

**Investigation into the circumstances surrounding the  
death of a man at HMP Gartree  
In July 2009**

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

**January 2010**

This is the report of an investigation into the circumstances surrounding the death of a man, a prisoner at HMP Gartree. The man died on 6 July 2009. He was in his early forties. A post mortem showed that the cause of his death was a heart attack.

I offer my sincere sympathy and condolences to the man's family, as I do to all of his friends and acquaintances who are touched by his passing.

The investigation was carried out on behalf of the Ombudsman by my one of colleagues. Both he and I would like to thank the Governor of HMP Gartree and all the staff, in particular one of his governor's, for their full and ready co-operation during the course of our enquiries. I also thank the doctor for the clinical review he led on behalf of Leicestershire County and Rutland Primary Care Trust (PCT).

This report recognises that the clinical care and consideration given to the man by the staff at Gartree was equitable to that expected in the community. I make no recommendations, and I am pleased to recognise the professionalism of staff who responded the emergency response and the good efforts of the staff who liaised with the man's family.

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**Deputy Prisons and Probation Ombudsman**

**January 2010**

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## SUMMARY

When the man was remanded in prison on 29 October 2007, he was sent to HMP Leicester where a nurse conducted a First Reception Health Screen with him. He told the nurse that he had seen his doctor for alcoholism and depression. Confirmation of his medication was received from his general practitioner and the man agreed to participate in the substance misuse programme.

On 9 November, he saw a prison doctor as he had a swollen right leg. The doctor diagnosed deep vein thrombosis (DVT) (the formation of a blood clot in a deep vein) and prescribed medication

In the following 11 months, the man had 19 separate reviews of his medication with either the prison doctor or healthcare staff.

On 30 October 2008, the man appeared in court. He was sentenced to life imprisonment, to serve a minimum of 18 years. By 20 January 2009, the man had 11 further reviews of his medication.

The man transferred to HMP Gartree on 23 January, and a nurse carried out a full health review to confirm his medication, weight, height and blood pressure. He saw the doctor on 26 January who recorded that he had thrombosis in the right leg and high blood pressure, and requested blood tests to be taken.

Three days later a nurse saw the man to explain that the blood tests had to be repeated. The man was unhappy at this and signed a disclaimer refusing further treatment and all medication. The disclaimer was endorsed by the nurse to the effect that he had been made aware of the severe implications of his decision.

A week later the man saw a nurse from the Mental Health Inreach Team who confirmed that he was mentally capable of accessing healthcare services if he changed his mind and that there was no need for any Inreach Team intervention.

There were no concerns about the man's health until, at approximately 8.10am on 6 July, an officer unlocked his cell as usual. Attempts were made to wake him without success and it appeared that he was not breathing. A call was made for urgent medical assistance and an emergency ambulance. Healthcare staff started cardiopulmonary resuscitation (CPR) until the paramedics arrived at 8.35am. However, they judged that the man had died and his death was pronounced at 8.40am.

The man's mother was visited later that morning by a governor and family liaison officer from Gartree to inform her of his death. The governor arranged for her to visit the prison two days later to see his cell and talk to staff. The prison also offered financial assistance to meet the costs of the funeral expenses.

The clinical review highlights that the care he received at Gartree was equitable with that expected in the community. Whilst I make no formal recommendations, I do ask the Healthcare Managers at Leicester and Gartree to consider the findings of the

clinical review. I do recognise the areas of good practice in the emergency response and family liaison.

## THE INVESTIGATION PROCESS

1. The investigation was opened on 7 July 2009 when the investigator issued notices to staff and prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make them known. No one came forward as a result.
2. The investigator visited HMP Gartree on 24 July. During his visit he was given copies of all the documentation relating to the man, which included his main prison record and medical records. He also visited the houseblock to see the man's cell. The investigator returned on 25 August when he interviewed four members of staff.
3. Leicestershire County and Rutland Primary Care Trust appointed a doctor to carry out a review of the man's clinical care. The investigator and the clinical reviewer discussed aspects of the man's treatment and healthcare whilst he was at Gartree. I am grateful to the clinical reviewer for providing such a thorough and timely review.
4. The investigator contacted HM Coroner to inform him of the nature and scope of the investigation and to request a copy of the post mortem report. Upon completion, this report will be sent to the Coroner to assist in his enquiries into the man's death.
5. One of the family liaison officers (FLO) from the Ombudsman's office contacted the man's mother to inform her of the investigation. The FLO and investigator later met her and she raised the following concerns:
  - Why did the man have repeated blood tests and why were some tests lost?
  - In view of his mental health history, was the man in the right state of mind to make the decision to sign the medical treatment disclaimer?
  - When did the man stop taking his medication?
6. I have attempted to address the issues raised by the man's mother within the report and I hope that it provides her with a better understanding of the treatment he was given. His mother expressed her gratitude to the prison family liaison officer for her sympathetic and professional manner.

## **HMP GARTREE**

7. HMP Gartree opened in 1966, originally as a category C prison. Within a year, it was converted to a top security dispersal prison and maintained this function for approximately 25 years. In the early 1990s, Gartree was re-categorised to a B category training prison for adult male life sentenced, and now indeterminate sentenced, prisoners. Typically, it holds prisoners in the early stages of their sentence for up to five years and can hold 575 prisoners.
8. The prison's purpose is to help prisoners come to terms with their sentences, to assess their individual needs and to provide specific interventions, such as offending behaviour programmes, until such time that they can move through the prison system towards eventual release.
9. Gartree has four residential wings (A to D) with B wing being the induction unit. There is a therapeutic community unit, a healthcare unit and a supervision and assessment unit.
10. Her Majesty's Chief Inspector of Prisons carried out an unannounced inspection at Gartree in April 2008 as a follow up to a full inspection in August 2005. She noted that a healthcare recommendation made in 2005 had been achieved. The recommendation had said:

“The healthcare staff skill mix should be reviewed to ensure appropriately qualified and graded staff are available to meet the clinical needs of patients, particularly those with mental health problems.”

This had been achieved by:

“The skill mix had been reviewed in February 2007 and several changes had been made. Nursing staff were appropriately qualified with a good range of skills, including in mental health. There were two full-time on-site pharmacy technicians. GPs from a local practice ran morning surgeries every weekday. The healthcare team was almost at full strength and offered a comprehensive service to prisoners.”

11. In her summary of the unannounced inspection Her Majesty's Chief Inspector of Prisons commented:

“Of the 49 recommendations in this area, 15 had been achieved, 12 partially achieved and 22 not achieved. We have made 33 further recommendations. On the basis of this short follow-up inspection, we considered that the prison continued to perform reasonably well against this healthy prison test.”

## **Healthcare centre**

12. Gartree delivers both primary and secondary healthcare services, akin to a doctor's surgery and an inpatient facility. The healthcare centre is over 40 years old. The Independent Monitoring Board (IMB) commented in 2006/07 that refurbishment plans were currently under discussion at senior and area

management level. Despite appearances, the IMB report said that the healthcare centre delivered an “excellent service”.

13. When new prisoners arrive, they are seen by a member of the healthcare team in reception who assesses their needs. The healthcare centre employs a number of registered mental nurses, general nurses, one counsellor and a visiting psychiatrist who carries out, on average, one session every two weeks. The inpatient facility has 14 beds, one of which is reserved for prisoners at risk of suicide who require continual observation. It is fitted with closed circuit television.
14. The IMB commented that numerous prisoners located in the inpatient wing should be accommodated in more appropriate accommodation, such as secure hospitals, where the necessary treatment could be provided.
15. There have been 12 previous deaths at Gartree since 2004. There are no similarities between those deaths and the man.

## KEY FINDINGS

16. The man was born in July 1966 and lived in Leicestershire. He had a daughter but was divorced. He had a history of alcohol dependency, depression and was a smoker. He was remanded into custody at HMP Leicester on 29 October 2007.

### HMP Leicester

17. When he arrived at Leicester a nurse conducted a First Reception Health Screen. Health Screens are conducted to obtain a brief confidential medical and psychiatric history from the prisoner to ensure that he receives the appropriate medical treatment. The man told the nurse that he had seen his doctor before coming into prison for alcoholism and was prescribed medication of Fluoxetine (antidepressant medication), Chlordiazepoxide (for alcohol withdrawal syndrome) and Zopiclone (for insomnia).

18. The man told the nurse that, prior to coming into prison, he consumed a litre of whisky daily and suffered from alcohol induced fits. He also said that he smoked and did not intend stopping. He said that he had never used illicit drugs in the past. His blood pressure was taken and recorded as 159/116. (The normal range for blood pressure is 100/70 to 140/90, although the pressure does vary throughout the day depending on the individual's activities. A blood pressure reading of greater than 140/90 is classed as high and a reading of 90/60 or below is classed as low.) The nurse referred the man to the detoxification nurse as it was evident that he was withdrawing from alcohol.

19. The following day the man saw the specialist detoxification nurse. The nurse recorded that he suffered from tremors, shivers, insomnia and anxiety. His blood pressure was recorded as 141/98. He agreed to take part in the substance misuse programme and the nurse authorised the 30mg Chlordiazepoxide with a plan to reduce this amount over a 12 day period.

20. Later the same day, healthcare staff requested confirmation of the prescriptions from the man's general practitioner. The general practitioner responded on 1 November, confirming that the man was last issued Fluoxetine and Zopiclone on 10 October.

21. On 3 November the man saw the triage nurse in healthcare. He asked to see the doctor and did not want to discuss his concerns with the nurse. An appointment was made with the doctor on 9 November when the man saw a prison doctor. The doctor recorded that the man had a swollen right calf and ankle. He told the doctor that he had previously suffered from Deep Vein Thrombosis (DVT). The doctor recorded the man's blood pressure as 117/78 and prescribed Dalteparin (for DVT) and Naproxen (non-steroid anti-inflammatory for moderate to severe pain relief) and the use of support stockings.

22. The man next saw the triage nurse on 21 November when he asked for another appointment with the doctor. He was seen the following day by the doctor and blood samples were taken. The reason for taking the samples was to test for his international normalised ratio (INR) indicates whether the blood clots adequately.

The result was that the man had a low INR of 1.1. (A high INR level, such as five, indicates that there is a high chance of bleeding. An INR of 0.5 shows that there is a high chance of a blood clot. The normal range for a healthy person is 0.9 –1.3 and 2.0 – 3.0 for people who are prescribed Warfarin.). Due to his history of DVT, the doctor prescribed Warfarin of 8mg a day to prevent thrombosis.

23. Over the next 11 days the man saw the doctor on five separate occasions to review his INR. On 8 December the doctor decided that the man's prescription for Warfarin needed to be increased to 9mg. Due to his low mood he should stop taking Fluoxetine and take Mirtazapine (antidepressant) instead at a dose of 15mg per day.
24. Between 14 December 2007 and 7 May 2008 the man had ten separate reviews of his INR, eight of which were with the doctor. His medication remained the same although it was noted that his mood had not improved and so the dosage of Mirtazapine was increased to 30mg.
25. On 9 May, the man saw a nurse from the Mental Health In-reach Team. He told the nurse that he heard voices in his head which he was unable to describe. He said that he was taking his antidepressants and had no thoughts of harming himself.
26. The man next saw the doctor on 11 June. The doctor recorded that his INR was 1.9 and that the dose of Warfarin should remain at 9mg. The man had five more INR reviews with nursing staff up to 4 August. At this last review a nurse recorded that his blood pressure was 147/107 and advised that he needed to see the doctor. However he told the nurse that he did not want an appointment with the doctor.
27. The doctor did see the man on 9 September and reviewed his INR which was 2.3. The doctor advised continuing with 9mg of Warfarin. The doctor saw him again seven days later as he had been concerned about his blood pressure. The man had not been sleeping and felt stressed due to his forthcoming court appearance. The doctor prescribed Propranolol (beta blocker used to treat high blood pressure) and Promethazine (to treat insomnia).
28. Between 22 September and 21 October the man made 19 separate court appearances at Leicester Crown Court. On each occasion a nurse recorded that he was fit to attend court.
29. On 29 October, the man saw the doctor who reviewed his INR which was recorded as 1.4. The doctor increased the daily dose of Warfarin to 10mg to be reviewed in seven days. The man appeared in court on 30 October where he was convicted and sentenced to life imprisonment, to serve a minimum of 18 years. Six days later the doctor saw him and reduced the dose of Warfarin to 9mg.

30. The man had three more reviews of his INR with nursing staff before he saw the doctor again on 10 December. The doctor recorded that his INR level was 2.4 and that a daily dose of 8mg Warfarin would be appropriate.
31. On 2 January 2009, the man saw a nurse who recorded his INR level as 5.7 and noted that a doctor should review the dose of Warfarin. Two days later he saw another nurse who recorded that he wished to see a doctor because he was concerned over "being overloaded with body fluids". (No appointments were made with the doctor after either of the consultations with the nurse.)
32. A nurse saw the man on 9 January and recorded his INR level as 1.6 and again requested a review by a doctor. Four days later he saw a nurse who recorded the INR level as 1.9 and made a further request for a review by a doctor as the last time he had seen one was on 10 December 2008.
33. On 19 January, the man was seen in healthcare by a nurse because he felt generally unwell. The nurse recorded that he was to be referred to the blood clinic and an appointment was made for him to see the doctor three days later.
34. The following day a nurse saw him and recorded his INR level as 4.2 and also noted that he was to be transferred to HMP Gartree. The nurse also recorded that the doctor needed to prescribe sufficient Warfarin to allow Gartree healthcare time to assess and continue his treatment. (There is no record that a doctor saw the man, as arranged on 22 January.)

### **HMP Gartree**

35. On 23 January, the man transferred to Gartree where he was seen by a nurse who did a full health review to confirm his medication, weight and height. The nurse offered smoking cessation advice as he smoked 40 cigarettes a day, but he said that he would not give up. His blood pressure was recorded as 174/117. The same nurse saw him the next day to check his blood pressure which was 160/94 and that he was to see the doctor in two days time.
36. The man saw a doctor on 26 January. The doctor recorded that he had thrombosis in the right leg and had high blood pressure since he arrived at Gartree. He told the doctor that he smoked and confirmed that he would not give up. The doctor recorded that he was short of breath on exertion, had an occasional chest wheeze and a swollen right ankle. The doctor prescribed Glucosamine (for arthritis) and requested full blood tests. The doctor noted that the aim was to achieve a stable INR and monitor his blood pressure over the next two weeks.
37. The blood samples were taken the following day by a nurse and the results were reviewed and recorded by a doctor. In relation to the INR it was recorded that the incorrect sample bottle had been used which meant that the test had not been completed. The test results also showed that the man had a high potassium level of 5.7. (The normal serum level of potassium is 3.5 to 5 but a higher level can indicate potential risks such as fatal abnormal heart rhythms or kidney disease.)

38. On 29 January, the man saw a nurse who explained the reason and the need to repeat the INR tests. The man was unhappy that problems had arisen and told the nurse that he would decline any further procedures or medication. The nurse made him aware of the serious implications of his decision and he signed a disclaimer refusing further treatment and medication. The disclaimer was countersigned by a nurse confirming that he had been made aware of the implications.
39. Seven days later the man saw a nurse from the Mental Health Inreach Team. The nurse recorded that he was a physically and mentally capable individual. He told the nurse that he did not want to see healthcare as he had no faith in them due to the numerous blood tests. The nurse's assessment was that he was mentally capable of accessing healthcare services if he felt he needed to and that there was no need for Mental Health Inreach Team intervention. This was the last contact the man had with medical staff.
40. In the six months that followed, prison records show that the man continued with prison life and there were no concerns or incidents recorded by wing staff. From the 29 January he did not take any medication, nor did he have any prescribed.

### **Events of 6 July**

41. At approximately 8.10am an officer unlocked the man's cell as usual. On looking through the observation flap the officer saw him lying in his bed apparently asleep. The officer called out the man's name and said good morning but received no response. He called several more times but still got no response and went into the cell. The officer said that he gently shook the man at the same time as calling his name in an attempt to wake him but still got no response. The officer visually looked for signs of movement and saw that his chest was not rising and falling.
42. The officer called to a Senior Officer (SO), who was just outside the man's cell, and said that he did not think the man was breathing. The SO entered the cell and checked for a pulse but did not find one. He immediately made a Code Blue call (emergency response call for a prisoner found not breathing) over the radio network.
43. At approximately 8.20am a Healthcare Senior Officer (HCSO) and a Healthcare Officer (HCO) were in the healthcare centre when they responded to the Code Blue call. (Healthcare Officer is a title given to prison service staff who are qualified nurses who work for the healthcare centre). The HCSO collected the emergency resuscitation bag out of the cupboard on the wing and arrived at the man's cell at approximately 8.23am. Having visited Gartree the investigator was able to confirm that at quick walking pace it takes up to five minutes to get from healthcare to H wing. It would not be unreasonable for someone running to take two to three minutes to cover the same distance.
44. On arriving at the man's side the HCSO checked his vital signs but found no pulse or sign of breathing. An emergency ambulance was requested at 8.24am. The HCSO, assisted by the HCO, commenced cardio pulmonary resuscitation (CPR) and a doctor arrived with the defibrillator. No output was identified by the

defibrillator and so the HCSO and HCO continued CPR until the paramedics arrived.

45. The paramedics arrived at the prison at 8.32am and were at the man's side at 8.35am to take over CPR. They assessed that he had died and the doctor confirmed his death at 8.40am.
46. A Governor held a debrief for all staff at 9.05am to go through the events of the emergency response and offer support to those staff affected by the man's death.
47. At 11.00am that morning a Governor and the prison family liaison officer visited the man's mother to inform her of his death. The prison also offered financial assistance towards the cost of funeral expenses. Arrangements were also made for his mother to visit the prison on 8 July to allow her to see his cell and speak to staff. She was given flowers on behalf of the Governor and staff.

## ISSUES

### Clinical care

48. The clinical review undertaken by the doctor considered the care that the man received whilst at Leicester and at Gartree. The review concluded that his death could not have been avoided as his lifestyle, particularly his smoking, made him vulnerable to heart disease. The review specifically stated "Many people have a fatal heart attack as the first evidence of their heart disease and die unexpectedly and unseen by others".

49. The clinical review considered the care that the man received whilst at Leicester and made the following comments:

"He was noted to have high blood pressure on several occasions and tried on medication briefly but this was not followed up systematically with a review of all his risk factors such as his smoking or cholesterol levels."

"I also note he continued to be on Warfarin for a deep vein thrombosis for more than the usual six months but no reason for this is included in the notes I have seen. There may be good reasons for this such as it being a recurring problem for him or him having a problem with his blood clotting that made him more susceptible to blood clots."

"He was also prescribed an anti-depressant called Mirtazapine which can enhance the Warfarin. Regular blood tests meant that this was relatively safe as he was on a stable dose of the Mirtazapine."

50. In considering the care the man received at Gartree, the clinical review found it to be equitable to what would be expected in the community. The review also considered the effect of his refusal of treatment from 29 January 2009 onwards, and stated:

"The man's signing of the disclaimer refusing further treatment could, therefore, have had a bearing on his death. There may have been other interventions that would have prolonged his life but for how long it is impossible to say and he would have had to have more blood tests which he clearly did not feel happy with and so may not have complied with."

"Continuing Warfarin may have reduced his risk as it prevents clots building up and part of the process leading to a heart attack is a clot in one of the arteries supplying the heart"

"The man's choice not to continue medication was correctly assessed and it is clear he had a right, and was allowed to exercise that right, to decline treatment given sufficient information to make an informed decision."

51. The clinical review highlights that, now that the Prison Service uses computerised clinical records, consideration could be given to use integrated dosage testing software. This would have to be evaluated to establish if it would be cost

effective to introduce. Whilst I make no formal recommendation I do draw this to the attention of the Primary Care Trust.

### **Emergency response**

52. An officer raised the alarm and CPR was started and a defibrillator was being used within three minutes. The staff continued CPR as directed by the defibrillator, until the paramedics arrived and took over the attempt to resuscitate him.

53. I believe that the staff who responded to the man's need for emergency assistance acted with speed and professionalism. This is an example of good practice

### **Family liaison**

54. Gartree appropriately followed the guidance given in PSO 2710, "Follow up to death in custody". The man's mother told my Family Liaison Officer that she was very impressed with the after care service offered by the prison and I recognise the good practice of an officer as family liaison officer.

## **CONCLUSION**

55. During his time at Leicester the man did have well document regular interventions with doctors and other healthcare staff. Despite these, however, there were some examples of omissions in arranging doctor appointments.

56. I am satisfied that the care that the man received at Gartree was equitable to that expected in the community. He had a responsibility for his own health and could have accepted medical attention but insisted he exercised his right to refuse treatment for the last six months of his life. The clinical review confirms that continual medical treatment might well have prolonged his life.