Investigation into the circumstances surrounding the death of a man whilst in the custody of HMP Gartree in May 2007

Report by the Prisons and Probation Ombudsman for England and Wales

March 2008

This is the report of an investigation into the death of a man who was a prisoner at HMP Gartree. The man who died from natural causes on 22 May 2007. He was 53 years old.

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.

I would like to add my personal condolences to those already expressed to the man's family on behalf of this office by one of my Family Liaison Officers.

This investigation was undertaken by one of my investigators. He and I would like to thank the Governor of HMP Gartree and her staff for their assistance. A doctor was asked by Leicestershire County and Rutland Primary Care Trust to undertake a review of the man's clinical care and I also much appreciate his help.

I have noted the issues highlighted by the clinical reviewer and endorse the recommendations made in the clinical review.

Stephen Shaw CBE
Prisons and Probation Ombudsman **March 2008**

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SUMMARY

The man was born in 1954. He was 53 years old when he died on 22 May 2007 at HMP Gartree. The man died from natural causes as a consequence of an acute myocardial infarction (a heart attack), caused by narrowing of the main coronary artery.

The man had been received into custody on 18 September 2001 after he had been placed on remand. On 12 April 2002, he was sentenced to life imprisonment at Preston Crown Court. The man was initially held at HMP Manchester and HMP Preston, before being transferred to Gartree on 25 September 2002**.**

The man had suffered from epilepsy, asthma and arthritis for some time. He was diagnosed with lymphoma (lymph node cancer) in November 2004.

Around 12:34pm on 22 May 2007, a prisoner on C wing heard a strange noise from the cell occupied by the man across the hallway. The prisoner rang his cell bell and explained what he had heard to a prison officer. The officer looked into the man's cell and saw him lying on the floor. The officer asked a colleague to request medical assistance from the healthcare centre. The officer then returned to the man's cell accompanied by two other colleagues. They unlocked the cell door and one of them checked for a pulse on the man but could not find one. Two Healthcare Officers arrived soon after. They too could not find evidence of a pulse and immediately commenced cardio-pulmonary resuscitation (CPR). When paramedics arrived at around 1:10pm, they took over the man's care. Resuscitation attempts were unsuccessful and death was pronounced at 1:20pm.

The clinical review concludes that the man's clinical care was appropriate and equivalent to that available in the community. I have endorsed the two recommendations in the clinical review.

THE INVESTIGATION PROCESS

1. The investigation was opened on 23 May 2007 when my investigator issued notices announcing the investigation to staff and to prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known to my investigator. My investigator also studied all relevant prison records relating to the man. These included his main prison record, medical records and statements made by staff.

2. The Leicestershire County and Rutland Primary Care Trust commissioned a General Practitioner (GP) Investigator/Reviewer to carry out a review of the man's clinical care. I am grateful to him for undertaking the review.

3. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the Post Mortem report. Upon completion, this report will be sent to the Coroner to assist him in his enquiries into the man's death.

4. One of my Family Liaison Officers contacted the man's family. This gave them the opportunity to discuss the purpose of the investigation and to raise any concerns or questions that they would like explored and addressed. The family had one concern relating to the man's treatment while in custody. The man had told his family that in December 2006 he had been knocked down some stairs by another prisoner. He had also allegedly suffered chest pains at the same time. The clinical reviewer and my investigator have explored these points and I hope that this report helps the family better understand the events leading up to the man's death.

5. My investigator visited Gartree on 3 July 2007 and discussed aspects of the man's treatment with staff and the clinical reviewer.

HMP GARTREE

6. Gartree is a category B prison whose principal function since 1997 has been to accommodate and rehabilitate adult male life sentence prisoners. The average tariff (minimum time to serve) for these prisoners is 15 years. Around 18 per cent of the population now consists of prisoners sentenced to indeterminate sentences for public protection. These prisoners typically have much shorter tariffs.

7. In common with the rest of the Prison Service, places on offending behaviour related courses, which lifers must necessarily complete in order to progress towards release on licence, are at a premium. It is not uncommon for prisoners to have to wait up to three years to gain a place on some courses.

8. Gartree is part way through a major refurbishment that will continue for the next two years. When complete, it will give Gartree a certified normal accommodation of some 680 prisoners and make it the biggest lifer centre in Europe.

9. Commissioning of healthcare within Gartree is the responsibility of the Leicestershire County and Rutland Primary Care Trust. The healthcare centre has 14 cells, provides 24 hour nursing care and has doctors from a local practice who visit daily. Only two cells in the healthcare centre are for in-patients as the remainder form part of the prison's Certified Normal Accommodation (CNA).

10. Medication is administered on a weekly and/or monthly basis to those prisoners who have been risk assessed as suitable for holding it in their own possession. It is administered on a daily basis to other prisoners, when either they are considered to be at risk or the medication is considered unsuitable to be held in their possession.

KEY EVENTS

11. The man arrived at Gartree on 25 September 2002, after being previously held at both Manchester and Preston. His medical history comprised epilepsy, asthma, arthritis in his knees and lymphoma (lymph node cancer). A range of medications was prescribed to the man to treat his various conditions and he was allowed to keep these in his possession for self administration.

12. On 11 October 2002, a prison doctor at Gartree made a referral to a Consultant Surgeon at a local hospital. The referral was made because the man had been experiencing pain in his groin which appeared to be getting worse.

13. In a letter dated 4 June 2003, the Consultant Surgeon confirmed that he had examined the man and had found a lump in his right groin. The Consultant Surgeon said that he wanted to know what had caused the lump as the man's blood tests were normal. The Consultant Surgeon confirmed that he had agreed to put the man on a waiting list for an exploratory operation on his groin. The man's condition continued to be reviewed by healthcare staff and they regularly checked with the hospital about the proposed operation. A date for the man's operation was received on 3 September 2004.

14. On 15 October 2004, the man was admitted to the local hospital. He had a gland removed from his right groin and this was sent to the laboratory to be tested and studied.

15. In a letter dated 29 November 2004, another Consultant Surgeon confirmed that tests had shown that the man had a follicular lymphoma. He said that this type of cancer usually responds well to chemotherapy and arrangements were then put in place for a course of treatment for the man.

16. In a letter dated 15 September 2005, a Consultant in Clinical Oncology confirmed that the man's cancer was now in remission.

17. During the evening on 14 December 2006, an officer was patrolling G wing at Gartree when he observed the man play fighting with another prisoner. The officer ordered the two prisoners to stop, but whilst he was giving the order the man fell over. The man was taken to the healthcare centre with a swollen right ankle and pain in his wrist and elbow. He was then taken to a local hospital by ambulance with suspected fractures to his wrist and ankle. It was later confirmed at the hospital that he had broken both his wrist and his ankle. The man returned to Gartree later the same day and he was relocated in the healthcare wing to recuperate.

18. On 30 March 2007, after his plaster was removed and he had completed his physiotherapy, the man was discharged from healthcare and was housed in a cell on C wing.

19. During the afternoon on 15 May 2007, the man attended healthcare and complained of having pains in his upper abdomen. An ambulance was called and the man was again taken to a local hospital. A diagnosis of gastritis (inflammation of the stomach) was made on the basis of his long term use of diclofenac (the medication used to treat his arthritis). Gastritis is a common side effect of the medicine. This diagnosis was made after a blood test and an electro-cardio-gram (ECG) both showed no evidence of an acute heart problem. The man returned to Gartree the following day.

20. On 20 May, when he was asked about his health the man said that he still had slight stomach pains but he was definitely feeling better.

21. During the morning on 22 May 2007, the man told a Senior Officer that he did not feel well. The Senior Officer told the man that he should see how he was later. If there were any more problems, he was to use his cell bell. When another officer was locking the prisoners up at lunchtime, at around 12:15pm, the man told him that he still did not feel well. The officer asked him if he had spoken to anyone about this during the morning. The man replied that he had spoken to the Senior Officer. The officer asked the man what he had been told by the Senior Officer and the man reported what they had agreed. The officer confirmed this information with the Senior Officer and he then left the wing.

22. Around 12.34pm, a prisoner in cell number 232 on C wing was sitting down doing some course work. As he got up and walked towards his kettle he heard a crash. The prisoner initially did not think anything of it but after a couple of minutes he looked through the gap of his cell door towards the man's cell (229) which was across the hallway. When interviewed for my investigation, the prisoner said the man wore prison clothing and the top was quite bright. He said that, when he looked over towards the man's cell, he could see him on the floor against his cell door and he could also hear him making a strange noise. The prisoner rang his cell bell to summon assistance from prison staff.

23. An officer responded almost immediately. She opened the observation flap in the cell door and asked what was wrong. After she had been told about what the prisoner had heard, she looked into the man's cell. She saw that the man was lying on the floor with his head wedged up against the cell door. The officer ran and asked her colleague to request medical assistance from the healthcare centre. Her colleague made a request via the prison communications room. The officer then returned to the man's cell and was accompanied by two other colleagues.

24. The officer unlocked the cell door and held the man's head to enable her colleague to push the door open. Once the door was opened sufficiently, her colleague stepped over the man's body and reached for a pillow. He gave the pillow to the officer who placed it underneath the man's head. The officers ensured that the man's airway was clear. One of the officers checked for a pulse but could not find one. The officer who was holding the man's head noticed a faint pulse emanating from the area around his temple.

25. When the Head of Operations for Gartree arrived at the man's cell he asked staff in the prison communications room to call an ambulance. He was accompanied by a Principal Officer and a Senior Officer. The Head of Operations relieved the officer who had found the man and, as she left the cell, two Healthcare Officers arrived. The Healthcare Officers could not find evidence of a pulse and immediately commenced cardio-pulmonary resuscitation (CPR). When the paramedics arrived at around 1:10pm, they took over the man's care. Resuscitation attempts were stopped at 1:20pm and death was pronounced by the paramedics.

26. When the prisoner who raised the alarm was unlocked after lunch he asked about the man. An officer told him that the man had passed away. The prisoner told my investigator that the prisoners on that spur of C wing were then allowed to go to their afternoon activities (work/education/gym). As the prisoners left the spur they were asked if they wanted to talk to someone from the chaplaincy or a Listener (a prisoner who has been trained by the Samaritans to give support to fellow prisoners) about what had happened. The spur was closed after the prisoners left so that no-one else could gain access.

27. Gartree made arrangements for staff from HMP Manchester to contact the man's family to inform them of his death. A Senior Officer was appointed as Gartree's family liaison officer. He contacted the family on the day after the man's death to offer condolences and support. The Senior Officer maintained contact with the family and assisted with the arrangements for the funeral. (The prison provided financial assistance with the cost of the funeral.) The man's popularity was demonstrated by a collection by prisoners on his wing that raised £138. This was used to buy a wreath, with the remainder being given to charity.

28. The post mortem report records the man's death as being due to natural causes, as a consequence of an acute myocardial infarction (a heart attack), caused by thrombotic occlusion and atheromatous stenosis (narrowing) of the right coronary artery.

CONCERNS RAISED BY THE MAN'S FAMILY

29. The man's family raised a concern relating to his treatment while in custody. The man had told his family that in December 2006 he had been knocked down some stairs by another prisoner. He also apparently suffered chest pains at the same time.

30. In response to the concern raised by the family, my investigator looked into the circumstances surrounding the incident when the man was injured. In his statement to my investigator, an officer confirmed that on 14 December he had observed the man play fighting with another prisoner and had ordered them to stop. Unfortunately, whilst the officer was giving the order, the man fell over. The man was later taken to hospital and treated for injuries to his wrist and ankle. The officer's statement mirrored the information in the man's main prison records and medical records that my investigator had studied.

31. The clinical reviewer did not feel that the fall contributed to the man's death and there was no evidence of heart problems when the man attended hospital after his accident.

32. After receipt of the draft report, the man's family raised the following additional concerns. The family felt that the man would have received a number of 'health-checks' prior to receiving chemotherapy, and questioned why any problems with his heart were not identified at this stage, particularly as there is a long history of heart problems within their family. The family questioned why the prison did not inform the family (in particular the man's sister) of his ill health. The family also said it was not easy to contact someone in prison and they felt there was a need for the prison to provide families with information when someone is in poor health.

33. A prison doctor stated that the man was having regular checks both by the hospital and the prison. As part of those checks, it was noted that he had mild hypertension. In September 2006 it was felt that, although his blood pressure was not very high, it would benefit from slightly better control and therefore the man was started on a mild blood pressure tablet. As part of the man's general monitoring, an electro-cardio-gram (ECG) was carried out which showed only the mild changes that do occur with slightly high blood pressure but no signs of ischaemic heart disease. The prison doctor confirmed that the man had never presented with any symptoms to suggest that he had angina or heart disease and therefore, any more invasive investigations would not have been appropriate.

34. In response to the additional issues raised by the family, the clinical reviewer said, “There are issues related to his (the man’s) care and the potential to mitigate against him having cardiac disease. In General Practice it has become common to look for and treat the risk factors for heart disease and this has become even more prominent since the introduction of the Quality and Outcomes Framework (QoF) which rewards practices for levels of screening and prevention work. The man would have been offered monitoring of his blood pressure, cholesterol levels and smoking in a more systematic way than his records suggest was the case in Gartree. He was noted to have high blood pressure and was put on tablets but had problems with side effects. It was decided to monitor his blood pressure after this but this was not done regularly or in a planned way. I can only find one record of a cholesterol level in his notes and that was raised at 7.8 which, combined with a high blood pressure and smoking would have put his risk of cardiovascular disease at more than 20% in the next ten years and a cholesterol lowering medication may have been appropriate. I could see no evidence that this had been suggested. Systematic recording of problems and risk factors will assist in the reduction of long term health problems in the same way that QoF has in wider general practice. The use of information technology is central to this and I was pleased to hear that this is now being put in place. This will also ensure that allergies are not overlooked.”

35. In relation to the issue of informing the family of the man’s poor health. Gartree has to make every effort to respect patient confidentiality. I appreciate that efforts should be made to ensure that relatives are made aware of serious health concerns. However, this is not always possible. It is not always the case that people want their loved ones to know about the state of their health. Healthcare staff need to respect patient confidentiality as well as the patient’s own wishes.

CLINICAL REVIEW

36. As noted, a review of the man's medical care was undertaken by a doctor on behalf of Leicestershire County and Rutland Primary Care Trust. The review found that the man had suffered from significant long-term chronic diseases.

37. From the medical records, it was clear that the man was seen regularly by healthcare staff and, when necessary, referred to secondary care services. The clinical review concludes that there are no circumstances indicating that the man's death could have been anticipated or prevented.

38. The clinical reviewer says that when the man collapsed he was in a situation that maximised his chances of survival. He had been heard to collapse and help was available rapidly. This would not necessarily be the case for anyone living in the wider community. Unfortunately, attempts to resuscitate the man were not successful despite the prompt attention.

39. The clinical reviewer draws attention to issues related to the man's care and the potential to mitigate against him having cardiac disease. The clinical reviewer says that in general practice it has become common to look for and treat the risk factors for heart disease. This has become even more prominent since the introduction of the Quality and Outcomes Framework (QoF) which rewards GP practices for levels of screening and prevention work. The man would have been offered monitoring of his blood pressure, cholesterol levels and smoking in a more systematic way than his records suggest was the case in Gartree.

40. The clinical reviewer says that healthcare staff had noted that the man had high blood pressure. He was put on tablets but had problems with side effects. It was then decided to monitor his blood pressure but this was not done regularly or in a planned way. The clinical reviewer could only find one record of a cholesterol level in the man's notes. This showed that it was raised at 7.8 which, combined with a high blood pressure and smoking, would have put him at risk of cardiovascular disease in the next ten years. This would also indicate that a cholesterol lowering medication might have been appropriate. The clinical reviewer could see no evidence that this had been suggested.

41. The clinical reviewer also draws attention to the man's epilepsy as another problem that was long standing and needed regular review. There is some evidence that reviews took place in that there are checks on the blood levels of his epilepsy medication (carbamazepine), but the clinical reviewer could not find a record of the presence or absence of seizures in the man's notes.

42. Another issue the clinical reviewer discovered in the records is that of the man having a possible allergy to penicillin. This is clearly recorded on the reception screening on 26 September 2002, although after this date the man was given penicillin based drugs on two occasions. There was no record of adverse events after these prescriptions. The clinical reviewer suggests this may be because the 'allergy' was not actually an allergy but a separate problem that at the time was thought to be an allergic reaction.

43. The clinical reviewer notes that there were two occasions when the man was unhappy with changes in his medication. The first was the stopping of amitriptyline (as a pain killer) within the prison. The man had been on this medication for pain and was unhappy to have it stopped. The clinical reviewer judges that it was appropriate to stop the drug in the prison generally, and in the man's case in particular. (Amitriptyline can be very toxic to the heart, particularly in overdose but also in those patients with heart disease.) The second change was the stopping of the codeine prescribed when the man attended outside hospital on 15 May 2006. The clinical reviewer says codeine is an effective painkiller, but it is also a drug of abuse and not appropriate within the prison setting for most situations.

44. The clinical reviewer concludes that there were several areas that might be opportunities for learning and change. The first relates to the recording of health information. A similar concern had already been expressed earlier in 2007 in a review of a death at the prison, and is being addressed by the Head of Healthcare at Gartree. The clinical reviewer concludes that systematic recording of problems and risk factors will assist in the reduction of long term health problems in the same way that Quality and Outcomes Framework has in wider general practice. The use of information technology is central to this. Both the clinical reviewer and I are pleased to hear that this is now being put in place. This will help to ensure that allergies are not overlooked in the future.

45. Although he recommends that policies are developed for chronic disease management, the clinical reviewer recognises that the move to an information technology based health record will make this a more practical proposition:

    An Information Technology (IT) based systematic chronic disease management procedure should be developed within the prison's health care system.

46. The clinical reviewer judges that the man would have benefited from a more individually tailored approach to taking up help to stop smoking. The clinical reviewer says he would like to see an attempt made to tailor this assistance:

    Assistance to help prisoners to stop smoking should be tailored to their individual needs.

47. In the clinical reviewer's opinion, the man's death was one that could not have been directly avoided. The man's lifestyle and particularly his smoking made him vulnerable to heart disease. The clinical reviewer judges that this could have been dealt with more thoroughly, although the man's reluctance to stop smoking would have reduced the effectiveness of any other interventions.

CONCLUSION

48. The man moved to Gartree in September 2002, and died there of natural causes in May 2007.

49. Given the generous collection following his death, and the comments made by staff and prisoners at Gartree, it appears the man was a respected and well liked prisoner.

50. In light of the findings of the clinical review, and my own investigation, I conclude that the man's medical care was satisfactory. I have endorsed the two recommendations from the clinical review. These need to be addressed by the Leicestershire County and Rutland Primary Care Trust in partnership with the Governor of Gartree.

RECOMMENDATIONS

Medical

1. **An Information Technology (IT) based systematic chronic disease management procedure should be developed within the prison's health care system.**

   Accepted locally – This is in progress and will be ultimately based on the Quality Outcomes Framework (QoF) and supported by the Primary Care Trust. At present we have patient management lists for chronic disease management.

2. **Assistance to help prisoners to stop smoking should be tailored to their individual needs.**

   Partially accepted – Pharmacy technicians provide this service at present. Prisoners are seen individually for assessment before group cessation work takes place. However, at present only NRT patches are available due to security and prescribing issues.