

**Investigation into the circumstances surrounding the
death of a man in July 2010,
at an outside hospital whilst in the custody of HMP Gartree**

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

January 2011

This is the report of an investigation into the death of a man, a prisoner at HMP Gartree. The man died in July 2010 at an outside hospital, having been found collapsed in his cell the previous day. He was 52 years old. The cause of his death was an acute upper gastro intestinal bleed due to chronic liver disease, with a secondary condition of end stage renal failure. I offer my sincere sympathy and condolences to the man's family and to all who have been affected by his loss.

The investigation was carried out by one of my colleagues. A review of the man's medical care in prison was carried out by a clinical reviewer on behalf of Leicestershire County and Rutland Primary Care Trust. I am most grateful to the clinical reviewer for his assistance.

I would also like to thank the Governor and staff of Gartree for their full and ready co-operation during the course of the investigation. My particular thanks go to the head of safer custody and residence for her work in liaising with the investigator.

This man was diagnosed with kidney disease prior to coming into prison. Throughout his time in prison, he rarely followed his suggested medical treatment plan. His reasons varied, but the most common was that he had a long sentence and did not want to be "messed about". Nevertheless, my investigation found that he received a high quality of care at Gartree. The clinical reviewer describes the work that went into assessing the man's capacity to refuse treatment as an example of good practice.

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
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SUMMARY

The man had a notable medical history prior to his arrival at HMP Leeds on 22 April 2004. Although his consultant described him as having significant kidney disease, he had recently stopped going to his outpatient appointments. He agreed to be re-referred after being imprisoned, but rarely took his prescribed medication throughout his time in custody.

Following his transfer to HMP Gartree in November 2005, the man was referred to a local kidney specialist. However, after consistently refusing to take his medication or agree to blood tests for a year and a half, the specialist removed him from his consulting list. Over the next two years, he missed several appointments with prison doctors and rarely collected his medication.

The man consented to blood tests in April 2009, the results of which showed a very severe deterioration in his kidney function. He agreed to see the specialist at an outside hospital again, although he did not take his medication any more regularly than before. The man's kidney function continued to deteriorate to the extent that, by June 2010, he required dialysis (the artificial replacement of kidney function) three times a week. He went to two sessions at an outside hospital before declining all future appointments.

The most common reason he gave for not co-operating with his treatment programme was that he had a long sentence and did not therefore want to be troubled with appointments and medicines and the like. As a consequence of his refusal and occasionally inconsistent decisions, the man's capacity to decide for himself was assessed. This process involved interviews with a number of professionals both internal and external to Gartree. Although there were differing opinions, the majority view was that the man had the mental capacity to make an informed decision about his treatment. The clinical reviewer commends the assessment of the man's capacity as good practice.

The man was found collapsed in his cell on a morning in July 2010. An ambulance was called and he was admitted to an outside hospital. His condition did not improve and he was pronounced dead at 1.46am the following morning. The investigation found that the man received a high quality of care at Gartree. I make no recommendations.

THE INVESTIGATION PROCESS

1. The investigation was opened on 9 July 2010 when the investigator issued notices announcing the investigation to staff and prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known to the investigator. No one came forward as a result.
2. My investigator and one of the Ombudsman's family liaison officers visited Gartree on 14 July. They met the Governor, head of healthcare and the prison's family liaison officer. They also visited the healthcare centre and the wing on which the man lived. They were provided with copies of the man's prison records, including the medical record.
3. A review of the man's medical care in custody was carried out by a clinical reviewer on behalf of Leicestershire County and Rutland Primary Care Trust. The clinical reviewer and the investigator visited Gartree on 27 August and interviewed three members of staff.
4. My family liaison officer wrote to the man's next of kin, his two brothers, on 23 July. She explained the purpose of the investigation and provided the opportunity for them to ask questions or raise any concerns they might have. Both of the man's brothers later telephoned my family liaison officer and said they felt the prison did all they could to care for him. Nevertheless, I hope this report clarifies any issues that might remain unclear for the man's family and helps them better understand what happened in the time leading to his death.

HMP GARTREE

5. HMP Gartree is located outside Market Harborough in Leicestershire. With a capacity of 689, it is the largest of three dedicated prisons in England and Wales for indeterminate sentenced prisoners. The prison consists of six residential units, each of which is generic with no specific function. All the accommodation in the residential units is in single cells.
6. Health services at Gartree are delivered by Leicestershire County and Rutland Primary Care Trust. Prison doctors are contracted from a local practice and provide eight surgery sessions a week. An inpatients unit, which held up to 14 prisoners, closed in June 2010. All the prisoners who previously lived on the unit, including this man, moved to a standard residential unit. Despite the closure of the inpatient unit, nursing staff continued to provide 24 hour on site cover.
7. Her Majesty's Chief Inspector of Prisons (HMCIP) last inspected Gartree in May 2010. The inspection found that Gartree had improved considerably since the last full inspection. Primary care health services were described as satisfactory, with a very good service of prison doctors and good chronic disease management. They also commented that care for the prisoners who had moved out of healthcare prior to its impending closure was working well.
8. The Independent Monitoring Board (IMB, a body of local people who independently monitor and report on the prison) report for 2009 described the healthcare team as "very able". However, they also noted concern that death in custody action plans were not being followed through.
9. This is the sixth death that the Ombudsman has investigated at Gartree since January 2009. There has subsequently been one further death at the establishment. Four of the previous deaths were due to natural causes. In the main, the circumstances are not the same as happened to this man but one of the previous reports commended the exceptional care provided to a challenging prisoner by both prison and healthcare staff.

KEY EVENTS

10. Prior to his imprisonment, the man had been diagnosed with polycystic kidney disease (the development of fluid filled cysts in the kidneys) and was described by his consultant as having significant kidney disease. He had also reported some back and abdominal pain. Shortly after his arrival at Leeds on 22 April 2004, the prison doctor wrote to the man's consultant for further information on his medical history. His consultant replied that the man had recently refused to see both him and his colleague, but enclosed a report prepared for the man's solicitor regarding his medical history. This described the man's likely future needs as follows:

“One must be guarded about renal [kidney] prognosis. He is likely to progress in terms of renal impairment with a strong possibility that at some point in the next few years he will require kidney dialysis. Our principal weapon in slowing down progression would be aggressive control of blood pressure. At the present level of kidney function one would not expect any particular implications to his general health in terms of energy, physical capacity etc and he does not need particular dietary restrictions.”

11. Following his imprisonment, the man agreed to be re-referred to a consultant nephrologist (kidney specialist). He subsequently went to a review at an outside hospital on 19 November. The consultant made some changes to the man's medication, increasing his dose of lisinopril (medication to lower blood pressure). The man told the consultant that he had been diagnosed with cancer at another hospital. The consultant therefore wrote to Leeds to request further information regarding this diagnosis. A prison doctor replied a week later and confirmed that there was no evidence to suggest that the man was suffering from cancer.
12. A consultant forensic psychiatrist interviewed the man in January 2005 in order to prepare a report prior to sentencing. During the interview, the man repeated his claim that he had cancer and said he was terminally ill. The consultant forensic psychiatrist noted that there was no evidence to support this. The doctor noted that the man was generally unco-operative during the interview and concluded that a previous diagnosis of an antisocial personality disorder was reasonable. (An antisocial personality disorder is a persistent disregard for, and violation of, the rights of others.)
13. The man was subsequently sentenced to life imprisonment on 11 February, with a tariff (the minimum time that must be served) of 34 months. He next attended the nephrology clinic on 19 May, at which his kidney impairment was described as “fairly stable”. No changes were made to the man's treatment.
14. On 9 November, the man transferred to HMP Gartree. At a health screen following his arrival at the prison, the man repeated his claim that he had stomach cancer. It was noted that this was not the case. Within a week of his transfer, a prison doctor referred him to the nephrology department

- at an outside hospital. He also referred the man to a gastroenterologist (stomach specialist) on account of his claim to have stomach cancer.
15. The man subsequently attended a clinic with a consultant nephrologist at an outside hospital on 18 January 2006. The consultant nephrologist noted that the man was not currently taking any blood pressure medication and asked that he be prescribed lisinopril. (It is not clear from the notes when and why the man stopped taking this medication.) The man repeated his claim that he had recently been diagnosed with stomach cancer and given three to six months to live.
 16. The following month, the man returned to outside hospital to see a gastroenterologist. He described suffering from “off and on” abdominal pain for over two years. Upon examination, the consultant felt a “firm mass” in the man’s abdomen. He suspected this was an enlarged kidney but requested further tests to exclude any other cause. An ultrasound examination was subsequently booked for 21 March. However the man did not attend this appointment, for reasons which are not clear from the notes.
 17. An appointment for a gastroscopy (examination of the stomach) was made for 19 April. However, the procedure was cancelled as the man had not fasted beforehand, as he had been instructed to do. The procedure was subsequently rebooked for 17 May. The results showed the presence of a lesion in the man’s stomach.
 18. The man next visited the department of gastroenterology on 11 January 2007. The results of a biopsy of the lesion were discussed and he was told that it did not confirm a diagnosis. The consultant therefore requested that a CT scan of the man’s abdomen be arranged, in order to determine what the abnormality was. This scan went ahead on 20 February, and showed a compression in the man’s stomach which was most likely caused by cysts in his liver. (It was therefore clear at this stage that the man did not have cancer of the stomach.)
 19. At a clinic with the consultant nephrologist on 13 June, the man reportedly became very aggressive and said he had not been given his blood pressure medication by the prison. The consultant nephrologist telephoned Gartree on 25 June to discuss the matter further. He spoke to a prison doctor who said that the man’s medication had been prescribed “many times” but he never collected it. The prison doctor added that the man had also refused to have his blood pressure taken or blood taken for tests on many occasions. Three days later, the consultant nephrologist wrote to Gartree and said that, as the man did not cooperate, his attendance at clinics was “pointless” and his care should be left to Gartree’s healthcare department.
 20. Through the remainder of 2007 and the whole of 2008, the man had little contact with prison healthcare. He declined to attend an outpatient appointment on 3 August 2007 and, in July 2008, it was noted that he had

not collected his medication for “a long time”. He did not attend an appointment booked with a prison doctor to discuss this further.

21. On 2 April 2009, the man saw a prison doctor and asked to be passed unfit for work. He said this was because he had kidney disease and it occasionally hurt when he passed urine. The prison doctor described the man as “bright and chatty” and noted that he looked well and did not appear to be in pain. He also noted that he was still not taking his medication. The prison doctor observed that the man was “probably fit for a number of jobs” at the prison and persuaded him to have a blood test. (The man did not have a prison job at the time and did not take one through the remainder of his time at Gartree.)
22. The blood test was taken the following day, and the results showed a “very severe deterioration in renal function”. The results were reviewed by a prison doctor who requested that an appointment be made for the man to see a doctor. (Each day one of the prison doctors reviews the results of all prisoners’ blood tests taken that day and makes an entry in the electronic medical record recommending the appropriate course of action.) However, the man did not see a doctor for some weeks. Later entries indicated that he declined to see a doctor, although this was not recorded at the time. The prison doctor repeated his request on 30 April and, on 2 July, a nurse manager noted that the man needed to be reviewed by a doctor due to “lots of ongoing issues”. An appointment was made for 3 July, but again he did not attend.
23. However, the man did agree to have his blood tests repeated on 3 July. The results showed a further deterioration in his renal function. An appointment was made with a prison doctor for 7 July, with a view to encouraging him to agree to return to the renal clinic. However, the man again failed to attend the appointment.
24. Two days later the man did attend healthcare and was reviewed by a prison doctor. During the review, the doctor explained the consequences of the man’s deteriorating renal function and persuaded him to agree to be re-referred to the consultant nephrologist. An appointment was made for 2 September.
25. The man duly attended the clinic at an outside hospital. In his follow up letter, the consultant nephrologist commented that the man had relatively few symptoms despite the rapid deterioration of his renal function. His diagnosis was that the man now had advanced chronic kidney disease and was likely to need dialysis in the upcoming weeks or months. (Dialysis is the artificial replacement of kidney function for people with renal failure. This is usually by haemodialysis, when a patient is connected to a machine in hospital for around four or five hours at a time. Blood is drawn from the body, usually from the forearm, and ‘cleaned’ by the dialysis machine, before being returned to the body through a second access point in the forearm. An access point can also be made in the chest instead of the forearm.)

26. The results of a blood test taken on 18 September showed a high level of potassium in the man's blood. (High potassium levels can be caused by unhealthy kidneys and can cause the heart to beat irregularly.) After seeking advice from the hospital, the man was taken to the Accident and Emergency department for further investigation. He was discharged the following day, having been treated with insulin dextrose until his potassium levels fell to the normal range.
27. Three weeks later, the man was admitted to hospital overnight for the creation of arteriovenous fistula. (An AV fistula is the surgical process by which an artery and vein in the forearm are directly connected, allowing the vein to grow larger and stronger. As a result, repeated needle insertion for haemodialysis treatment is easier. The fistula can take some weeks or months to develop following surgery.) He returned to prison the following day. The man's medication was now listed as amlodipine (for high blood pressure) and calcium resonium (to lower blood potassium by drawing the potassium out of the blood). A week later, however, it was noted that he was not taking the amlodipine.
28. The following week, the man spent seven days in the segregation unit following an adjudication hearing (a prison disciplinary hearing held to consider a contravention of prison rules). Whilst there, he was given his medication every day by a nurse. (He had previously held it 'in possession', meaning that he was given a week or several weeks medication at a time to store in his cell and take as prescribed. He usually did not collect his medication.) This arrangement resulted in him taking his medication consistently and led to an improvement in his blood pressure. However, after leaving the segregation unit, he immediately stopped taking his medication. Staff considered asking him to collect his medication on a daily basis, but felt he was very unlikely to do so. They therefore reverted to giving the man his medication 'in possession' again.
29. The man returned to the renal clinic on 18 November for a review. The follow up letter indicated that he would need regular dialysis "very soon". On 26 November a prison doctor saw the man as he was still refusing to take any medication. The man had told a nurse the previous day that he did not take his medication because it "wasn't doing him any good". The prison doctor explained at length the implications of not taking medication, and persuaded the man to consider restarting them. He noted his opinion that the man had the mental capacity to refuse medication and understood the likely consequences.
30. The following day, the man again refused his medication. Later that day he had a mental health assessment. The man said he was fully aware of the risks involved in refusing his medication. The member of staff who was doing the mental health assessment concluded that the man was indeed fully aware of the potential consequences but remained adamant that he would refuse any intervention offered.

31. On 16 December, a formal psychiatric assessment was undertaken by a doctor at an outside medium secure unit. The doctor said he was unable to come to a definitive diagnosis but thought that the man might have some cognitive impairment (meaning some difficulty with memory). However, the doctor added that it was for those professionals treating the man to determine his competence to accept or refuse the treatment offered.
32. Five days later, the man saw a prison doctor for a review. She noted that the man was now taking his medication, with the exception of calcium resonium. She explained the potential consequences of high potassium levels if he did not take this medication, which she noted as “possible arrhythmia/death”. (Arrhythmia is an irregular heartbeat.) Despite her warning, the man was adamant that he did not want to take calcium resonium. He did, however, agree to increase the dose of amlodipine as his blood pressure was higher.
33. The man moved to a cell on the healthcare inpatients’ unit on 22 December. This followed a period in which his personal hygiene had deteriorated, despite encouragement from staff to take greater care of himself. In the previous few months he had received a number of warnings regarding his sometimes abusive or inappropriate behaviour and the cleanliness of his cell. Shortly after his arrival in healthcare, the man was reported as making inappropriate remarks towards staff.
34. Whilst an inpatient in healthcare, the man’s blood pressure was checked every day. The readings fluctuated a little, although he continued to take his blood pressure medication. On 19 January 2010, he refused to go to a scheduled appointment at the nephrology clinic. The reason for the man’s refusal is not recorded.
35. On 1 February, the man was prescribed a course of doxazosin, an additional medication to control his blood pressure. This followed a discussion between a prison doctor and staff at the renal unit at outside hospital. The man moved to the segregation unit on 18 February after an adjudication hearing regarding his behaviour on 22 December 2009. He returned to the healthcare centre three days later, but lived under cellular confinement conditions for the remainder of his three week punishment.
36. The man agreed to attend his next scheduled appointment with the consultant nephrologist on 2 March. The consultant nephrologist described the man as “more settled than when I have seen him before”. However, he went on to say that the man “remains close to the point of needing dialysis”.
37. During a long conversation with a nurse on 10 March, the man admitted to feeling “frustrated” at times due to worries about his health. They discussed the man’s recent behaviour. He described himself as sometimes “over zealous” and “inappropriate”, but described this as part of his character. He also admitted to trying to manipulate some staff,

which he said was “making mischief” rather than trying to cause trouble. The man added that his abdomen was swollen of late which was causing him pain. The nurse made him an appointment with a prison doctor.

38. The following day, the man saw a prison doctor regarding his abdomen. He told the doctor that his abdomen had gradually become more swollen over a few months. The doctor examined the man and noted that his liver was very enlarged. He asked for blood tests to be taken and, when the results were available that evening, suggested that the next day’s duty doctor discuss the results with the hospital. The following day, a further prison doctor telephoned the on-call specialist, who advised that the man should be observed by healthcare staff and could be seen in outpatients as usual.
39. On 12 March, the consultant nephrologist telephoned Gartree and suggested that the man should start dialysis on 17 March. However, this plan was discontinued on 15 March when he was taken to an outside hospital in an emergency after developing a blood clot in his fistula. He returned to Gartree the same day, having seen the consultant nephrologist. It was determined that the man’s fistula could not be used and he would have to be admitted on a later date for a new fistula to be formed on his other arm. He could not therefore start dialysis as scheduled.
40. The following day, the man told a prison doctor that he did not want the new fistula and he was aware of the potential outcome if his kidney condition was not treated. The day afterwards, the man reiterated his decision in conversation with a nurse. He said he did not want the new fistula because he was “too old to be messed around with” and “wouldn’t be bothered if he died tomorrow”.
41. The same day, the man was assessed by a consultant forensic psychiatrist and a doctor from an outside medium secure unit. The man was described as chatty and jokey during the consultation, but he also made comments described as inappropriate to the doctor from the outside medium secure unit. The consultant forensic psychiatrist noted concern about the man’s capacity to make decisions about his treatment. His assessment showed that the man might not have the ability to retain the information necessary to make a decision.
42. The man again reported continuing pain in his abdomen on 22 March. He was examined by a prison doctor on 23 March, who noted that his abdomen was swollen and he had an enlarged and tender liver. The prison doctor made an urgent referral for an abdominal scan to investigate the cause. He also prescribed a course of lansoprazole (to treat conditions caused by too much acid in the stomach) as a trial.
43. Three days later, the man was assessed for a second time by the consultant forensic psychiatrist. After an initial discussion, the man became abusive when the consultant forensic psychiatrist raised the issue

of his mental capacity to refuse treatment. The assessment did not continue. Following the assessment, the consultant forensic psychiatrist again expressed reservations about the man's capacity to refuse treatment. He recommended that the implications should be discussed further with the consultant nephrologist and that the man might need an independent mental capacity advocate (a person appointed to support and represent someone who lacks capacity to make decisions about their treatment and who is faced with decisions about serious or long term care plans). The consultant forensic psychiatrist also recommended that they should identify the man's catchment area medium secure unit with a view to arranging a transfer. Three days later, the consultant forensic psychiatrist contacted Gartree to confirm that he had arranged for representatives of a medium secure unit to visit and assess the man.

44. On 30 March, the man was prescribed tramadol for his abdominal pain. The following day, he was visited by the consultant forensic psychiatrist but refused to be seen. He later told a mental health nurse that he was determined not to allow another fistula to be formed as they "made a mess of the last one". The man again said he was aware of the consequences of this and that he was "prepared to die in prison".
45. The head of healthcare at Gartree telephoned the Treasury Solicitors (legal advisors to government departments) on 1 April for advice regarding the man's comments. She was advised to contact a local solicitor to facilitate the creation of an advance directive setting out what treatment the man was willing to accept. (An advance directive is an instruction given by someone to set out what actions should be taken regarding their health in the event that they are no longer able to make decisions due to illness or incapacity.)
46. A week later, the man was visited by two doctors from an outside medium secure unit. The man was cooperative throughout the assessment. The following day, a local solicitor visited the man to discuss the advance directive further. Although the man was unwilling to sign the document, the solicitor told the head of healthcare at Gartree that it was his opinion that the man understood what was being discussed and asked of him.
47. The same day, the head of healthcare at Gartree telephoned the consultant nephrologist to update him on the developments. The consultant nephrologist replied in writing later that day. His view, he wrote, was that the man's capacity was essentially irrelevant as it was not "practical or feasible or indeed in his best interests to forcibly restrain him ... and transfer him three times a week for haemodialysis". The consultant nephrologist also wrote that he had made a referral to an advocacy agency.
48. An appointment for the ultrasound requested by one of the prison doctors was made for 13 April. However, on the day of the appointment, the man refused to go with the appointed escort staff. (Prisoners who attend outside hospital appointments are accompanied by two prison officers for

security reasons.) Due to the importance of the scan, the escort staff were changed. However, the man also refused to go with the new escort. A nurse noted that he had a long discussion with the man about the importance of the scan. His opinion was that the man understood why he should go to the hospital.

49. The following day, the man reiterated his desire not to have an ultrasound scan. He said this was because he did not think he was getting “the right treatment” from hospital. At a mental health review later that afternoon, the man said he “had a long sentence with nothing to look forward to so why should he bother [with treatment]”.
50. An independent mental capacity advocate visited the man on 20 April. In her report, written the following day, she outlined the principles of the Mental Capacity Act 2005 (legislation designed to protect people who cannot make decisions for themselves) and how they might apply to this man. As the man said during the assessment that he would like to discuss his treatment further with someone from the hospital, she recommended that this should be facilitated if at all possible. An appointment with the consultant nephrologist was subsequently arranged for 7 May.
51. Following a consultation at an outside hospital on 23 April, the man agreed to have a new fistula formed. Two days later he told a nurse that he was looking forward to having the procedure done, and was described as being in good spirits. However, on 28 April, the man said he was now unsure as to whether he wanted to go ahead with the new fistula.
52. The report by the doctor from the outside medium secure unit was completed on 28 April. He concluded that, although the man showed signs of some difficulty with memory, he had the capacity to consent or otherwise to any medical procedures. However, on account of the deficits in the man’s memory, his capacity to consent to procedures should be re-assessed when they were to take place. The doctor also thought the man showed signs of early dementia. He did not think that he should be admitted to a special hospital.
53. The man refused to attend his rearranged ultrasound appointment on 30 April, despite healthcare staff trying to persuade him otherwise. Four days later, a quantity of the man’s blood pressure medication was found in his cell. It was apparent that he was not taking his medication as prescribed. On 5 May, the man moved from healthcare to a cell on A wing, in advance of the forthcoming closure of the healthcare inpatient facility. A nurse explained how he should access healthcare services from the wing.
54. The consultant nephrologist visited the man at Gartree on 7 May. The man reiterated his desire not to have dialysis, and said that he understood the consequences of his decision. The consultant nephrologist told the head of healthcare at Gartree, who was present during the meeting, that it was his view that the man had the capacity to make this decision. The

man also said that he did not wish to be resuscitated were he to become seriously unwell. It was agreed that the head of healthcare at Gartree would consult the Treasury Solicitors for advice. Finally, it was agreed that the man would be given his medication in a daily pack to encourage him to take it as prescribed. Three days later, the consultant nephrologist wrote a follow up letter to confirm the agreed arrangements. He also reiterated his opinion that it was neither practical nor in the man's best interests to bring him for dialysis three times a week against his will.

55. On 11 May, the man went to an outside hospital and underwent a procedure to create a fistula in his left arm. The same day, the head of healthcare at Gartree spoke to the Treasury Solicitors for a second time, regarding the man's wish not to be resuscitated. They again advised the head of healthcare to contact the local solicitor, which she did. The local solicitor advised that a meeting involving the man, the solicitor and healthcare professionals should be arranged to determine how to proceed.
56. Two days later, a prison doctor discussed resuscitation with the man. The man said he did not wish to be resuscitated if he were to collapse. The prison doctor explained that staff could not act on this unless he signed the relevant directive, to which the man said that he would give it some thought.
57. On 19 May, it was noted that the man was again not taking his medication, saying that it made him feel ill. He was reminded of the importance of taking his medication by a nurse and he subsequently agreed to take his blood pressure drugs and pain relief. The following day, the man declined to attend an appointment made with a prison doctor to discuss his medication. He said this was because he could not be bothered to wait. On the same day a care plan was written to set out what action staff should take to help the man in areas such as eating and drinking, personal care and monitoring and maintaining his health.
58. An appointment with a prison doctor was arranged for 25 May, as the man had complained about his abdominal pain to a prison nurse the previous day. He did not attend the appointment. The following day, a conference was held involving the man, the head of healthcare at Gartree, a senior officer (a manager on A wing) and the man's personal officer. (Each prisoner is assigned a personal officer on their wing, whom they can approach first with any problems or queries.) The purpose of the meeting was to discuss the man's management on the wing, as the senior officer and the man's personal officer had raised concerns about his ability to cope on A wing.
59. At interview with the investigator, the senior officer clarified their concerns:

"It seemed obvious that [the man] needed more care than [we] could provide on the wing. [The man] did not need help with cell cleaning, showering etc but needed help to motivate himself. He was

cantankerous and dismissive of staff and couldn't be bothered to clean up after himself. Staff tried to raise this with [the man] and encourage him to take more care of himself and his environment, but he would not listen to their concerns."

60. During the meeting, the man said he was happy on the wing but felt he needed help with his personal hygiene and cell cleaning. It was agreed that the man would carry out light cleaning duties on the wing in return for an additional £2.00 pay per week. The senior officer told the investigator that the aim was to encourage the man to come out of his cell more and therefore develop better relationships with staff and prisoners. A 'compact' was written to this extent, which also covered the man's responsibility to keep his own cell clean and tidy and attend to his personal hygiene. The head of healthcare at Gartree also reiterated that healthcare staff would visit the man every day, as set out in his care plan, and he could raise any concerns with them.
61. During a visit to the man on 1 June, a nurse noted that his cell was "very unclean", and she encouraged him to clean it out. She also noted that he tended to take his medication if staff were present and encouraged him. The nurse made an entry in the electronic medical record, in capitals, to ask staff to encourage the man to take his medication in their presence to aid his compliance. However, two days later, the man refused all medication except his pain relief, despite encouragement from a nurse. For the remainder of the month, he continued to take his medication intermittently.
62. On 22 June, the man attended a review with the consultant nephrologist. He told the doctor that he now wished to have dialysis if the alternative was that he would die. In his follow up letter, the consultant nephrologist expressed doubt that the man would be willing to attend for dialysis regularly, but thought they were obliged to try. The first appointment for dialysis was made for 23 June.
63. The man duly attended his first dialysis session on 23 June, and the second session two days later. However, these were the only two appointments he agreed to attend. The next session was scheduled for 29 June, but, despite staff attempts to persuade him otherwise, the man said that he did not want to go. He also refused all of his medication on 29 June and said he no longer wanted to take any.
64. The consultant forensic psychiatrist visited the man the following day for an assessment. During the course of the interview, the man struggled with his short term memory. The consultant forensic psychiatrist also spoke to wing staff afterwards. They described the man as "impossible to deal with" on account of his poor personal hygiene and inappropriate behaviour to female staff.
65. On 1 July, the man again refused to attend his scheduled dialysis session. He told a prison doctor, who visited the man in his cell, that he "did not

- want to be messed about by anyone at the hospital or at Gartree". The prison doctor asked the man whether he was aware of the consequences should he refuse dialysis. The man replied that he was not afraid to die.
66. The prison doctor discussed the man's refusal over the telephone with the consultant nephrologists who wrote to Gartree in follow up the following day. In his letter, which was copied to the head of healthcare at Gartree, the consultant nephrologist discussed the man's prognosis and possible release from prison:
- "I do think that careful consideration should be given to his continued incarceration. It is very likely now that his prognosis is measured in days or weeks ... I think it is quite clear that his prognosis is so poor that at the very least consideration should be given to releasing him on compassionate grounds. His prognosis will certainly be much worse than many patients with many terminal malignancies."
67. The man continued to refuse most of his medication during the course of the week. On 6 July, he was asked if he had reconsidered dialysis, to which the man replied that he "wasn't interested". The following day he was visited on the wing by a nurse, who described him as "alert and oriented". The man again declined all of his medication.
68. On a morning in July, a nurse visited the man on A wing. The man declined his medication but was described by the nurse in the medical record as "alert and cheerful". The nurse took the man's blood pressure which, at 160/102, was high but within the man's usual range, and his pulse, which was normal.
69. At around 11.40am, the man was found collapsed in his cell by a prison chaplain. He had last been seen around 20 minutes earlier by an officer who saw him sitting on his bed. The prison chaplain ran to the wing office and asked one of the officers to make a 'code blue' call for assistance. (Code blue is an emergency call to indicate to staff that a prisoner is collapsed or not breathing.) An ambulance was also called. The nurse who had before encouraged the man to clean out his cell responded to the emergency call, along with a further two nurses. On their arrival they found the man breathing but not responding. He was given oxygen until the paramedics arrived at around 12.00 noon. The ambulance left for an outside hospital at around 12.30pm.
70. Two officers escorted the man in hospital and restraints were not used. The man did not improve and, at around 4.30pm, the duty governor telephoned the man's brother to inform him of his brother's condition. The man's brother and sister-in-law visited later that evening and left the hospital at around 9.00pm. His condition continued to deteriorate and he died at 1.46am that night. The cause of death was later recorded as an acute upper gastro intestinal bleed due to chronic liver disease, with a secondary condition of end stage renal failure.

71. Shortly after the man died, his brother was telephoned by a member of hospital staff, who passed on the news. (It had been agreed during the man's brother's visit earlier that evening that hospital staff would telephone were anything significant to happen.) The man's funeral was arranged by Gartree's family liaison officer. The investigation found that the prison's contribution to the funeral costs was in accordance with PSO 2710 (the Prison Service Order that sets out the actions to be taken following a death in custody).

ISSUES

Refusal of treatment

72. Prior to his imprisonment in April 2004, the man stopped attending appointments with his renal consultant. He agreed to be re-referred following his imprisonment, but did not take his prescribed medication for the majority of his time in prison. He also regularly refused to have his blood pressure taken or have blood taken for tests. On account of poor compliance, the man was removed from his consultant's clinic list in 2007. He continued to miss local appointments with prison doctors.
73. After a significant deterioration in his renal function, the man began to see the consultant nephrologist again in 2009. By then he had advanced kidney disease and it was expected that he would have to start dialysis very soon. As a result, a fistula was surgically created in October 2009. However, when this failed around five months later, the man was reluctant to have another and initially refused the procedure. He eventually agreed and, after much persuasion, began dialysis. However, the man only went to two dialysis sessions before declining any further treatment.
74. During his time in prison, the man gave a variety of reasons for not complying with his treatment plan. He often said he did not take his medication because, he felt, it "wasn't doing him any good". With regard to his fistula and the dialysis process, the man told staff that he was "too old to be messed about" and "didn't want to be messed about". On similar lines, he refused an ultrasound scan because he had a "long sentence with nothing to look forward to, so why bother".
75. The head of healthcare described the man as follows:
- "He was an eccentric personality, very likeable, very chatty ... he was also quite stubborn. [He] had very fixed ideas about what he would and wouldn't do, hence his input was great one day, not so good the next ... He didn't disengage with us completely, it was just over certain aspects of his treatment that he didn't want to engage with."
76. The head of healthcare went on to explain at interview that the man indicated that he felt he would never get out of prison and did not therefore want to go through with a lengthy treatment programme.
77. As well as his refusal of treatment, the man sometimes presented with peculiar or eccentric behaviour. Prior to sentencing he was diagnosed with an antisocial personality disorder. In his first years in prison, he told several healthcare professionals that he had stomach cancer and sometimes added that he had just a short time to live. There was no basis to this claim and it is not clear why he repeated it. His behaviour towards female staff was often described as "inappropriate" and he was occasionally aggressive towards staff. His personal hygiene was poor and he was usually happy to live in a dirty and untidy cell.

78. It is apparent from the medical notes and from interviews with staff that a great deal of time and effort was put into encouraging the man to comply with his treatment. Different collection regimes were tried to persuade him to take his medication regularly and, whilst he went through some periods in which his compliance improved, no method was successful in the long term.
79. The clinical reviewer agrees that healthcare staff made “considerable and on-going efforts to enlist [the man’s] co-operation in his medical care”. He provides examples of good practice, including the joint work between Gartree and an outside hospital that led to the consultant nephrologist visiting the man in prison to discuss his management plan. The clinical reviewer also highlights the team work between prison healthcare staff and other professionals in the establishment as good practice.
80. The clinical reviewer commends Gartree for their “ability to deliver a complex medical management plan”. He concludes that the man received a “high quality of care” from healthcare staff at Gartree. I agree with his conclusions.

The man’s capacity to refuse treatment

81. As a consequence of his general refusal of treatment and inconsistency in decision making, the man’s mental capacity to make decisions regarding his treatment had to be assessed. This process began in December 2009 with the visit of a consultant psychiatrist from an outside medium secure unit. The consultant psychiatrist thought that the man might have some difficulty with memory, but advised that a decision regarding his capacity should be made by the professionals responsible for the man’s treatment.
82. The first view that the man might not have capacity to determine his treatment was put forward by a consultant forensic psychiatrist in March 2010. His view was based on the man’s poor memory which, he thought, meant the man could not fully retain the necessary information to make a decision about his treatment.
83. The man was subsequently visited by other specialists, including consultant psychiatrists from a medium secure unit in his home area. Their view was that the man did have the capacity to consent or otherwise to medical procedures. This view was shared by the consultant nephrologist and numerous prison staff, including those interviewed during the course of the investigation. The consultant nephrologist also put forward the view that the man’s capacity was, essentially, irrelevant since it could not be argued that it was in his best interests for him to be forcibly taken to hospital for lengthy dialysis sessions three times a week.
84. The man was also visited by an independent mental capacity advocate, who gave advice on how the Mental Capacity Act 2005 applied to him. (The clinical reviewer outlines the principles of the Act in the clinical

review. There are five key principles, the first of which is that “Every adult has the right to make his or her own decisions, and should be assumed capable of doing so unless it is proven otherwise.”) In addition, a local solicitor twice visited the man with a view to setting up an advance directive to determine what future treatment he was prepared to accept. However, the man did not fully commit to this process and did not reach the stage where he was ready to sign the form.

85. The clinical reviewer notes in the clinical review:

“[The man’s] end of life care was planned, documented and followed, within the constraints of his agreed level of involvement ... When [the man] expressed his views on his medical management plan his views were heard, were questioned as was appropriate, but ultimately were followed, as was his right.”

86. The clinical reviewer adds that Gartree followed the recommended procedure to establish the mental capacity of a patient. He commends as good practice the assessment of the man’s mental capacity. I agree with the reviewer and also note that the prison and hospital made extensive attempts to secure the man’s agreement, but to no avail.

Social care

87. In autumn 2009, the man’s personal hygiene began to deteriorate. This was a significant contributory factor in his admission to healthcare in December 2009. During his time as an inpatient in healthcare, staff spoke to the man on a number of occasions about his personal hygiene and the cleanliness of his cell. It is apparent that it was the man’s choice to neglect these matters. On one occasion, for example, he told a member of staff that he did not clean his cell “to discourage others going in”.

88. Ahead of the closure of the inpatients’ unit, the man moved to a cell on A wing on 5 May 2010. His personal hygiene did not improve, and a meeting was subsequently arranged for 26 May to discuss his management. Prior to this meeting, the care plan written on 20 May addressed the man’s hygiene. The agreed outcome of the meeting was that the man would be paid an extra £2.00 per week to carry out light cleaning duties.

89. At interview with the investigator, the senior officer explained why the man would not take care of his personal hygiene:

“[The man] did not need help with cell cleaning, showering etc but needed help to motivate himself. He was cantankerous and dismissive of staff and couldn’t be bothered to clean up after himself. Staff tried to raise this with [the man] and encourage him to take more care of himself and his environment, but he would not listen to their concerns.”

90. The head of healthcare spoke along similar lines:

“It’s not that he couldn’t [take care of himself], he wouldn’t do it. He needed a lot of encouragement to do basic stuff ... he’d lived that way all his life.

“We were visiting him daily, twice daily some days, and encouraging him to take care of himself but the fact that he wasn’t taking care of himself wasn’t indicative of his illness, it’s just the way I’m afraid he always lived ... He wasn’t one who had great issues with his personal appearance.”

91. The senior officer told the investigator that the man would do his extra cleaning if he asked him to. However, he would often refuse if another member of staff asked him. He added that staff would take clean sheets or a mop and bucket to the man’s cell to encourage him to clean, but he was often rude to them and would refuse to do it.
92. The man was on the standard level of the prison’s incentives and earned privileges scheme. (IEP is a three tier system designed as an incentive to reward good behaviour in prison. Incentives include access to in-cell television, more private cash to spend and more time out of cell.) Consideration was given to downgrading the man to the basic level. However, the senior officer explained that this would likely have had a negative effect on the man and would not have achieved anything. He thought that removing the man’s television would “just have made him worse”.
93. Some prisons operate a ‘buddy’ system, whereby prisoners who are ill or have mobility problems are assigned a fellow prisoner to help them with tasks such as collecting meals and cell cleaning. Gartree does not have such a scheme. Whilst such a system is undoubtedly helpful in some circumstances, I think it would have been unlikely to be appropriate for this man. It would be unfair to ask another prisoner to keep the man’s cell clean simply because he would not do so himself.
94. It is apparent to me that both healthcare and wing staff at Gartree put great effort into encouraging and persuading the man to take care of his personal hygiene and surroundings. No solution was found to work anything more than intermittently. I am satisfied that nothing further could have been done to induce the man to improve his personal hygiene.

Assessment, Care in Custody and Teamwork (ACCT) procedures

95. Assessment, Care in Custody and Teamwork (ACCT) is the process used for monitoring and supporting prisoners assessed as at risk of suicide or self-harm. The man spoke about death, in relation to his treatment, on a number of occasions in the last months of his life. For instance, in March 2010 he said he was “too old to be messed around with” and “wouldn’t be bothered if [I] died tomorrow”. Later the same month, the man refused a second fistula and, when asked if he was aware of the consequences,

said he was “prepared to die in prison”. The following month, the man refused a scan and said he “had a long sentence with nothing to look forward to so why bother [with treatment]”.

96. On numerous other occasions, when staff were trying to encourage the man to accept treatment, he said he was aware of the potential consequences of refusal. I have earlier discussed the man’s capacity to refuse treatment, and highlighted the majority view that he had such capacity.
97. The head of healthcare explained at interview why the ACCT procedures had not been initiated in this man’s case:
- “When he said ‘I’d rather be dead’ [this was] all related to the treatment, it wasn’t a question of self-harming or committing suicide ... It was about [he said] ‘what’s the point, I might as well be dead, I don’t want to go through all this, it’s not worth it because at the end of the day I’m not going to be able to have any benefit from it’ ... But there was never any question in my mind even as he became more frail that he would do anything to himself. He had no history of it.”
98. The benefits of opening ACCT procedures in such circumstances are that it might allow for better continuity of care and encourage a multi-disciplinary approach to support. However, I have already described the care and support that the man received, which came from a variety of sources both inside and outside the prison. My conclusion is that no more could have been done to help him and I am satisfied that the use of ACCT was not necessary in this man’s case. Indeed, using ACCT for these purposes, would detract from the overall aim of the system.

Early release on compassionate grounds

99. The possibility of the man being released early on compassionate grounds was first raised by the consultant nephrologist in early July 2010. He wrote as follows:
- “It is very likely now that his prognosis is measured in days or weeks ... I think it is quite clear that his prognosis is so poor that at the very least consideration should be given to releasing him on compassionate grounds. His prognosis will certainly be much worse than many patients with terminal malignancies.”

100. The criteria for early compassionate release on medical grounds for life sentenced prisoners are set out in Prison Service Order (PSO) 4700:

- the prisoner is suffering from a terminal illness and death is likely to occur very shortly (although there are no set time limits, three months may be considered an appropriate period for an application), or the prisoner is bedridden or similarly incapacitated, for example, those paralysed or suffering from a severe stroke; and
- the risk of re-offending (particularly of a violent or sexual nature) is minimal; and
- further imprisonment would reduce the prisoner's life expectancy; and
- there are adequate arrangements for the prisoner's care and treatment outside prison; and
- early release will bring some significant benefit to the prisoner or his/her family.

101. It is questionable whether adequate arrangements could have been made for the man's care outside of prison and also whether he would have gained significant benefit had he been released. However, PSO 4700 in any case goes on to give the following mandatory instruction:

"Examples of cases not meeting the criteria are where conditions are self-induced, for example: following a hunger strike or where a prisoner refuses treatment."

102. It is therefore clear that the man did not meet the criteria for early release on compassionate grounds. In many ways I consider that prison was the safest place for a man of his character and I am not convinced that he would have fared better had he been released.

CONCLUSION

103. Throughout his time in prison, the man was generally consistent in his view that he did not want to participate in his treatment programme. He rarely took his medication and, although he agreed to have a fistula created, it took some persuasion to encourage him to start dialysis. The man only attended two dialysis sessions before deciding that he did not want to participate any further. He said that he did not want to “mess about” with going to hospital three times a week for lengthy dialysis sessions.
104. Staff at Gartree put considerable effort to solicit the man’s co-operation in his medical care. The clinical reviewer commends their ability to deliver a complex medical plan, and highlights as good practice the assessment of the man’s capacity to refuse treatment.

GOOD PRACTICE

1. A number of outside specialists and advocates contributed to the assessment of the man's mental capacity, in line with recommended procedures.