

**Investigation into the circumstances surrounding the
death of a man
at HMP Swaleside in March 2010**

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

May 2011

This is the report of an investigation into the circumstances surrounding the death of a man who died from natural causes aged 77 years. He was serving a life sentence and had been in prison since 1984.

The investigation was led by one of my colleagues. The man listed his friend as his next of kin. Usually I contact the next of kin to offer the opportunity to raise any issues for me to investigate. On this occasion both the prison and the Coroner told me that the next of kin did not wish to be contacted by my staff. I send my condolences to the next of kin and to all who were touched by the man's death.

I am grateful to the clinical reviewer for providing a clinical review of the healthcare offered to the man in Swaleside. I received her final report on 1 July 2010. The delay in issuing this report is mine alone and I apologise for any inconvenience which this has caused.

I am also grateful to the member of staff at HMP Swaleside who acted as liaison for the investigator and to the Governor and staff for their co-operation with the investigation.

The man died after a long period of ill health. He resisted accepting medical treatment which contributed significantly to his death. He was looked after as an inpatient in Swaleside's healthcare centre for some three and a half years. I conclude that he received a high standard of care there. Unfortunately I have found that the issue of his wish not to be resuscitated was handled badly. The result was a distressing experience for the member of staff who found him apparently dead in March. I make one recommendation to prevent this happening again.

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

Jane Webb
Acting Prisons and Probation Ombudsman

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SUMMARY

The man was sentenced to life imprisonment in 1984. He had no contact with his family from this point on. He was a Jehovah's Witness and had very strong views about the treatment of certain illnesses.

He was diagnosed as suffering from bi-polar disorder (manic depression – a condition in which sufferers experience violent mood swings) in 1990. He was prescribed lithium to treat his condition. Prolonged use of lithium can cause renal (kidney) impairment/failure and he had regular blood tests to monitor his renal function.

He transferred to HMP Swaleside in 2003. In 2006 a blood test showed some renal impairment and his lithium dosage was reduced. He began to suffer from incontinence and was moved to the in-patient unit in November 2006.

His renal function continued to deteriorate. The prison doctor and other healthcare staff consistently advised him that he required hospital treatment but he refused to go to his appointments. Staff monitored him closely and regular care plans were implemented.

On 3 February 2010, a blood sample revealed that he was suffering from renal failure. He agreed to be admitted to hospital on 8 February. Following an ultrasound scan he was diagnosed with renal failure due to high pressure chronic retention of urine caused by an enlarged prostate gland. The condition was treatable and required him to have a catheter to drain his bladder and then prostate surgery, although the extent to which his kidneys would recover was uncertain. He refused to be treated and the hospital discharged him against their advice.

On 11 February a resuscitation status form was completed by staff from the hospice. With the man's consent, the form provided that he should not be resuscitated if his heart stopped. This form was countermanded by the prison doctor on 4 March because he erroneously believed that it was invalid.

The man died in March. Staff attempted to resuscitate him. I conclude that he received overall a very good standard of care at Swaleside but the confusion about his resuscitation status resulted in his wishes not being abided by and distress for staff.

I make one recommendation that Swaleside adopt a policy regarding the resuscitation status of terminally ill prisoners.

THE INVESTIGATION PROCESS

1. I was notified of the man's death on 22 March 2010. The investigation was allocated to an investigator on the same day. Notices were issued to staff and prisoners at Swaleside telling them that an investigation would be taking place, and inviting those who wished to see the investigator to make themselves known. The investigator did not receive any response to these notices. Another of my investigators, who was in the prison on another matter on the day following the death, opened the investigation.
2. The investigator spoke to the liaison officer and arranged for the man's prison record to be sent by post.
3. A clinical review of the man's medical care was commissioned from the local Primary Care Trust (PCT). A clinical reviewer undertook the review.
4. The investigator and clinical reviewer visited Swaleside on 7 June and interviewed five members of staff. They also met the Governor and gave him detailed feedback from the interviews.
5. The man had not had any contact with his family since his conviction in the 1980s and had named a friend as his next of kin. Although listed as the next of kin, his role was as executor and he was not in touch with him in a personal capacity. His friend asked not to be contacted by my office.

HMP SWALESIDE

6. Swaleside opened in 1988 and forms part of the cluster of three prisons on the Isle of Sheppey in Kent. Each prison retains a dedicated Governor and its own identity but the cluster is run by a single Chief Executive. The establishment is primarily a Category B Lifer Main Centre training prison but now also holds a number of lower category prisoners serving shorter sentences who were transferred from HMP Lewes. As a training prison it runs a number of educational, practical and offending behaviour courses. At the time of the man's death it had an operational capacity (maximum overcrowded capacity) of 1,132 and a certified normal accommodation (uncrowded capacity) of 1,112.
7. The prison has an 18 bed in-patient unit in the healthcare centre (HCC) providing 24 hour care for the most seriously ill prisoners. In addition there is a GP service on Monday to Friday with out of hours care provided by South East Health. The prison has primary and secondary mental health care teams and good links with the palliative care team in the local hospice.
8. Her Majesty's Inspectorate of Prisons last inspected Swaleside in a full announced inspection in 2008. Swaleside was found to be a safe and respectful prison but it lacked sufficient purposeful activity for a large training prison.
9. The Independent Monitoring Board (IMB - a voluntary organisation that monitors standards in prison) report for 2009-2010 concluded that Swaleside is a well run prison with good staff prisoner relations and an effective personal officer scheme. Commenting specifically on health care, the report said that staff had to meet the needs of some very complex and challenging patients. Recruitment is a big issue because of the relatively isolated position of the prison and agency staff are used regularly.
10. Shortly after the man's death General Practitioner (GP) services began to be commissioned from the local hospital to try to ensure equivalence with GP services in the community.

KEY EVENTS

11. The clinical review at annex 1 contains a detailed chronology of the man's mental and physical health during the entirety of his time in prison. This section of my report concentrates on events from September 2006, when he first showed signs of renal impairment, until he died in March 2010.
12. He was first prescribed lithium to treat bi-polar disorder (a condition then known as manic depression and characterised by severe mood swings) in 1990. He was still taking lithium when he transferred to Swaleside on 8 April 2003. Sustained use of lithium can impair renal (kidney) function and his lithium levels and renal function were tested regularly via blood tests. The mental health team reviewed him regularly because of his bi-polar disorder.
13. On 4 September 2006, routine blood tests showed that his renal function had become impaired. He had not been suffering from any symptoms associated with bi-polar disorder so his lithium dose was reduced in case this was affecting his kidneys. On 10 October he wrote to a consultant in renal medicine at hospital asking for advice. In his letter the doctor said that the man's GFR (glomerular filtration rate) indicated stage three (moderate) renal impairment but that otherwise he was "fit and sprightly" for his age. It is not clear from the man's electronic medical record what the outcome of this letter was as there is no reply from the consultant on the record.
14. Less than a month later on 6 November, he was transferred to the healthcare centre (HCC) as an inpatient. He had become incontinent and was struggling to cope on a normal wing. At interview the Head of Healthcare told my investigator that the man had been moved to the HCC for reasons of decency as well as for medical reasons.
15. The man's renal function appeared to stabilise but on 10 May 2007 a blood test showed that his lithium level was raised. His dose was reduced again. In early August, the prison doctor referred him to the hospital when tests showed his renal function had diminished again. He refused to go to hospital. According to his clinical record he told the doctor that he was worried he would contract MRSA (methicillin resistant staphylococcus aureus – the so called 'super-bug'). The doctor said at interview that he concluded that the man was a mentally competent adult who was entitled to refuse treatment.
16. By late August, blood tests showed a further decrease in his renal function. The doctor discussed his case with a consultant from the hospital and he advised him to stop the man's lithium and substitute it with a mood stabiliser called lamotrigine. He accepted this change in medication but continued to refuse to attend hospital to see a renal specialist.

17. On 21 September 2007, the doctor wrote to the consultant in the department of renal medicine at the hospital. It is clear from the letter that the doctor had contacted the consultant previously and it had been arranged for the man to attend a renal clinic on 24 September and have blood and urine tests. In his letter, the doctor told the consultant that the man had refused to go to hospital. He said that he had quoted to him the number of deaths from MRSA in hospitals and the number of accidents in accident and emergency departments. The doctor again accepted that he was a competent adult and entitled to refuse treatment. He added that the man had allowed him to take blood samples himself and asked the consultant to share the results with him in due course.
18. The doctor wrote to the same consultant on 29 November 2007, thanking him for his reply (which I have not seen) and telling him that the man had now agreed to attend hospital for tests. I am not certain from the record exactly what happened after this but he did not go to hospital. Another blood sample was taken by the doctor on 11 December and the record shows that it was subsequently lost by the hospital. On 5 January 2008, the man is recorded as telling Healthcare Officer A (HCO) on several occasions that he remained convinced that he would contract MRSA if he went to hospital.
19. In November 2007, the consultant psychiatrist who monitored the man's mental health had discussed drawing up an advance health care directive (instructions given by individuals specifying what actions should be taken for their health in the event they are no longer able to make decisions due to illness or incapacity) with him. However in January 2008, the man told a psychiatrist from the prison Inreach team that he did not want to sign a directive.
20. The prison doctor drew up a new care plan for him on 8 February 2008. The plan described the symptoms of renal failure that health care staff should record and monitor. His blood pressure and weight were to be measured weekly.
21. The doctor reviewed him again in March 2008. Another renal failure care plan was devised. The man told him that he had not been taking his lamotrigine because he blamed it for his decreasing renal function. He refused to have any treatment or tests including further blood tests to check his renal function.
22. On 23 May 2008, the doctor wrote a third time to the renal consultant at the hospital. He described the man's renal impairment as stage four (severe). He told the consultant that the man had asked him to write as he was now willing to go to hospital. He had not consented to a blood test since the previous December. He continued to refuse to give a sample. On 7 August another doctor, (a locum doctor), told him that he needed to give a sample so that the consultant could treat him.

23. The prison doctor wrote a further letter to the consultant on 1 September, asking for advice. He said that the man had again asked him to refer him to hospital but at the same time held firm in his desire not to accept treatment. The doctor told the consultant that he felt the best way forward was for an appointment to be offered and to see how the man responded. An appointment was made for 20 October but he refused to attend on the day.
24. A care plan review on 8 November 2008 reaffirmed that he continued to refuse all medical intervention including going to hospital. The doctor wrote in his clinical record on 27 November that the man had told him he was even more determined to decline treatment as he had been feeling better. He also refused a blood test. The doctor again advised him that he needed to go to hospital.
25. On 31 December, the doctor spoke to him in an attempt to persuade him to agree to treatment for his renal impairment. He wrote in the man's medical record that he had reiterated his determination not to have treatment. He told the doctor that he was flushing out his kidneys with fruit juices.
26. This situation continued throughout 2009. He remained in the HCC and his care plan was reviewed regularly. On 2 February 2009, he was examined by a locum GP because he was refusing to take an antibiotic that had been prescribed for him. The GP told him that he would need a blood test and unusually, he allowed a sample to be taken on 6 February. The results showed that he was suffering from uraemia (a disease that often accompanies renal failure when urea – normally secreted in urine – is retained in the blood due to poor kidney filtration). He was also found to be anaemic and was prescribed iron tablets.
27. On 5 March, he told the locum GP that he was feeling low and struggling to cope with his incontinence. The GP persuaded him to take an anti-depressant and prescribed Mirtazepine. Later the same month he reported that he was sleeping better as a result of taking Mirtazepine.
28. The prison doctor reviewed him on 23 March. They discussed options for managing his incontinence and he agreed to have another blood test to measure his prostate specific antigen level (PSA - a test that highlights whether prostate cancer may be present). This was taken the next day and the results in April showed a low count. He had another blood test on 20 April to determine his full blood count. The results showed nothing new.
29. The doctor examined him on 28 May, 16 June and 3 August and again discussed options to ease his incontinence. At the review on 16 June, he reiterated to the doctor that he did not want any treatment or interventions because his self-medication by drinking fruit juice meant

“everything is under control”. He specifically told the doctor that he did not want to go to hospital. He repeated this assertion on 3 August.

30. His appetite decreased during September and October and he was prescribed Fortisips (a high calorie drink for people who have difficulty eating). The doctor reviewed him on 22 October. Once again he advised the man that he needed treatment for his renal impairment and once again he declined any treatment and said he would not go to hospital.
31. By November 2009, he was complaining of fatigue and was consistently losing weight. On 6 November, an entry in his electronic medical record reads “the man is looking weaker day by day”. He allowed staff to take regular blood samples. In December, he was diagnosed with *heliobacter pylori* (a bacteria causing inflammation of the stomach lining) but refused to take medication to relieve the condition.
32. On 18 January 2010, the man agreed to have treatment for his *heliobacter* infection but rejected any treatment for his renal failure. The doctor saw him again on 25 January. He noted that he had told him that he was worried about the deterioration in his health and would prefer to be in a hospice. The doctor told him that he would have to be referred to a hospice which was likely to want evidence of his current state of health. This meant that he would have to have tests and scans, probably in hospital. The doctor reported that the man’s response was “I will have none of those, it’s all meaningless ritual”. They left it that referral to a hospice would be difficult if he did not agree to tests.
33. The man allowed another sample of his blood to be taken on 3 February 2010 and this revealed that his renal function had deteriorated further and was consistent with stage five (failure - end stage kidney disease). He agreed to be admitted to hospital on 8 February. Following an ultrasound scan he was diagnosed with renal failure due to high pressure chronic retention of urine caused by an enlarged prostate gland. The condition was treatable and required him to have a catheter to drain his bladder and then prostate surgery, although the extent to which his kidneys would recover was uncertain.
34. He refused the proposed treatment. The hospital doctors considered he was of sound mental capacity and understood the consequences of his actions. He was therefore discharged on 11 February and returned to Swaleside. The hospital wrote to Swaleside the same day outlining what had happened and confirming that he had discharged himself against their medical advice. The prison doctor was on leave and a senior nurse responsible for palliative care at Swaleside completed a referral form to a hospice the same day. Because he refused to be treated, his condition was deemed to be terminal.

35. The next day, on 12 February, the man was visited by the Clinical Nurse Specialist from the hospice. She spent some time with him and advised him that his condition could deteriorate quite rapidly. With his consent, she completed a resuscitation status form (a form used for terminally ill patients setting out their cardio pulmonary resuscitation status – in this case stating that he did not wish to be resuscitated in the event his heart stopped).
36. The form was signed by the Clinical Nurse Specialist and by an Associate Specialist from the hospice. The man and the senior nurse were also given advice on the medication appropriate for terminal care. The form was left for the prison doctor to see when he returned from annual leave.
37. The man’s medical record shows that he received regular checks from healthcare staff and nurses. On several occasions staff recorded conversations in which he reiterated his wish not to receive the treatment recommended by the hospital.
38. On his return from leave, the doctor visited him on 2 March. He told the doctor that he had been unable to accept the treatment proposed by the hospital because it did not “match his principles or beliefs”. The doctor wrote that he appeared more mentally and physically vigorous than when he had been taken to hospital on 8 February.
39. On 4 March, the doctor wrote in the man’s electronic medical record that he had read the ‘not for resuscitation’ form completed on 12 February by staff from the hospice. He said that it appeared that the man had been referred to the hospice without the blessing of a doctor in charge of his care from either the prison or the hospital. He added:
- “Resuscitation form is invalid.
- “This form ... is invalid for:
1. Not verified by name of the appropriate person, not signed, not dated.
 2. The section ticked ‘the patient is already fully aware that he is dying’ is rather contentious. This man has always been fully mobile without physical disability. He is capable of physical and mental self-caring.
- “Resuscitation form as it stands should be ignored by all staff. For clarity the man reverts to the default position for normal patients: i.e. he is for resuscitation until such a time that a valid status form is in place.”
40. At interview, the doctor said that he was not familiar with the particular type of form used and thought that it had needed a signature from a doctor or consultant. He said that he had not approved of the senior

nurse referring the man to a hospice in his absence. He felt he had built up a good relationship with him over a number of years and had often been the only doctor who he would accept treatment from. The doctor felt that he should have been involved in the process. He told my investigator that he had returned the form to the nurse and told her, "If you are going to do this, then get it done properly."

41. He said he did not follow up what had happened to the form after he spoke to the nurse and neither did he make any alternative arrangements to ascertain the man's wishes. With hindsight he realised that he should have done so, but said that he did not think of him as being close to death. At the time he thought that the involvement of hospice staff was premature. He was aware that the man did not want to be resuscitated and thought that, clinically, this was the correct decision.
42. The doctor examined him again on 8 March. He recorded in the electronic medical record that he complained of swollen legs, nausea and shortness of breath. Two days later, on 10 March, he agreed to have blood and urine samples taken. By 15 March, it was noted that he appeared increasingly frail and weak. Staff checked him every hour during the day and regularly during the night. On 18 March, his clinical record shows that he was eating very little but was not in pain. He was described as lethargic and disorientated.
43. The duty doctor examined the man on 19 March and found him to be very confused. The doctor asked that he should be transferred to the hospital for assessment. Healthcare Officer B wrote in the electronic medical record that he agreed to be taken to hospital but was "confused and cantankerous". The next day the Head of Healthcare wrote in the record that the man had once again refused treatment at hospital and so he was taken back to the prison.
44. Nurse A was on duty on the HCC on the night of 21/22 March. At interview she said she was usually based on the out-patient unit but worked on the in-patient unit some evenings. Although not responsible for his care, she had come into contact with the man previously. She described him as a lively character and said that she got on well with him.
45. She said he was sitting on the end of his bed when she made her first check of every patient on 21 March. (The checks were made by looking through the observation panel and did not include direct contact with the prisoners.) The nurse described him as looking "grey and ghastly". She asked him how he was and he replied, "Not too good". After she had completed her count of the patients she went back to see him and he told her that he did not feel well. She said she asked him if he wanted to go to hospital but he replied he did not. She told my investigator that she was aware that he held strong views about going to hospital and usually refused to go. She said that if she had not

known about his views she would have asked the night orderly officer to arrange an escort to hospital that night.

46. The nurse described him as “fidgety” and said he looked as though he could not get comfortable. She checked him frequently and each time he was sitting on the edge of his bed, awake and with the light on. She offered him pain relief medication but he refused. At about midnight and again at 00.30am she said she saw him sitting on his toilet. She told him that she was worried about him and that he could not spend the whole night on the toilet in case he fell. She watched him get back into bed. He was drinking lots of water but told her he did not want to lie down as it was too painful.
47. She said that she checked on him again at about 4.00am. He was still sitting on the edge of his bed and told her he was “too frightened to lie down”.
48. When she checked again for the morning roll check at 6.15am, he was lying back on the bed as if he had fallen backwards from the position he had been sitting in. At interview she said that when she saw him lying back on his bed she realised that he had died. She knew that he did not want to be resuscitated but that there was an instruction on his medical record that staff should attempt resuscitation.
49. The nurse did not carry keys to open the cell and so she used her radio to call for the night orderly officers. She said they arrived within a minute and unlocked the door. She said his pupils were fixed and dilated. The staff began to administer cardio pulmonary resuscitation. She used a face mask to begin recovery breaths and one of the night orderly officers did chest compressions. They continued to do this until the paramedics arrived and attached a defibrillator to him. There was no electrical activity in his heart and the paramedics pronounced that he had died.

ISSUES CONSIDERED

The general clinical care afforded to the man

50. From reading the man's extensive prison clinical record and from interviewing some of the staff who cared for him, it is apparent that he had very definite views on what medical treatment he would accept. He was a Jehovah's Witness and this informed some of his principles. The prison doctor told my investigator that the man was an avid reader of newspapers and retained a lot of information from them on certain health related subjects. A case in point was his extreme reluctance to attend hospital because he was afraid of catching the MRSA super-bug.
51. As the clinical reviewer points out, under General Medical Council Guidelines and case law, the man was entitled to refuse medical treatment and the doctor was required to respect his decision. Although his strong views meant that caring for him was sometimes challenging for healthcare staff, it is clear that significant effort was made to look after him within the limits which he himself imposed. In her clinical review she gives credit to the doctor for continually reviewing the options for treatment with the man and documenting what he would and would not accept at various times.
52. The clinical reviewer also comments that it was good practice to admit him to hospital once his renal function had deteriorated significantly. At interview the doctor spoke in detail about his relationship with him. Clearly their relationship was good with regular contact which meant that he was sometimes able to persuade him to accept blood tests and other treatment.
53. The man's clinical record contains copies of regularly reviewed care plans. Entries in the record clearly show that a number of staff spent considerable time talking to him and trying to find ways of best managing his symptoms, especially his incontinence. He was provided with pads and more regular laundering of his clothes and bedding was organised. During the last months of his life, the senior nurse and other staff made significant efforts to provide him with a diet that he could tolerate. Milk and yoghurts were ordered specially for him from the kitchen and clear instructions were written to staff to make sure that he had access to them.
54. I consider that the healthcare provided to the man was of a high standard. Staff spoke with obvious affection for him and with tolerance of his views about treatment. In her clinical review the clinical reviewer commented that:

"The nursing staff caring for the man respected his rejection of medical care and sympathetically helped him deal with his incontinence."

The man's resuscitation status

55. The man's refusal of life saving treatment from the hospital in February 2010 meant that his renal failure was deemed to be terminal. Accordingly the senior nurse contacted staff from a hospice. They spoke at length to him about the implications of his refusal of treatment and what was likely to happen to him in his final weeks or months. As a result, a resuscitation status form was completed that indicated that restarting his heart would not provide any benefit. The form was completed with his consent.
56. I consider that the nurse's decision to involve staff from the hospice in February was reasonable. The man was by that stage very ill and his refusal of potentially life saving treatment meant that his condition was likely to prove fatal in a relatively short space of time. By all accounts, including that of the prison doctor, his wish was that he should not be resuscitated. He is not on record specifically stating this but I have no reason to believe that it was not the case. I am satisfied that completing the resuscitation status form was therefore also reasonable.
57. The form was left in the doctor's in-tray pending his return from leave in early March. He told my investigator that he did not approve of the nurse contacting the hospice as he thought that her action was premature and he should have been involved in the decision. He also thought that the paperwork needed to be signed by a doctor or consultant and was therefore invalid. He returned the form to the nurse and did not follow up what had happened to it. He wrote on the man's medical record that the form was invalid and staff should attempt to resuscitate him if his heart stopped.
58. The head of healthcare told my investigator that when he saw the doctor's entry on the medical record he asked staff from the hospice for advice. He was informed that the fact the form had not been signed by a doctor did not affect its validity. He said that it had been difficult to know how best to advise staff in these circumstances. After consideration, he decided not to contradict the doctor and so staff were advised to resuscitate the man should the need arise. There is no record whether the man was aware that the doctor had changed his resuscitation status back to 'resuscitate' or what he thought about it.
59. In her review the clinical reviewer comments that, in her opinion, the doctor should have been guided by the fact that he knew that resuscitation would be futile. The doctor could then have planned a dignified and pain-free end to the man's life. The very unfortunate consequence of his action was that the man was resuscitated against his wishes by staff who knew that he would have been opposed to their actions. The doctor accepted this at interview and said that, with hindsight, he realised that this must have been distressing for staff, especially Nurse A who knew the man well. The nurse herself told my

investigator that she had found the experience of trying to resuscitate a man, who she judged to have died and who she knew did not want to be resuscitated, very distressing.

60. Clearly there was some confusion at Swaleside about the validity of the resuscitation status form. I do not make a judgement on the Head of Healthcare's decision not to contradict the doctor. The situation was obviously delicate. However, I believe that as a general principle a patient's wishes in this matter should be respected. The doctor was not familiar with the form used by the hospice and believed erroneously that it was invalid without a doctor's signature. Swaleside is a prison with a significant number of life sentence prisoners. It stands to reason that some of these lifers are liable to die in prison and it would therefore be sensible for Swaleside to adopt a policy on the question of the resuscitation of terminally ill prisoners.

I recommend that the Partnership Board of the Primary Care Trust ensures that the prison has an effective policy on do not resuscitate decisions for terminally ill prisoners. The policy should be consistent with the British Medical Association guideline 'Decisions regarding cardio-pulmonary resuscitation'. The policy should include guidance to healthcare staff on how to document such decisions.

The prison's response to the man's death

61. The control room incident log shows that a Senior Officer (SO), the Night Orderly Officer, was informed that the man was unresponsive at 6.17am. The SO and two officers went directly to the healthcare centre and went into the cell. In his statement the SO said that his first impression was that he was dead. He used his radio to ask the control room to call for an ambulance and then he and Nurse A and Officer A began cardio pulmonary resuscitation (CPR). The nurse had received refresher training in CPR and the use of a defibrillator in February 2010.
62. The control room log shows that the ambulance arrived at the prison gate at 6.33am and in healthcare at 6.35am. Two paramedics attached a defibrillator to the man but it showed there was no electrical activity in his heart. The paramedics pronounced him dead at 6.43am.
63. The friend identified by the man as his next of kin was contacted by a Principal Officer. The friend confirmed that he did not know him well but was acting as his executor. He did not want to be involved in any investigation into his death.
64. I am satisfied that the prison's response to the man's death was timely and efficient, notwithstanding my comments above about the question of whether resuscitation was appropriate.

CONCLUSION

65. The man's firmly held views on medical treatment meant that he could be a challenging patient. Despite this, I have found that staff at Swaleside offered him a high standard of care. Whilst respecting his views, they tried throughout his long illness to persuade him to accept medical treatment. They treated issues such as his incontinence sympathetically. The prison doctor was his regular doctor and they clearly had a good relationship. Unfortunately the doctor's decision that the resuscitation status form was invalid meant that attempts were made to resuscitate him, against his previously expressed request. This was very distressing for staff, as well as being a demeaning and undignified response to his clearly expressed wishes. Swaleside has many life sentenced prisoners and I hope that my recommendation will benefit others who are terminally ill.

RECOMMENDATIONS

1. I recommend that the Partnership Board of the Primary Care Trust ensures that the prison has an effective policy on do not resuscitate decisions for terminally ill prisoners. The policy should be consistent with the British Medical Association guideline 'Decisions regarding cardio-pulmonary resuscitation'. The policy should include guidance to healthcare staff on how to document such decisions.

The National Offender Management Service accepted this recommendation at draft report stage and commented:

"The NHS South East Coast, End of Life Care, Clinical Advisory Group overarching principles for NHS and voluntary sector organisational policies on Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) has been ratified and implemented as policy for Sheppey Prison Healthcare."