

**Circumstances surrounding the death of a man at
Hospital, on 8 October 2007 whilst a prisoner at HMP
Chelmsford**

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

July 2008

This is a report into the death of a man at Hospital on 8 October 2007. The man, who was 74 years old, was a prisoner at HMP Chelmsford. He died from natural causes, having been admitted to hospital ten weeks before his death.

The man had no registered next of kin and I was therefore unable to contact a family member to inform them of my investigation.

The man had been recalled to prison in June 2004, having been released on life licence. When he arrived at HMP Chelmsford in November that year, he was identified as suffering from ischaemic heart disease. He had previously undergone cardiac surgery, including a valve replacement. His health deteriorated during his time in custody, and he was further diagnosed with cancer. The Coroner has confirmed that the cause of his death was bronchopneumonia and cancer.

This investigation has been undertaken by one of my investigators. I would like to thank the Governor of Chelmsford, and his staff for their co-operation and active participation.

Mid Essex Primary Care Trust conducted a review of the care the man received whilst in prison. Unfortunately, due to staffing problems within the PCT, there were significant delays in completing this review. Nevertheless, I would like to thank the clinical reviewer for her contribution to the investigation.

As is the case in many of my investigations following a death from natural causes, I am greatly influenced by the findings of the clinical review. In this case it appears that the man received exemplary care from both clinical and discipline staff at HMP Chelmsford. Given that the prison has not had the happiest recent history, I might mention that this is not the first investigation I have carried out at Chelmsford where a high level of medical and nursing care has been highlighted.

The clinical report makes three recommendations and highlights two areas of good practice that will be shared with the Mid Essex Primary Care Trust. Of those recommendations, one relates to the impending introduction of a computerised records system for healthcare. The computerisation of medical records across the prison estate is much to be anticipated and welcomed.

My own investigation includes one recommendation (relating to when a prisoner's next of kin should be informed of emergencies). I also highlight three areas of good practice.

Stephen Shaw CBE
Prisons and Probation Ombudsman
July 2008

CONTENTS

Summary	4
The investigation process	6
HMP Chelmsford	7
Key findings	9
Issues	16
Recommendations and good practice	20

SUMMARY

The man was received at HMP Chelmsford on 29 November 2004, having been recalled to prison for breach of his life licence. He arrived at Chelmsford with a long standing illness - ischaemic heart disease (a disease of the blood vessels supplying the heart muscles with oxygen which is severe enough to cause temporary strain on the heart, or even permanent damage to the muscle). He had previously undergone cardiac surgery, including a valve replacement.

A month after arriving at Chelmsford, the man started to experience ill health, and pains in his prostate gland. He was transferred to the local hospital in Chelmsford and, after a number of consultations, was diagnosed as having urethritis (inflammation of the tube that conducts urine from the bladder to the exterior) in April 2005.

The man's condition worsened and he experienced continual abdominal and prostate pain. As a result of his ailments, he had ample contact with prison healthcare staff and was referred to hospital on numerous occasions for treatment. As his condition deteriorated, he was given a catheter (a thin, sterile tube inserted into the bladder to drain urine) by the hospital to try and relieve some of the pain he was experiencing. Despite this procedure the man continued to experience episodes of abdominal pain and urinary infections. This resulted in his frequent admissions into hospital care.

In a bid to resolve the man's complaint, he was added to the hospital operation waiting list to receive green light laser prostatectomy surgery (treatment delivered using a high powered laser to destroy surplus prostate tissue which is blocking the bladder).

Unfortunately, during this period, the man contracted bleeding piles (piles, also known as haemorrhoids, are swellings on the inside of the anal canal) and again had to be referred to the hospital for treatment. In June 2006, the man underwent his prostatectomy. Approximately three weeks later, he once more started to experience pain and urinary problems.

Over the next year, the man's ill health continued. The hospital carried out further tests and procedures to ascertain the underlying cause of his urinary and haemorrhoids problems. He was cared for by nurse specialists at the hospital, and they and the prison healthcare team made attempts to make the man more comfortable and reduce the pain he experienced.

In June 2007, the man was again admitted to hospital for treatment of his haemorrhoids. He also suffered from anaemia (a deficiency of red blood cells), and had to have a blood transfusion. He remained in hospital, where a number of further tests were carried out daily to identify the cause of his bleeding, abdominal pain and anaemia.

The man was discharged from hospital on 5 July 2007. Prison healthcare were informed that, if he had any recurrence of bleeding piles, they should

contact the hospital surgeon. Two weeks later, the man was admitted again for this very reason.

The man had only been out of hospital for about a week, when he was readmitted on 28 July. He had complained of feeling dizzy, was pale in colour and had a swelling on his left scrotum. The hospital urology nurse specialist arranged for the man to have an ultrasound and clinic appointment.

Following receipt of daily progress reports from the bed watch prison officers, the prison conducted a risk assessment. It was confirmed that the man now posed no security risk due to his ill health and his restraints were subsequently removed. He was also reduced to a single prison officer escort.

The man continued to undergo a number of tests in hospital. He was diagnosed with ischaemia of the bowel (cancer), and received appropriate surgery for this condition. Consideration was given by the prison to whether, should the man's condition improve, they could arrange his transfer to HMP Norwich (which has a unit for older lifer prisoners located on the ground floor of its healthcare centre). Unfortunately, he continued to deteriorate and remained weak and incoherent most of the time.

By September 2007, the man's cancer had started to spread and he was later moved to a private side room on the hospital ward. Hospital staff informed the prison that the man's prognosis was very poor and he now needed constant care. They were trying to locate a hospice or community hospital bed. The deputy governor said that consideration would be given to whether the man could be released early on compassionate grounds.

Unfortunately, within a short time the man started to experience periods of rapid, intermittent and then shallow breathing. Sadly, on the morning of 8 October 2007, the man stopped breathing. He was examined by the doctor and his death was certified at 8.00am.

THE INVESTIGATION PROCESS

1. My investigator considered the man's prison documentation, including his clinical records, before formally opening the investigation on 22 January 2008.
2. Prior to my investigator arriving at Chelmsford, notices were issued to staff and prisoners announcing the investigation and inviting anyone who had information relevant to the man's death to make themselves known to the investigator. No one came forward. My investigator interviewed one member of staff.
3. Whilst in prison the man had no listed next of kin. He did however have a friend, a former prisoner, who continued to visit him up until his death.
4. My investigator contacted Her Majesty's 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 with his enquiries.
5. Mid-Essex Primary Care Trust (PCT) conducted a review of the clinical care the man received whilst in custody. It is attached to this report as an annex. The review was slightly delayed but I thank the clinical reviewer for her detailed contribution.

HMP CHELMSFORD

6. HMP Chelmsford is a category B local prison that serves the courts of Essex and surrounding areas. It predominantly holds sentenced and unsentenced adult male prisoners, but almost a third of the population is made up of young offenders aged between 18 and 21. The accommodation is split between the original Victorian wings and newly built residential units. Like most local prisons there are constant population pressures, and the jail is one of the most overcrowded prisons in England and Wales.
7. HM Chief Inspector of Prisons, Ms Anne Owers, inspected Chelmsford in a full, announced inspection in July 2007. Ms Owers found a prison suffering a range of difficulties. The population was very fluid, with prisoners staying a relatively short time and with insufficient activity to occupy them. Staff turnover was high and shortages were a constant feature.

Healthcare

8. Healthcare at Chelmsford is provided in a spacious, modern and well-equipped two-storey building completed in 2004. There is an inpatient unit with 12 large individual cells, fitted with safe furniture except for two cells that have hospital-type beds. Two cells are fitted with CCTV. The building has full disabled access, including a lift and toilet, with accessible bath and shower facilities in the inpatient unit. Treatment rooms are also on E, F and G wings. G wing was where the man was located.
9. Patients with long-term conditions can be referred to the gymnasium for specific exercise programmes. The man had been a regular gym attendee until his health deteriorated.
10. Primary care staff include both nurses and doctors. Paper-based clinical records are used in all departments. A healthcare administrator manages prisoner outpatient appointments in conjunction with healthcare staff using a traffic light prioritising system.

Personal officer scheme

11. All prisoners at Chelmsford are assigned a personal officer. Their role is to meet the prisoner on a regular basis and to discuss any issues or concerns the prisoner may have.

Bed watch

12. If a prisoner is admitted to outside hospital, they will generally be escorted by two officers who will stay beside their bed at all times. Two or three daily shifts of officers will stay with the prisoner until treatment is completed. However, depending on the circumstances, the bed watch

may be withdrawn if the prisoner is terminally ill or nearing the end of a sentence. The number of staff may also be increased or decreased if the risk assessment warrants it.

13. The prisoner may be handcuffed whilst in bed. This is usually done by means of a closing chain, which allows the prisoner to be attached to a member of staff. The chain must not be attached to a bed.

Compassionate release on medical grounds

14. Chapter 12 of Prison Service Order 6000 sets out the following criteria for compassionate release on medical grounds:
 - The prisoner is suffering from a terminal illness and death is likely to occur soon; or the prisoner is bedridden or similarly incapacitated
 - The risk of re-offending is past
 - There are adequate arrangements for the prisoner's care and treatment outside prison
 - Early release will bring some significant benefit to the prisoner or his/her family.

KEY FINDINGS

Prior to arriving at HMP Chelmsford

15. On 26 May 1960, the man was convicted of manslaughter and sentenced to six years imprisonment. He was released five years later, but was convicted of murder and armed robbery on 11 March 1966. He was sentenced to life imprisonment.
16. The man started his life sentence at HMP Wandsworth and continued to serve his sentence at no fewer than 17 prison establishments. During this time, the man had nine Parole Board reviews. He was eventually released on life licence on 26 November 1999, after spending 33 years in continuous custody.
17. On 24 June 2004, the man was stopped in his car by the police and a firearm was found in his possession. He was arrested and charged with possession of the weapon. He was held in police custody and appeared at Basildon Magistrates' Court on 26 June. His life licence was revoked and he was recalled to prison, arriving at HMP Belmarsh later that day. Given his long experience of prison life, he settled into the regime without any concerns.

The man's arrival at HMP Chelmsford

18. On 29 November 2004, the man was sentenced to seven years imprisonment for the firearms offence and transferred to HMP Chelmsford. When he arrived he went through the normal prison reception process. It was recognised that he suffered from ischaemic heart disease and had previously undergone cardiac surgery, including a valve replacement. His condition was now stable with medication and he was referred to the prison doctor for a review of his medication needs. No other concerns were raised.
19. A little over a week later, on 9 December 2004, the man was experiencing pain caused by his prostate gland (an organ that is located at the base or outlet of the bladder). He was seen by the prison doctor and later rushed to the local hospital. Following a number of consultations, in April 2005 the man was diagnosed by a consultant at the hospital as having urethritis (inflammation of the tube that conducts urine from the bladder to the exterior).
20. Over the next 12 months, the man attended the hospital on a number of occasions. He had experienced several bouts of pain whilst on the prison wing. A principal officer told my investigators that the man did not really wish to be admitted into the healthcare unit, and received the majority of his treatment on the wing. Aware that he had healthcare complaints, staff tended to him and liaised with the healthcare staff as appropriate. They visited the man in his cell on a regular basis. The man also attended the GP clinics in the prison. The healthcare team

liaised with the hospital to ensure he was receiving the right treatment and kept them abreast of changes to his condition.

21. In a bid to try and resolve the pain he had been experiencing, the man attended hospital on a number of occasions to try the use of a catheter (a thin, sterile tube inserted into the bladder to drain urine). But following this procedure he continued to experience episodes of abdominal pain and urinary infections, and was treated with antibiotics accordingly. Prison healthcare staff maintained their communication with the hospital and, as and when necessary, the man was returned to hospital for treatment.
22. One of the problems that arose was that the man's catheter became blocked from time to time. As the procedure to remove a catheter could not be carried out in the prison, the man would be transferred to hospital. As his condition was monitored and no improvement seen, his name was added by the hospital consultant to the operation waiting to receive green light laser prostatectomy surgery (treatment delivered using a high powered laser to destroy surplus prostate tissue that is blocking the bladder).
23. During April 2006, the man continued to experience pain. By this time he had contracted numerous urinary infections. Not happy that the man's problem had become more frequent, the prison doctor wrote to the hospital to request that his operation be brought forward. The hospital subsequently responded and a date of 21 June was scheduled.
24. Prison wing and healthcare staff monitored and managed the man's discomfort and pain as best they could, and he was referred to hospital as necessary to unblock his catheter. He also started to experience piles which were bleeding and again had to be referred to the hospital for treatment.
25. On 21 June 2006, the man was admitted to hospital to undergo the prostatectomy. He returned to prison soon after. Three weeks later he again had pain and urinary problems. The prison nurse contacted the nurse specialist at the hospital in a bid to bring forward his review. In the meantime, prison healthcare staff provided the man with antibiotics to help combat his urinary infections.
26. The man received his hospital appointment on 2 August, and was seen in the Urology Clinic. He was given medication to ease the urinary problem and placed on a waiting list for a procedure called flexible cystoscopy (when a thin telescope is passed into the bladder via the urethra, allowing a doctor to see around bends). His piles continued to cause him problems and he was again referred to the hospital where he later received external haemorrhoid injection treatment.
27. On 30 December, the man attended hospital for a gastroscopy (an examination of the inside of the stomach). No abnormalities were

detected. Two days later he was seen on the wing by staff, complaining of abdominal pain and tenderness. He was also unable to pass urine and was dribbling fresh blood. Healthcare staff were alerted, and the man was immediately transferred to the local hospital's Accident and Emergency Department where he was treated and prescribed antibiotics on trial without his catheter. He returned to prison soon after.

28. Throughout January 2007, the man was still experiencing discomfort caused by his piles. Once again, the prison doctor referred him to hospital for further assessments. He was then seen by the surgeon and placed on the hospital waiting list for a sigmoidoscopy (a procedure to confirm the cause of his rectal bleeding). Throughout the man's care, healthcare staff asked wing staff to keep an eye on him and to inform them of any changes in his condition.
29. On 30 May 2007, the man attended the hospital's Urology Clinic for an appointment where the nurse specialist taught him self-catheterisation. It was hoped this would ease his problem of being unable to empty his bladder fully. When he was returned to prison, the healthcare nurses checked on him regularly in his cell.
30. After a few days had passed, the man complained to a nurse that he felt unwell. He had a headache and felt shivery. The man was examined and found to have contracted another urinary infection. He was given antibiotics and paracetamol to control the pain. His sigmoidoscopy appointment had to be cancelled because of his poor health.
31. The man's personal officer told my investigator that in prison the man was a likeable person who was always very polite and respectful. He got on well with everyone, although he tended to keep himself to himself. In his early days in Chelmsford, he was employed as a gym orderly but this had to cease as his health declined. The man's personal officer said that, despite the man being aware of his ill health, he was reluctant to go prison healthcare or indeed to outside hospital. However, his attitude changed as his health further deteriorated.
32. The urology nurse specialist contacted prison healthcare on 19 June 2007. The man had recorded an abnormal blood test result when he was last at the hospital, and it was requested that he be re-tested. Soon afterwards, the man had to be admitted again into hospital for treatment of his piles. Four days later, the hospital contacted prison healthcare to inform them that the man needed a blood transfusion as he was suffering from anaemia.
33. The man remained an in-patient at the hospital. Tests were carried out on him daily to assess his condition. Surgeons also performed the sigmoidoscopy and gastroscopy procedures to try to identify the cause of his bleeding, abdominal pain and anaemia.

34. During this time, as per prison bed watch procedures, the man was supervised by two prison officers and restraints were applied. The officers kept an occurrence log to record important events and kept in contact with the prison on a regular basis (approximately every four hours) to report on the man's condition.
35. On 5 July, the man was discharged from hospital with the instruction that he should be referred to the hospital surgeon if his piles continued to bleed. Prison nursing staff, as usual, checked on him that evening in his cell. The man was comfortable and raised no concerns. His prison medical records noted that during his hospital stay the following procedures had been undertaken and diagnoses made:
- colonoscopy – colonic polyps
 - GI Endoscopy – duodenitis (examination of the stomach)
 - reflux oesophagitis
 - abdominal U/S – abdominal aortic aneurysm
 - prostate minimally enlarged.
36. Following examination on 18 July by the healthcare nurse, the man was again found to be experiencing rectal bleeding. He attended hospital the next day when it was found he had possible rectal prolapse (piles) problems. He was treated and told his condition would be reviewed over the next three months. If necessary, he would receive a prolapse surgical procedure to rectify his problem.
37. When the man was examined in his cell by nursing staff on 21 July 2007, he reported no problems. His catheter was in place and working well. However, two days later, he complained of feeling unwell and had a swelling on his left scrotum. He was examined by the healthcare nurse, and the hospital urology specialist nurse was asked for advice. The man was prescribed a course of antibiotics later that evening. The nurse specialist subsequently arranged for the man to have an ultrasound at a clinic appointment.
38. On 28 July, whilst awaiting his hospital appointment, the man complained of feeling dizzy and was pale in colour. He was examined by healthcare nurse who found that his piles were clearly visible from his bowels. The prison doctor made an urgent referral to the surgical team at the hospital and the man was admitted as an in-patient straight away.
39. The man had been admitted to hospital now on numerous occasions, and his health appeared not to be improving. The prison's senior management reviewed the daily progress reports on his health (submitted by escort officers), and conducted a risk assessment. On 30 July, a second governor confirmed that the man no longer posed a security risk due to his ill health, and his restraints could be removed. He would also be reduced to a singleton prison officer escort.

40. The principal officer told my investigators that the man had become ill on and off in the months prior to this admission to hospital. When the man was in hospital, the principal officer carried out several bed watch duties, and sat with him on various occasions whilst he received treatment.
41. Throughout August 2007, the man underwent a number of tests whilst in hospital. During this time, it was identified that he had ischaemia of the bowel. As a consequence, he underwent abdominal surgery and required intensive support for an embolic event to his right leg (a term used to describe a sudden onset arterial event that leads to oxygen deprivation of a limb). Afterwards, mobility became difficult for the man.
42. The hospital continued to telephone to update prison healthcare staff on the man's condition. Healthcare staff also visited the hospital regularly to keep abreast of the man's condition and the treatment he was receiving. This was coupled with the escort officer's progress report to prison management. Consideration was given to the possibility of the man being transferred to HMP Norwich should his condition improve. However, his state of health was described now as poorly, with no known indication of when he could be discharged from hospital.
43. The man's health continued to deteriorate. During September, a bone scan revealed he had multiple metastases consistent with metastatic cancer of the prostate (the spread of cancer from one part of the body to another). He was now immobile and slept most of the time. When he was awake, he was often in pain and incoherent. He was subsequently moved to a private side room on the hospital ward that offered more privacy.
44. The hospital contacted the prison healthcare team on 4 October to inform them that the man's condition was worsening. The following day, a prison healthcare nurse accompanied by the deputy governor attended the hospital to visit the man. They spoke with the man to ask if there was anything they could do for him. He responded that there was not.
45. Whilst at the hospital, the deputy governor met with the ward sister who disclosed that the man's prognosis was extremely poor, and that he now needed constant care. He had been examined earlier in the day by one of the hospital medical professors. Given his condition, they were trying now to find a hospice or community hospital bed. It was possible that this could take between two and four days. It was also noted on the man's medical records that deputy governor would look into the possibility of the man being released early on compassionate grounds.
46. Following this, the hospital doctor faxed a letter to the prison confirming the man's prognosis. Since the man's admittance into hospital in July, he had had a complicated stay including a bowel operation and removal of his spleen. It had also been found that he had metastatic cancer which probably originated from his prostate.

47. The principal officer told my investigator that, during the entire time the man had been in hospital, no family members ever visited him. The only person who visited was a former prisoner from Chelmsford with whom the man had become friends while in prison. The former prisoner visited the man on a daily basis.

Events from 7 October 2007

48. The principal officer arrived at the hospital at 8.10pm to carry out his bed watch duty. He relieved a prison officer who gave him a full handover on the man's condition. The man was asleep when he arrived and remained so throughout the night. The principal officer was informed by hospital staff that the man was receiving pain killers that were automatically given by a machine. He was in a very poor condition and his life expectancy was not long. During the night, the man displayed periods of rapid and shallow breathing and occasionally noises came from his chest.
49. At around 7.00am the following morning, the man opened his eyes. The principal officer attempted to talk with him but got no response. At 7.10am, the man's rapid breathing ceased and was replaced by shallow, very intermittent breaths. The principal officer told my investigator that at around 7.30am the man appeared to stop breathing. At that stage he went out into the main ward to inform a nurse who returned to the man's room with him.
50. The nurse and the principal officer sat at the man's bed, with the nurse indicating that the man's life was imminently coming to end. Approximately ten minutes later, the nurse confirmed that the man had died and she left the room to alert the doctor. When the doctor arrived, he examined the man and certified his death at 8.00am on 8 October 2007.

After the man's death

51. The principal officer immediately contacted the prison and informed the deputy governor and the duty orderly officer of the man's death. As per the prison contingency plans, he remained with the man until he was taken to the hospital mortuary at 11.10am. When the principal officer returned to the prison, he made a note of events to give to the duty governor.
52. The prison activated its death in custody contingency plans. A central element in those plans is that the deceased's next of kin should be informed as quickly as possible. However, the man had no one officially recorded as his next of kin. Prison staff knew that he did have a daughter, but there had been no contact with her for a number of years. The man was not in contact with any other members of his family (a brother and sister), and was only ever visited in prison and hospital by the former prisoner with whom he had become friendly.

53. The Coroner was informed that the prison had no recorded next of kin for the man. The prison subsequently made preparations for the man's funeral. The principal officer was one of three members of prison staff who attended the service, together with the man's friend. The man was cremated. A memorial service was later held in the chapel and was well attended by both prisoners and staff.

ISSUES

Quality of care afforded to the man

54. After being recalled to prison in June 2004, the man was both treated on his residential wing and referred to hospital on many occasions due to his illnesses. The clinical reviewer comments that the care the man received within the healthcare centre and in HMP Chelmsford generally was exemplary. This included healthcare staff maintaining contact by telephone and in person with the hospital nurse specialist during the man's admission.

The healthcare team at Chelmsford made good use of the knowledge and expertise of the nurse specialist to ensure the best of care was offered to the man, including frequent contact with the local hospital.

55. Other members of prison staff also contributed to the man's care - including the staff on his wing where he spent most of his time when not in hospital. When the man was in the local hospital, information about his health was cascaded effectively by bed watch officers. The prison's management also took appropriate action in removing restraints as soon as it was known that the man's health had deteriorated. Unfortunately, the good intentions of the hospital to find a hospice space did not materialise in time.

I commend the Governor and his staff for the excellent care they gave to the man.

56. The clinical reviewer says that the time the man had to wait to receive surgical procedures was comparable to waiting times in the community. She also judges that the treatment received by the man was prompt and appropriate.
57. The clinical reviewer does comment that the prison environment was not conducive to managing a urinary catheter, and this may have contributed to the numerous infections the man suffered. There are clear indications, however, that both prison healthcare and hospital staff ensured the man was able to self-care for his catheter. This was also evidenced by way of a patient leaflet regarding catheter care in the man's healthcare record.

Removal of restraints

58. The man was escorted, under restraint, by two officers whilst an in-patient at the local hospital until 30 July 2007. The serious deterioration of his health was reported back to the second governor. A risk assessment was undertaken, and the escort was reduced to one officer, and the restraints removed. From this time until the man's death, the security measures remained at a single officer escort without restraints.

I commend the Governor for his timely risk assessment and the removal of restraints that allowed the man some dignity before his death.

Next of kin details

59. The man had not officially recorded anyone as his next of kin (it is not a requirement for any prisoner to provide such details).
60. HMP Chelmsford does not have a policy in place whereby, if a prisoner is admitted to outside hospital for a serious illness, the next of kin is informed. (If a prisoner requests contact to be made with next of kin, I understand this would be done.)
61. In the man's case, such a policy would have made little difference. However, in my judgement it should be routine for next of kin to be contacted when prisoners are in hospital with serious illnesses, unless there are overwhelming security objections. This should certainly occur in all instances (subject to security requirements) when it looks as though a prisoner is likely to die.

Chelmsford should review the system currently in place of when to inform next of kin if a prisoner is transferred to hospital.

CONCLUSION

62. Treating serious illnesses in a prison environment presents evident difficulties. I am pleased to record how hard the staff at Chelmsford worked to look after the man whilst he was in their care. This is evidenced within the man's medical records and by the numerous contacts and referrals made with the local hospital.

RECOMMENDATIONS

1. Chelmsford should review the system currently in place of when to inform next of kin if a prisoner is transferred to hospital.

Good Practice

2. The healthcare team at Chelmsford made good use of the knowledge and expertise of the nurse specialist to ensure the best of care was offered to the man, including frequent contact with the local hospital.
3. I commend the Governor and his staff for the excellent care they gave to the man.
4. I commend the Governor for his timely risk assessment and the removal of restraints that allowed the man some dignity before his death.

