

Document Details		
Title	HMP/YOI Stoke Heath Food Refusal Policy	
Trust Ref No	1285	
Local Ref (Optional)		
Main points the document covers	The process in which prisoners are managed during food refusal.	
Who is the document aimed at?	All staff working within the prison, discipline and healthcare.	
Owner	Helen Newton, Head of Healthcare, Mark Greenhaf, Governing Governor, Wendy Sweeney, Clinical Nurse Manager	
Approval Process		
Approved by (Committee/Director)	Quality, Safety and Delivery , HMPYOI Stoke Heath	
Approval Date	01/01/2024	
Initial Equality Impact Assessment	Yes	
Lead Director	Director of Nursing & Operations & Prison Governor	
Category	Operational	
Sub Category	Prisoner Safety	
Review Date	01/01/2027	
Distribution		
Who the policy will be distributed to	All prison staff. Prison healthcare staff	
Method	E-mail, meetings	
Document Links		
Required by CQC		
Required by NHLA		
Other		
Amendments History		
No	Date	
1	16/11/2021	Review and removal of old assessment
2	02/04/2024	Review and amended Governors names / roles
3	02/04/2024	Section 5.2 – includes continued nurse observations for 2 days after



Shropshire Community Health 
NHS Trust

HMP/YOI STOKE HEATH FOOD REFUSAL POLICY

CONTENTS

1. Purpose of Policy.
2. Supporting Documentation and Consultation
3. General Principles
4. Training, Dissemination and Implementation
- 5 Identification and reporting of prisoners refusing food.
6. Initial Action by Doctor.
7. Action to be taken if prisoner continues to refuse food and/or fluids.
8. Advance Statements
9. Roles and Responsibilities and supporting documentation

Annex A – Role of the Doctor

Annex B – Role of Primary Care Team

Annex C – Role of the Residential Staff

Annex D – Role of Primary Care Administration Team

Annex E – Role of Prison Managers

Annex F – Role of Duty Manager

Annex G – Food Refusal Log

Annex H – Reporting Procedures Flow Chart

Annex I – Initial Assessment of Individual Refusing Food

Annex J – Refusing Food or Drink – Prisoner or Detainee Advice Sheet

Annex K – Clinical Assessment of Risk of Refeeding Syndrome and Management of Refeeding Following a Period of Fasting.

Annex L – Mental Capacity Act 2005 Explanatory Notes Amended for the Management of People Refusing Food in Immigration Removal Centres and Prisons.

Contact Point: **Head of Safer Prisons. HMP & YOI Stoke Heath**

Policy Location: All prison residential units, primary care general office, Reception, Prison Service Intranet, prison Information Room

1.0 Purpose

The purpose of this policy is to ensure that prisoners who cease to take meals are properly identified, cared for and monitored. It sets out the guidelines for the treatment and care of such individuals and provides guidance regarding consent to treatment in these cases. The policy should be used in conjunction with the following two documents: Department of Health clinical guidelines for the management of people refusing food in immigration centres and prisons, and also Prison Service Instruction 64/11 – Management of Prisoners at risk of harm to self, to others and from others (Safer Custody)

2.0 Supporting Documentation and Consultation

2.1 The following documents are also available for guidance and are located in the Primary Care General Office:

HMP Information and Practice 3/ 2002 Guidance on Consent to Medical Treatment
Department for Constitutional Affairs (2007) Mental Capacity Act 2005 Code of Practice, London: DCA
Department of Health (2002) Seeking Consent: Working with People in Prison, London: DH
Department of Health (2009) Guidelines for the Clinical Management of people refusing food in Immigration Removal Centres and Prisons, London: DH
National Institute for Health and Clinical Excellence (2006) Clinical guideline- Nutrition support in adults: Oral nutrition support, enteral tube feeding and parenteral nutrition, London: NICE.
IMCA (2008) Making Decisions – The Independent Mental Capacity Advocate (IMCA) Service, London: IMCA
Shropshire Community Health NHS Trust policy on Advance Decisions

2.2 The following stakeholders were consulted in the preparation of this policy:

H. Newton	Head of Healthcare, Shropshire Community Health NHS
W Sweeney	Prison Healthcare Manager, Shropshire Community Health NHS
M Greenhaf	Governor, HMP/YOI Stoke Heath
J. Lane	Deputy Governor, HMP/YOI Stoke Heath
Dr. P.Staite	Associate Director/GP, HMP/YOI Stoke Heath

2.3 This policy will be reviewed at three yearly intervals or when there is a change in national policy.

3.0 General Principles – Consent to Treatment

3.1 In a series of legal judgements, the courts have recognised that a competent individual has the right to choose to go on a “hunger strike” or refuse food over the age of 18 years, as per the Mental Capacity Act 2005 Sections 24 – 26.

3.2 An individual is likely to lose capacity (become incompetent) towards the end of such a period and the courts have stated that if the individual has, whilst competent, expressed the

desire to refuse food until death intervenes, the person cannot be force fed or fed artificially without consent. Refusal to consent to treatment remains binding under these circumstances.

3.3 Legally the use of artificial nutrition and hydration (ANH) constitutes medical treatment. Therefore, the legal principles which apply to the use of ANH are the same as those which apply to other medical treatments.

3.4 Furthermore, it has been held by the courts that food and fluid refusal is not an attempt at suicide when not accompanied by a diagnosed mental illness or disorder.

4.0 Training, Dissemination and Implementation

4.1 Awareness of and training in this policy will be carried out in conjunction with the prison's safer prisons team during Assessment, Care in Custody and Team work (ACCT) update training, through local governance forums and at team meetings.

4.2 All new healthcare staff will be trained in the policy as part of their induction by the Clinical Lead.

5.0 Identification and reporting of prisoners refusing food

5.1 When it appears to any member of staff that a prisoner is not taking food or fluids (and this is an active refusal rather than just missing a meal because they are not hungry), the following process must be activated:

The prisoner's details and information about the food refusal (ie whether any fluids are being taken or canteen items are still being purchased, the duration of refusal so far and what meals have been refused) must be reported to the Orderly Officer (Oscar 1) and the primary care nursing team.

A record must be entered in the prisoner's case notes on Prison-nomis of all meals refused, plus any other observations of any other food taken (e.g. canteen) and the monitoring of fluid intake as far as possible (e.g. if prisoner is observed drinking).

An ACCT document may be opened at any time during this process, in order to provide a management plan, but must be opened once the food refusal has gone on for three days.

Wing staff will report to the wing manager and handover daily if any food refusals have been reported.

The Duty Governor must report the situation to the Prison Group Directors Office in Stafford after the third day of food refusal and every third day thereafter and when the food refusal has finished; it must also be reported on the Intelligence Report System (IRS) system.

After three days (or one day if fluids are not being taken) wing staff will liaise with nursing staff on at least a daily basis as to the status of the food refusal. It is important to assess the length of time the prisoner has been refusing food and whether this is food and/or fluids.

The primary care nursing team will highlight any ongoing health concerns to the wing manager and Duty Governor. A set of baseline observations must be measured and recorded in the prisoner's clinical record at this stage. These should consist of:-

Current weight and height - any loss of weight since reception or most recent check?
Body mass index - any reduction

General observations – oral hydration - check whether oral mucosa are moist and pink
Tissue turgor - does skin rebound quickly when pinched?
Muscle wasting - is there an obvious loss of muscle mass?
Oedema - is there any oedema present in any areas?
Examination of the tongue - is the tongue moist and pink?
Blood pressure
Urinalysis - any ketones present on testing?
Temperature and pulse - unusually high or low temperature?
Blood glucose

The primary care team will maintain a log of the ongoing food/fluid refusal and will also update the Clinical Nurse Manager on a daily basis. The wing manager will ensure that the Duty Governor is updated as to the status of food refusal, liaising with the primary care team as necessary. Primary care staff will also maintain and update the clinical record on at least a daily basis, to include physical and mental condition and a brief assessment of current capacity.

Wing staff will inform the primary care team when a prisoner ceases food refusal.
Nursing staff will continue to monitor the patients physical state for 2 days after commencing eating again (for those not at risk of refeeding syndrome).

5.2 A flow chart outlining this process is attached at annex H.

6.0 Initial Action by Doctor

6.1 When it appears that a prisoner is not regularly taking food and/or fluids (i.e. refusing food for more than three days or fluids for one day), a doctor must assess the prisoner as soon as possible.

6.2 It is essential at this stage that the prisoner is informed of the risks and consequences of his actions by the doctor in order that the prisoner can make an informed decision as to whether to continue with the food refusal. This should include the possibility of and a description of deterioration and pain.

6.3 The doctor must then make an initial assessment of the prisoner, which should include the following:-

1. Establishing the reason the prisoner gives for refusing food and a preliminary view on the prisoner's seriousness of intent. The Duty Governor should be informed if the doctor's view is this intent should be taken seriously (see role of Duty Governor).
2. An initial assessment by the primary mental health team should be sought if not already carried out. A referral to the In-reach team should also be considered at this stage.
3. Consideration should be given to whether there is any possible physical illness which is contributing to weight loss and loss of appetite (e.g. cancers, cirrhosis, diabetes, thyroid disorder, tuberculosis or tropical infestations).
4. Physical illness can also lead to mental illness and food refusal (i.e. side effects of medications such as anti-hypertensives and corticosteroids, infectious illness and delirium. Consideration should be given, if the Prisoner is agreeable, to checking full blood count, urea and electrolytes, liver function tests, erythrocyte sedimentation rate, C Reactive Protein and any other tests deemed suitable.

5. The prisoner's mental capacity to give or withhold consent to medical treatment; early evaluation will inform decisions regarding capacity of the individual to refuse food.
6. Whether there is any evidence that the prisoner may have made a relevant advance directive (i.e. advance refusal of treatment in the past) and if not whether the prisoner wishes to make one now.

6.4 If the doctor establishes that the prisoner is refusing food as a way of pursuing a grievance, they should discuss this with the Duty Governor to arrange for the prisoner to pursue that grievance through all legitimate channels. This may be sufficient action to persuade them to eat again.

6.5 It is important to thoroughly assess all prisoners who refuse food repeatedly.

7.0 Action to be taken if prisoner continues to refuse food and/or fluids

7.1 Where a competent prisoner refusing food and/or fluids is also refusing medical treatment at a time when a doctor judges it is becoming necessary, whether or not an advance refusal of treatment has been made, the doctor must explain the consequences of these refusals to the prisoner, in the presence of another registered clinical practitioner. These explanations must include the following information:-

1. That the deterioration in their health will be allowed to continue without medical intervention unless they request it.
2. That continuing food refusal will lead to death. This must include a description of the process in terms of pain, what can be offered to help with their symptoms and the physical effects of food refusal

7.2 The doctor must then:-

1. Write a full record of what has been said in the Prisoner's clinical record, verified by both the doctor and the second clinician to say that they were both present when this advice was given. It may be advisable for the doctor to repeat this practice from time to time.
2. Inform the Duty Governor that this stage has been reached, with an indication of the likelihood of the need to transfer the prisoner to an outside hospital. (The Duty Governor must monitor the situation daily at this stage and sign the log accordingly.)

7.3 Where food refusal continues to the extent that a prisoners long term health is placed at risk, whatever the outcomes of the doctors own assessments, they must arrange for a second assessment to be carried out as soon as possible by a psychiatrist to give a second opinion about mental health issues and/or lack of capacity.

7.4 In the event of continuing doubt about capacity which might result in the need for court intervention, the doctor must seek legal advice by contacting the Legal Advisers Branch at the Home Office.

7.5 An individual who recommences eating after refusing food for more than a few days is at risk of re-feeding syndrome. Prisoners at medium, high or extreme risk (see Annex J) must be admitted to hospital following discussion with a hospital specialist team

7.6 It is expected that all individuals refusing food will be located on residential units but prisoners should be considered for transfer by the multi-disciplinary team if deterioration occurs in his mental or physical health. This decision should be taken following a case conference involving, but not limited to, health staff, residential staff, managers and the Prisoner. It may be appropriate to consider transfer to an establishment with 24 hour healthcare facilities following a similar case review approach, although it must be noted that transfer is unlikely to be approved if the Prisoner is refusing to accept treatment.

8.0 Advance Statements

8.1 It must always be assumed that a person has capacity to make a decision unless it can be established that they lack capacity.

8.2 A Prisoner who is currently competent may wish to make an “advance directive” or “living will” specifying how they would like to be treated in the case of future incapacity. Further guidance on this can be found in chapter 6 of the document *‘Seeking Consent: Working with People in Prison’* and the *‘Mental Capacity Act 2005 – Code of Practice’*.

8.3 In most cases where Prisoners refusing food or fluids wish to make such an advance directive, they may want their own legal adviser to draw it up. Alternatively, a model version can be obtained from the Legal Advisers Branch at the Ministry of Justice. A person can change or completely withdraw the advance decision if they have the capacity to do so.

8.4 Case law is clear that an advance refusal of treatment which is valid and applicable to subsequent circumstances in which the Prisoner lacks capacity is legally binding. An advance refusal is valid if made voluntarily by an appropriately informed person with capacity. Failure to respect such an advance directive can result in legal action against the practitioner. The role of the Independent Mental Capacity Advocate (IMCA) should be explained at the initial meeting between the Prisoner and GP and reiterated frequently.

8.5 Ideally, a copy of the directive should be in the prisoner’s clinical record, signed by the prisoner and one or more of the doctors determining capacity. However, it should be noted that it is not legally necessary for the directive to be made in writing or formally witnessed. An oral directive must be followed if sufficient evidence exists of its terms and validity.

8.6 Other forms of care, provided that they are consistent with the terms of the directive, should continue to be provided. Basic or essential care includes keeping the Prisoner warm, clean and free from distressing symptoms, such as breathlessness, vomiting and severe pain.

8.7 A prisoner may be transferred to a psychiatric hospital for treatment under the Mental Health Act when they are suffering from a mental illness/disorder which requires urgent treatment. Sometimes this will be the case even though the prisoner retains the capacity to consent to or refuse treatment. Capacity should therefore be assessed separately from the presence or absence of mental illness. In this context advance directives may be over ridden by the Mental Health Act only in a hospital setting.

9.0 Roles and Responsibilities and supporting documentation

The roles and responsibilities for individuals and areas, along with supporting documentation, can be found at the following annexes:

Annex A - Doctor

Annex B – Primary care staff

Annex C – Residential staff

Annex D – Healthcare administration team

Annex E – Prison managers

Annex F – Duty Governor

Annex G – Food refusal log

Annex H – Reporting procedure flowchart

Annex I – Initial assessment tool

Annex J – Prisoner advice sheet

Annex K - Clinical assessment of risk of re-feeding syndrome

Annex L - Mental Capacity Act (2005) explanatory notes amended for prisons

ROLE OF THE DOCTOR

1. To see the Prisoner after three days for food refusal or one day for fluid refusal for initial assessment.
2. Outline the risks and consequences of refusing foods / fluids over time to the Prisoner.
Advice sheets (Annex L) may be given at this time.
3. Assess the reasons for refusing food and the seriousness of intent. If the prisoner's intention is serious, inform the Duty Governor.
4. Refer for assessment when there is any indication of a mental health problem.
5. Assess the Prisoner's capacity to give or withhold consent (seek a secondary care mental health assessment at this time), in accordance to the Mental Capacity Act.
6. Assess whether there is any evidence that the prisoner may have made a relevant advance directive.
7. If it is identified that a prisoner is refusing food as a way of pursuing a grievance, liaise with Duty Governor to assist prisoner in pursuing this grievance through legitimate channels.
8. If food refusal continues, explain the consequences of this refusal to the prisoner in the presence of another registered clinical practitioner and make a full record of what has been said in prisoner's medical record, with signatures of both doctor and second professional. Repeat this procedure from time to time if the food refusal continues.
9. Inform the Duty Governor when the prisoner deteriorates physically, particularly if the Prisoner is to be transferred to an NHS bed.
10. When food refusal continues to such an extent that the prisoner's long-term health is at risk, a second assessment must be then undertaken by the In-reach Team.

ROLE OF PRIMARY CARE NURSING TEAM

1. If informed of a food refusal inform the Duty governor and Doctor as soon as possible. Make an entry in the Food Refusal Log Book and the prisoner's clinical record. This should also be reported via the Datix system.
2. To visit the prisoner at least daily. All consultations with the prisoner must be written in prisoner's clinical record and electronic care plans. Discuss issues of confidentiality and capacity with the prisoner.
3. Maintain and record observations at least weekly as detailed in Section 5.0 (vii). Eventually daily assessment will be required, and at the onset if fluids are refused as well.
4. The prisoner should be encouraged, where possible, to take fluids/food.
5. The Primary Care Service Manager should be informed on a daily basis of developments in prisoner's condition via handover sheet.
6. A member of the primary care team will attend regular multi-disciplinary/ACCT case conferences so that all are aware of any advance directive and can share care planning.
7. If the stage is reached where terminal care becomes necessary close liaison between the family, National Offender Management Service, prison staff, the GP and the NHS Trust will be necessary.
8. If a psychiatrist recommends transfer to hospital the Prisoner must be housed in an in Prisoner bed whilst awaiting transfer, if one is available. Exceptionally a transfer to general hospital for treatment under common law may become necessary. If clinically indicated and there is no in Prisoner unit at the prison a transfer to a prison with an in Prisoner facility should be considered.

ROLE OF RESIDENTIAL STAFF

1. When it becomes apparent that a prisoner is refusing meals, contact the primary care team with all relevant details (what meals have been missed, what fluids are being taken, duration of refusal, etc). This must be recorded on Prison-nomis.
2. Offer prisoner contact information for Independent Monitoring Board, Chaplaincy, Listeners/Samaritans, and other relevant agencies.
3. Record details of all meals missed (and whether prisoner is eating canteen items etc) in prisoner's Prison-nomis case notes and ACCT document.
4. Ensure information is provided in ways the prisoner can understand, if necessary using an interpreter.
5. Continue to monitor and ensure prisoner is actively offered his meals and that these are left where they can be accessed. A note of this must be made on the Prison-nomis case notes.
6. Open an ACCT when the refusal reaches three days.
7. Help the prisoner to plan for the future and if appropriate, offer support with writing letters, contacting a solicitor etc.
8. Phone the primary care team on a daily basis for as long as refusal continues, providing details as indicated above.
9. Do not pressure the prisoner to eat what is in front of them but fluids such as fruit juice should be encouraged. Prisoners may eat packaged food that they open themselves if they believe the food is poisoned and this can be offered if necessary.
10. When food refusal ceases telephone the primary care team to inform them.
11. If the stage is reached where terminal care becomes necessary, close liaison between the family, National Offender Management Service, prison staff, the GP and the PCT will be necessary.

ROLE OF PRIMARY CARE ADMIN TEAM

1. On receipt of any phone call indicating Food Refusal, inform the primary care nurse-in-charge.
2. Begin a log for that individual prisoner (see annex G) and record all relevant details.
3. Inform Doctor and arrange for prisoner to be seen as soon as possible.
4. Maintain log until end of food refusal. Inform Security Department and Duty Governor every third day that the prisoner is still refusing food.
5. When informed that prisoner has stopped refusing food inform Duty Governor and the Security Department.
6. File log in prisoner's clinical record and send copy to residential wing for the wing file.
7. If the stage is reached where terminal care becomes necessary close liaison between the family, National Offender Management Service, prison staff, the GP and the PCT will be necessary.

ROLE OF PRISON MANAGERS

1. Ensure food refusals are reported via Incident Reporting System on third day of refusal and every third day thereafter and when food refusal finishes
2. If the stage is reached where terminal care becomes necessary close liaison between the family, National Offender Management Service, Offender rights and responsibilities group, deputy director custody staff officer, prison staff, the GP and the NHS Trust will be necessary.

ROLE OF DUTY GOVERNOR

1. The Primary Care Team will contact the Duty Governor to check if there are any prisoners reported to be refusing food. If so, check and sign log located in the Primary Care Centre and if applicable see prisoner.
2. If informed that the prisoner is on the third day of food refusal, inform Deputy Director of Custody's Staff Officer (and on each third day thereafter). An initial case review should be held in line with PSI 64/11.
3. If informed by the Doctor that the prisoner's intentions are to be taken seriously, tell the prisoner that unless they specifically direct otherwise their next-of-kin will be informed.
4. The prisoner's lawyer or probation officer should be contacted to give information to the prisoner regarding advance directives.
5. If this stage is reached, Briefing and Casework Unit must be informed.
6. Regular case reviews must be held.
7. Briefing and Casework Unit must also be informed if the Prisoner is competent and refusing medical treatment at a time when the doctor judges it is necessary and when the prisoner is transferred to NHS facilities.
8. If the stage is reached where terminal care becomes necessary close liaison with the family, NOMS, prison staff, the GP and the NHS Trust will be necessary.

SHROPSHIRE PRISONS – PRIMARY CARE/HEALTHCARE CENTRE**SHEET NUMBER -----****ANNEX G****FOOD REFUSAL LOG**

Prisoner's Name:	Prisoner's Number:
-------------------------	---------------------------

Location:	Date of Birth
------------------	----------------------

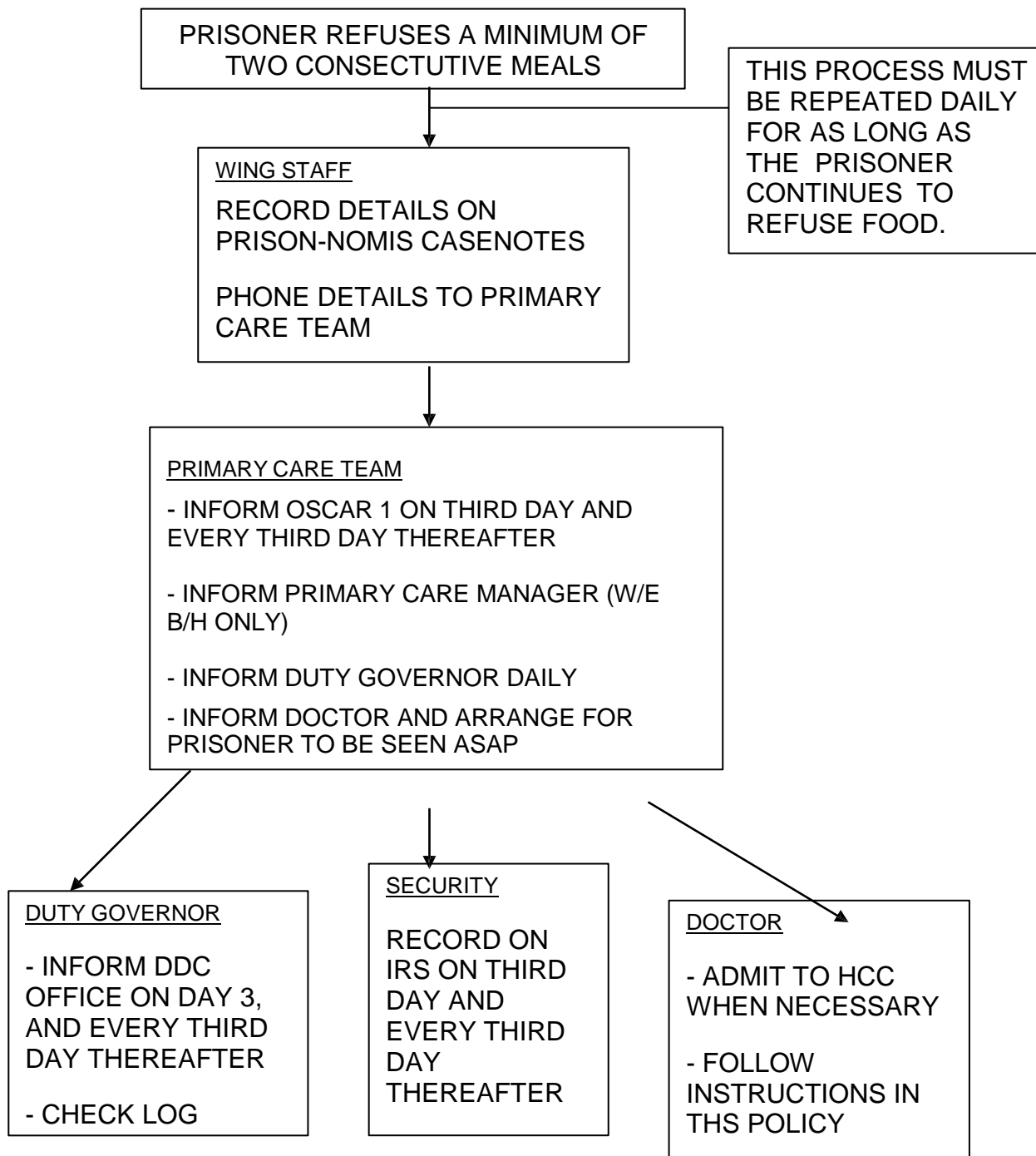
(Update if prisoner moved)

INFORMED

Day	Date/time	Comments	Duty Governor	Doctor	Security	Nurse signature
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						

Use Continuation Sheets as necessary

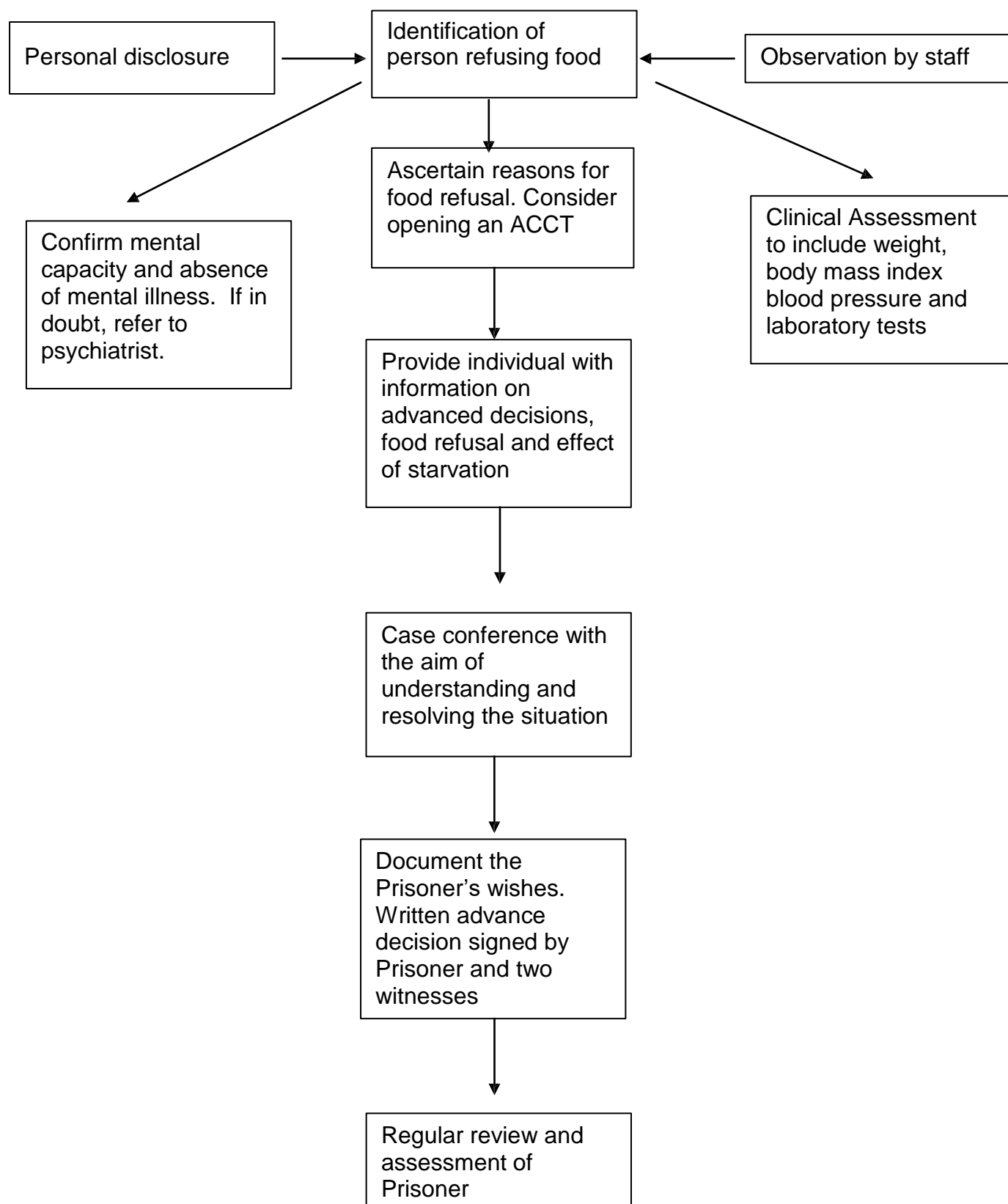
REPORTING PROCEDURES FLOW CHART



NB: At weekends, as well as informing primary care staff, wing staff must also inform Duty Manager.

When food refusal has ceased, primary care staff must be informed. They will then inform Security, the Doctor and the Duty Governor. Security and Duty Governor must then record this on Incident Reporting System and inform Area Office respectively.

INITIAL ASSESSMENT OF INDIVIDUAL REFUSING FOOD



REFUSING FOOD OR DRINK – PRISONER OR DETAINEE ADVICE SHEET

Introduction

You have decided to refuse or severely limit your intake of food and/or drink. This decision is your right but it is important that you know about the likely effects of your actions at the outset. This advice sheet will help you to understand the effects of starvation and why you will be given different medical advice at different stages if you continue to refuse to eat or drink. It also explains why you might need to take great care and even have close medical supervision if you decide to start eating and drinking again after a prolonged period of starvation.

Your Legal Rights

Anybody has the legal right to refuse food and fluids and, although we will try to persuade you to eat and drink, we will not try to feed you against your will unless independent experts believe that you have a psychological or physical illness that makes you unable to decide for yourself. The relevant parts of UK law that allow you to make your own decisions about taking food and fluids (or any other type of treatment) are laid out in Sections 24 to 26 of the Mental Capacity Act 2005 and you can see the details of this if you wish and in the Prisoner information booklet *Making decisions about your health, welfare and finances... Who decides when you can't?* which is published in 11 languages and is available on the Ministry of Justice website (www.justice.gov.uk).

Your refusal to consent to having food or fluid remains binding on everybody even if starvation or illness makes you unable to go on resisting feeding or other treatment. You will not therefore be given food or fluids artificially if you continue to make it clear that this is your wish, even if you can no longer express your desires by either talking or indicating them. This applies even if it means that you will die. However, you can change your mind at any time to stop your fast and agree to appropriate treatment.

The Effects of Starvation

Starvation affects every body and it will make you weak and vulnerable to infections. Your skin may become fragile and you are likely to develop uncomfortable or painful sores, particularly in the mouth and on bony pressure points. You may feel cold and people often become constipated although some develop diarrhoea. Lack of food is likely to affect your thinking, probably making you very depressed or withdrawn. Eventually, it will start to damage your major organs which can fail completely, leading to death.

If you are well nourished when you begin to refuse food, and you are prepared to take adequate fluids, you are unlikely to die from starvation for at least six to eight weeks, even if you eat nothing. However, you will be affected in some ways very quickly. Weakness and lowered resistance to infection can occur within three days of refusing all food and, if you are already undernourished when you stop eating, or you have any illness, survival will be much shorter. Even well nourished individuals can die from starvation in three weeks if they become ill.

The Effects of Avoiding Fluids

If you decide to refuse all fluids, your deterioration in health will be extremely rapid and you could die within a week to 10 days, especially during hot weather.

Medical Care During Food Refusal

If you have decided to refuse food or fluids, you will be offered care. This will include an initial assessment of your general health and eating habits and a general physical examination. We would also recommend that you have some blood tests to be sure that you are starting in good health or, that if you do have a problem, you are fully aware of it and the extra risks it might entail. We will also recommend that you take at least one multivitamin supplement each day and that any food that you do decide to eat is reasonable from a nutritional point of view.

If you go on fasting, we will offer you a further medical assessment each week, and more frequent assessments as you become weaker and more likely to develop problems. We will also suggest weekly blood tests which might also need to become more frequent. Whenever you have a medical assessment (and quite possibly at other times), you will be asked to confirm that you do wish to go on refusing food and/or fluids and that you understand the increasing risks.

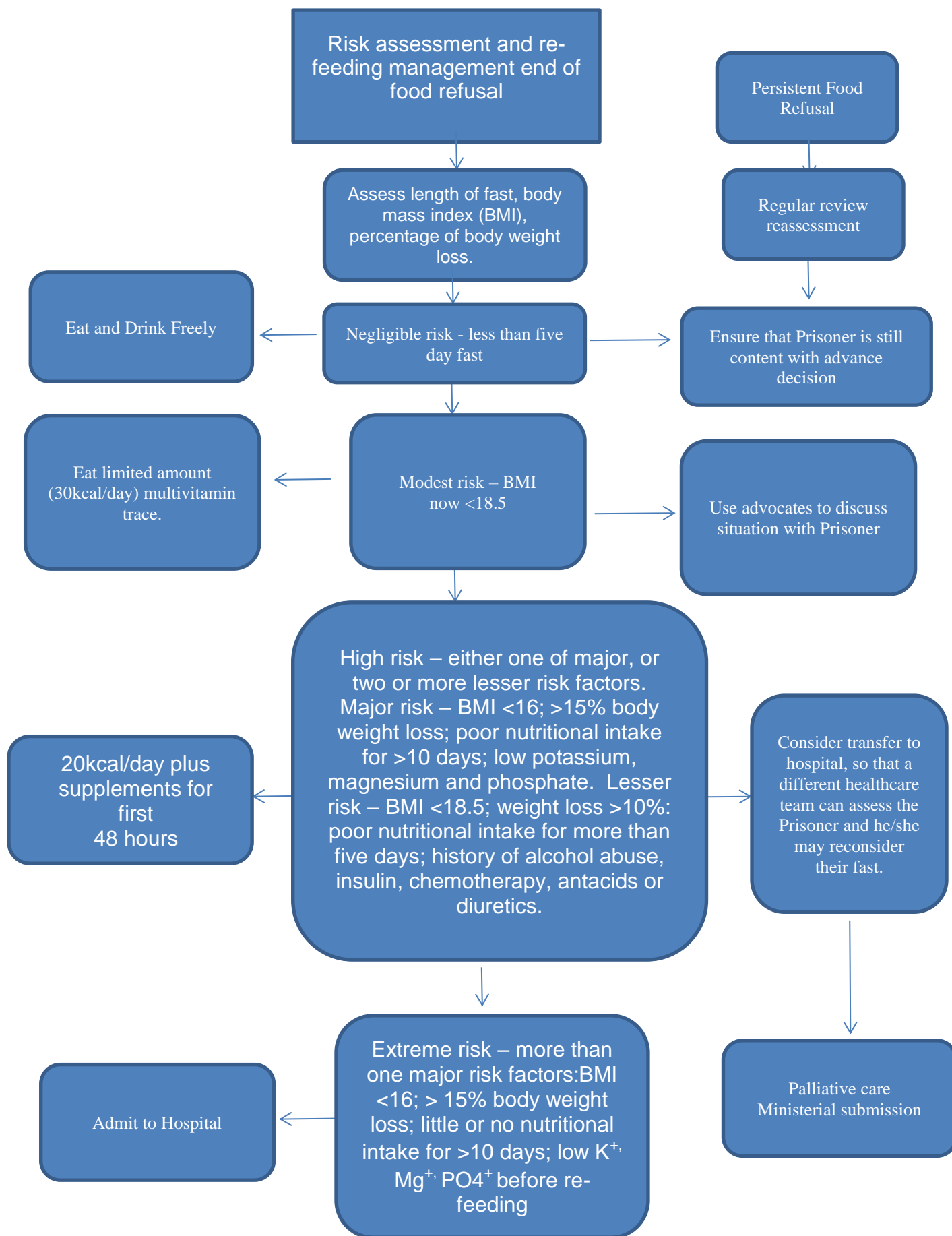
The Dangers While Refeeding

When the body starves, it loses many minerals and vitamins and the function of all cells and organs is decreased. This can make reintroduction of food quite dangerous. As a result, if you do decide at some point to stop your food refusal protest, you may be advised very strongly to eat very little at first while taking plenty of vitamin and mineral supplement tablets. Indeed, if you have become very malnourished, the dangers of refeeding can be so extreme that you might even be advised to go to hospital for very close monitoring of your heart and blood chemistry while food is trickled back into your system possibly via a tube in the nose.

Choosing a Representative

Since refusing food will eventually lead to your becoming very ill and even dying, you will be asked to find a suitable person to ensure that your wishes are followed once you cannot express them yourself. This could be a relative or friend who you trust, but could also be a member of your own faith, your doctor, an independent doctor if in an immigration removal centre, or another health professional of your choice. Information on the protocol for visits by external medical practitioners to detainees in immigration removal centres can be provided for you. It is clearly essential that you discuss all of your wishes with your representative throughout your period of food refusal and that you feel that they can represent your intentions accurately. You should also appreciate that this may be very difficult for a relative or friend.

ANNEX K CLINICAL ASSESSMENT OF RISK OF REFEEDING SYNDROME AND MANAGEMENT OF REFEEDING FOLLOWING A PERIOD OF FASTING



MENTAL CAPACITY ACT 2005 EXPLANATORY NOTES AMENDED FOR THE MANAGEMENT OF PEOPLE REFUSING FOOD IN IMMIGRATION REMOVAL CENTRES AND PRISONS

The Mental Capacity Act 2005 received Royal Assent on 7 April 2005. It aims to clarify a number of legal uncertainties and to reform and update the current law where decisions need to be made on behalf of others. The Act governs decision making on behalf of adults, it covers a wide range of decisions on personal welfare as well as financial matters and substitute decision making, such as made by clinicians involved in the management of people refusing food.

Key Principles of the Act

The starting point is a presumption of capacity. A person must be assumed to have capacity until it is proved otherwise.

Mental Capacity

For a Prisoner to have the requisite mental capacity to refuse medical treatment (including refusal of food and/or fluids), a doctor must be satisfied that the Prisoner is able to:

1. Comprehend and retain information about the treatment offered
2. Believe that information
3. weigh up the information, balancing risks against needs.

As a matter of practice in custodial settings or places of detention, such a test should be applied through consultation between healthcare staff and, if necessary a psychiatrist.

A person must also be supported to make his or her own decision, as far as it is practicable to do so. The Act requires “all practicable steps” to be taken to help the person. This could include, for example, making sure that the person is in an environment in which he or she is comfortable, or involving an expert in helping the person express their views. It is expressly provided that a person is not to be treated as lacking capacity to make a decision simply because he makes an unwise decision. This means that a person who has the necessary ability to make the decision has the right to make irrational or eccentric decisions that others may not judge to be in his best interests.

Advance Decisions to Refuse Treatment

Some people already choose to make such decisions and their legal effect has been analysed in a number of judicial decisions. It has been confirmed by the High Court that a competent adult Prisoner’s anticipatory refusal of consent remains binding and effective notwithstanding that he has subsequently become incompetent. Broadly, this clarifies the current common law rules, integrating them into the broader scheme of the Act. An “advance decision” is a special type of advance statement which represents an actual decision to refuse treatment, albeit at an earlier date.

The key characteristics of an advance decision for the purpose of the Act are as follows:

~~The decision must be valid, specific and applicable~~

It must be made by a person who is 18 or over and at a time when the person has capacity to make it. A qualifying advance decision must specify the treatment that is being refused, although this can be in lay terms (for example, using “tummy” instead of “stomach”). It may specify particular circumstances, again in lay terms, in which the refusal will apply. A person can change or completely withdraw the advance decision if he has capacity to do so. The withdrawal, including a partial withdrawal, of an advance decision does not need to be in writing and can be by any means, preferably witnessed.

An advance decision will not be applicable if the person actually has capacity to make the decision when the treatment concerned is proposed.

It will also not be applicable to treatments or in circumstances not specified in the decision

The decision will not be applicable if there are reasonable grounds for believing that the current circumstances were not anticipated by the person and, if they had been anticipated by him, would have affected his decision. For example, there may be new medications available that radically change the outlook for a particular condition and make treatment much less burdensome than was previously the case.

An advance decision will not apply to life-sustaining treatment unless a statement is made confirming that the decision applies to that life-sustaining treatment, even if life is at risk. The decision and the statement verifying it must be in writing, signed and the signature witnessed. It is important to note that a person does not physically need to write his advance decision himself. Advance decisions recorded in medical notes are considered to be in writing.

If the maker of the advance decision cannot sign then another person can sign for him at his direction and in his presence. As with a signature by the person himself, the witness must be present when the third party signs.

A treatment provider may safely treat unless satisfied that there is a valid and applicable qualifying advance refusal, and a treatment provider may safely withhold or withdraw treatment as long as he has reasonable grounds for believing that there is a valid and applicable qualifying advance decision.

If there is doubt or a dispute about the existence, validity or applicability of an advance decision, then the Court of Protection can determine the issue.