptional care from both discipline and healthcare staff. A number of staff worked outside of their responsibilities (and hours) to ensure that the man was comfortable and cared for. In particular, the Safer Custody Co-ordinator and the SO that had discussed the man's cell move with him should be commended.

139. The man himself wrote to the Governor to thank staff for the way he had been treated, as did his brother. Staff showed care and compassion to ensure that the man's wishes were followed correctly.

140. Case conferences about the man were held regularly by senior managers, and an ACCT review and medical review was held daily. Notes from these meetings were recorded clearly. The man was asked repeatedly whether he wished to change his mind and his replies were accurately noted.

141. It is hard to see how Stafford could have done anything more for the man. Staff were kept informed, and were well supported by their managers.

RECOMMENDATIONS

To the Governor and Head of Healthcare

1. Other than in 999 situations, prison healthcare should seek an outside medical opinion wherever possible prior to sending prisoners to Accident and Emergency.
2. As part of the strategy to develop end of life care for prisoners, additional staff training be considered.