

**Investigation into the circumstances surrounding the
death of a man in hospital in January 2011,
whilst in the custody of HMP Gartree**

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

July 2011

This is the report of the investigation into the circumstances surrounding the death of a man who died in January 2011, at hospital. He was in the custody of HMP Gartree when he passed away. He was 41 years old.

The loss of any family member can be distressing, but especially when they are in custody. I offer my sincere condolences to the man's family and friends.

As he died from natural causes, the findings of the clinical review play an essential part in my report. The review shows that he received good care whilst he was in prison.

He became ill in December 2010 and suffered from a number of non-specific symptoms such as diarrhoea, vomiting and a high temperature. It was initially thought that he might have swine influenza. After a number of weeks of different treatments from prison healthcare staff, he was taken to hospital where it became clear that he was suffering from an infected heart. He was kept in hospital while being stabilised for surgery. Unfortunately, he died before this was possible.

The clinical review makes it clear that it was very hard for the prison doctor to make an accurate diagnosis as his symptoms were not typical of the illness he was suffering from. The clinical reviewer finds no fault with his medical care. I endorse his findings, and make no recommendations.

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.

Thea Walton
Acting Deputy Prisons and Probation Ombudsman

July 2011

CONTENTS

Summary

The investigation process

HMP Gartree

Key Findings

Issues

Conclusion

SUMMARY

1. The man was born in Kingston, Jamaica in May 1969. He came to the United Kingdom in 2002 where he developed a drug habit. During a burglary, he committed a murder. He was arrested in 2002 and sentenced to life imprisonment in 2003. He was initially at HMP Belmarsh, before transferring to HMP Cardiff, and finally HMP Gartree in January 2009.
2. During his reception healthscreen at Gartree, he explained that he was a gym user with no concerns about his health. He did not see healthcare staff for any significant reasons until November 2010, when he complained of stomach problems after eating and drinking.
3. For the next two weeks, he frequently complained of stomach pain, vomiting and diarrhoea. His temperature went up and down, and he was given various medications to treat his symptoms. At times, he appeared better but his stomach problems continued to return.
4. On 16 December, he said that he felt very ill, and his temperature and pulse rate were high. As there had been no improvement despite treatment, he was transferred to an infirmary where he was diagnosed as suffering from infective endocarditis (an infection in the heart).
5. He was transferred to a hospital the next day for surgery that revealed the infection had substantially damaged his heart. He was treated post-operatively for a number of weeks with a plan to stabilise the infection before operating again. Unfortunately he declined on 14 January and it was decided to undertake the operation immediately, despite the failure to stop the infection. However, by the next day, he was too ill for the operation and it was clear that his condition was terminal. He died later that day with a friend by his side.
6. The prison had difficulty finding a working telephone number for his family in the Caribbean, but was provided with one by another prisoner at Gartree. The prison held a memorial service, and assisted with the funeral.
7. I make no recommendations in this report.

THE INVESTIGATION PROCESS

8. My office was notified of the man's death on 17 January 2011. The investigation was carried out by my colleague. He visited HMP Gartree on 25 January to open the investigation. He met with senior staff and collected the documentation relating to the man.
9. Notices announcing the investigation were supplied by my office and displayed by the prison to staff and prisoners, who were invited to contribute any relevant information.
10. All the relevant prison records relating to the man were studied by my investigator. They included his main prison record and medical records. One of my family liaison officers contacted the family who had some questions regarding his property. I trust I have addressed these matters in the investigation report. My investigator was told that the prison were in the process of facilitating the return of his belongings.
11. A clinical review of his healthcare was undertaken by a clinical reviewer of the local Primary Care Trust. He also made himself readily available to answer any queries during the investigation, and his assistance was much appreciated.
12. The family made a number of comments following the publication of the draft report. My investigator consulted with the clinical reviewer, and they are discussed at the appropriate place in the report.

HMP GARTREE

12. HMP Gartree opened in 1965 as a category C training prison, but changed its role to become a high security prison, before reverting to a category B prison in 1992. Prison Service Order (PSO) 0900 (Categorisation and Allocation) explains the reason for categorising prisoners:

“Prisoners must be categorised objectively according to the likelihood that they will seek to escape and the risk that they would pose should they do so.”

13. Category B prisoners are defined in the PSO as:

“Prisoners for whom the very highest conditions of security are not necessary, but for whom escape must be made very difficult.”

14. The population of life-sentenced prisoners grew and in 1997 its role changed to a main lifer centre. It accepts adult male prisoners who have been sentenced to life imprisonment. The regime includes employment in gardens, education and offending behaviour programmes. It has an operational capacity of 677 with single cell accommodation.
15. The local Primary Care Trust is responsible for the delivery of health services in the prison. The prison healthcare facilities include in-patient treatment facilities and 24 hour nursing cover. Doctors provide daily medical cover.

Her Majesty’s Chief Inspector of Prisons

16. Her Majesty’s Deputy Chief Inspector of Prisons made a full announced inspection of Gartree between 10 and 14 May 2010. In the report of the inspection, the Deputy Chief Inspector said:

“The Governor provided strong leadership and support to the health care team and was active in the development of health services. A new building due to open in June 2010 would provide much improved facilities. Primary care services were satisfactory and included a good GP service, life-long conditions management and visiting specialists.”

Independent Monitoring Board

17. Each prison is monitored by an Independent Monitoring Board (IMB), members of which are drawn from the local community. They have full access to prisoners and every part of the establishment. In its latest annual report, covering the year ending 30 November 2009, Gartree's IMB said,

“The Board is well aware that the prison is served by a very able Healthcare team.

“We see and discuss Healthcare provision with prisoners regularly, and also visit the Centre on all our Rota visits. There are few healthcare issues or complaints raised, as is reflected in the analysis of our applications. We are also pleased to see the Centre working so well with the GP practice – and winning the Partnership Award, Leicestershire and Rutland Justice Award.”

Previous deaths at Gartree

18. Gartree experienced two deaths from natural causes in 2010. Neither of the cases had any direct similarities to the death of the man.

KEY FINDINGS

19. The man was born in Kingston, Jamaica in May 1969. He had eight sisters and his mother still lives in Jamaica. He arrived in Britain from Jamaica with no legal papers on 23 January 2002. He had previously worked in the construction industry. Unable to find legal employment, he shared a flat in London where he became involved in illegal drugs activity, involving delivering drugs. He continued to smoke cannabis, and then developed a cocaine habit.
20. On 5 July 2002, he committed a murder during a burglary and was initially remanded in custody at Belmarsh. Following his trial in July 2003, he was convicted and given a mandatory life sentence with a minimum tariff of 14 years.
21. He transferred from HMP Belmarsh to HMP Cardiff on 23 September 2004. He was employed in education where he learned to read and write. He appeared to settle into the prison regime, and worked in the kitchen and the tailor workshop.
22. Following an appeal against his sentence on 22 March 2007, his tariff was reduced to 12 years.
23. After complaining that his left knee was swollen, he was sent to hospital on 21 February 2008, where he saw a physiotherapist. He was diagnosed as having a Baker's Cyst (a harmless collection of joint fluid behind the knee) and was treated with anti-inflammatories and painkillers.
24. On 20 January 2009, he transferred from Cardiff to HMP Gartree. During his reception interview he said that he enjoyed going to the gym and played table tennis most days. He was then seen by a healthcare nurse. She noted that he smoked four cigarettes a day. He had no concerns regarding his physical health. He was prescribed naproxen (an anti-inflammatory medication).
25. The following month, he saw a nurse as he had a rash on his neck, legs and buttocks. The nurse referred him to Prison Doctor A, who prescribed eumovate cream (an anti-inflammatory) to reduce his eczema (skin inflammation, often characterised as a dry skin condition).
26. Six months later, on 11 September, he complained of dry skin and achy joints and he was prescribed E45 cream (for dry skin), glucosamine (for joint pain relief) and cod liver oil (a nutritional supplement for easing pain and joint stiffness).
27. When he was seen in healthcare's Wellman clinic (a general health check) on 12 October, it was noted that he had no mental health problems, smoked three cigarettes a day and was on a normal diet. He attended the gym six times a week, using both the weights and cardiovascular equipment. He said that he had no health worries.

28. Prison Doctor B saw him on 5 November, when he complained of having a “fever and malaise” for the previous four days, as well as a cough. His chest was clear and the doctor diagnosed his condition as an influenza-like illness.
29. Complaining of a recurrent itchy spot on his back, he saw a nurse on 17 December. The nurse noted it as a fungal infection, and advised him to use some moisturiser and referred him to Prison Doctor A. The doctor diagnosed a tinea (a skin infection) and prescribed some medication.
30. On 20 January 2010, he was again referred to Prison Doctor A by a nurse as he felt that the medication was not working. The doctor examined his back and found that the spot was improving, was less itchy, less discoloured and was now flat. The doctor stopped the daktarin and prescribed eumovate, noting that it should be reviewed if it did not continue to heal.
31. A nurse saw him on 7 April, when he told her that he had ankle pain when getting up in mornings, although it improved through the day. On 13 April, he saw Prison Doctor C, complaining that his left hand had altered sensation in the thumb, index and middle fingers for about two weeks, especially in his middle finger and he wondered if he might have a circulation problem. The doctor could find no obvious trauma, but noted that his left hand fingers were slightly cooler. The doctor diagnosed that this could be carpal tunnel syndrome (pressure on a nerve in the wrist that can cause numbness in the fingers) and prescribed ibuprofen (an anti-inflammatory), which would be reviewed in two weeks.
32. A booster hepatitis B (an infectious illness caused by hepatitis B virus which infects the liver) vaccination was given to him on 16 April. When he saw Prison Doctor C for his review on 27 April, his left hand had improved following two weeks using ibuprofen, and so the doctor re-prescribed the anti-inflammatory for another month.
33. He saw a nurse on 9 August, and informed her that the skin problem to the centre of his back had returned. It gave him an itchy patch of skin between his shoulder blades which had increased in size, and he was using the eumovate again. The nurse booked an appointment with Prison Doctor A who saw him on 18 August. The doctor noted “no erythema [redness of the skin], no scale; skin flat but edge and definite itch”. He diagnosed that this could be fungal and prescribed lamisil (anti-fungal).
34. When the doctor checked his back on 15 September, there was no evidence of a rash. The doctor stopped the lamisil and told him to continue with the E45 cream.
35. A nurse saw him in the Wellman clinic on 29 September. He told the nurse that he did seven gym sessions per week, but had sustained a strain in his right thigh when playing football two weeks previously. He had dry skin between his shoulder blades and the nurse recommended additional stretching exercises, massage and gentle exercise for his thigh strain and continued use of E45 cream on his dry skin. No other concerns were raised.

36. On 22 November, he saw a nurse and said that, since the weather had become colder, he had constant joint pain in his arms and legs. He also had problems sleeping. The nurse gave him analgesia (painkiller) and referred him to Prison Doctor B who saw him three days later on 25 November. He had pain in his back, which was worse on his left side and was radiating into his right thigh. When he also complained of stiffness in all his joints, the doctor diagnosed a possible rheumatic flare up (condition or disease causing pain in the joints), and prescribed co-codamol (for relief of mild to severe pain) and diclofenac (an anti-inflammatory drug).
37. A week later, he again saw a nurse complaining of stomach problems when eating and drinking. She advised him that it could be a reaction to his medication and referred him to Prison Doctor C with instructions to stop his current medication. The doctor saw him on 3 December. He said the stomach ache had settled since stopping his medication and his back pain had improved. The doctor thought that it was indigestion and prescribed paracetamol (a pain reliever) and ibuprofen (an anti-inflammatory) with lansoprazole (to prevent his stomach producing digestive acid).
38. At 11.40pm on 7 December, the night patrol officer called Nurse A to attend to him in his cell as he was complaining that he had vomited six times, and had diarrhoea and pains in his stomach. The nurse told him only to take sips of water and try to rest. She also told him to see a nurse the next morning and added him to the doctor's appointment list for 8 December, but he did not attend.
39. The following week, at 12.27pm on 12 December, a nurse was asked by wing staff to see him in his cell, as he was complaining again of stomach pain. His temperature was 37.8 degrees centigrade (temperatures between 36.5 and 37.2 degrees may be considered in the normal range). He had slight tenderness in his epigastrium (upper central region of abdomen). He said that he had vomited the previous day after eating, but had not been sick since then. The nurse encouraged him to take painkillers and medication, and avoid foods which might aggravate his stomach. A doctor's appointment was booked.
40. Nurse B saw him at 4.50pm when he complained of feeling unwell. His temperature had risen to 40.2 degrees. The nurse advised him to rest and drink plenty of fluids. He contacted the out of hour's doctor's service and advised the wing to treat him according to the prison's swine flu contingency plan. At 5.55pm, a doctor rang back advising staff to treat him with paracetamol and ibuprofen and obtain tamiflu (an antiviral drug that slows the spread of the illness), as he had swine flu symptoms.
41. A nurse returned to see him at 7.30pm when he said he felt a lot better. His temperature had dropped to 38.4 degrees and the nurse advised him to take his paracetamol and ibuprofen.

42. Nurse C saw him the next day at 11.15am. He complained of stomach pain, wind and diarrhoea, but said that he did not have any aching joints or flu symptoms. His temperature had fallen to 36.2 degrees. Shortly afterwards, at 11.28am, Prison Doctor D examined him. The doctor thought that there was nothing to suggest that he had swine flu and instead diagnosed either gastritis (inflammation of lining of stomach) or a helicobacter pylori infection (bacteria that can cause inflammation to the stomach). The doctor stopped the non-steroidal anti-inflammatory drugs and started treatment for helicobacter pylori (bacteria) eradication instead. The doctor planned to continue monitoring him and review him if there was any deterioration, giving him a blood test the following day.
43. At 4.00pm, Nurse D saw him and noted that his temperature had risen again to 39.5 degrees, and contacted Prison Doctor D as per his instruction. The doctor told the nurse to check his temperature at 5.30pm, who should take paracetamol. The doctor told the nurse that, if his temperature reduced, he should be reviewed again in the morning, but if it increased the on call doctor's service should be asked for advice. He was told to contact healthcare with any concerns. He was alert and orientated when Nurse E saw him later at 5.15pm, and he said he was starting to feel better. His temperature had reduced to 37.8 degrees.
44. Prison Doctor A saw him the following day. His abdomen was still aching, he felt constipated and he was continuing to cough but without sputum (mucus coughed up from the airways). Blood samples were taken by a nurse for a full blood count. Prison Doctor B then reviewed the full blood count which, in view of his abnormal liver function tests, suggested an infection. The doctor noted that this could indicate cholangitis (an inflammation of the bile duct).
45. At 10.02am on 15 December, Nurse E found that his temperature had risen again to 38.4 degrees. He felt generally unwell and took his paracetamol when prompted. At 2.57pm his temperature had dropped to 36.0 degrees and he had taken more paracetamol. The nurse advised him to follow the medical advice and await the blood test results from the previous day.
46. When he saw a nurse the following morning, 16 December, he said that he felt very ill, had gastric pain and thought "he was going to die". He had not been able to eat for two days. His temperature had risen again to 37.4 degrees and his pulse was 110 beats per minute (which exceeded the normal range).
47. Prison Doctor B went to see him in his cell later at 12.10pm and noted that he was still in a great deal of pain. Tests revealed that his CRP (C-reactive protein level, a protein found in the blood, the levels of which rise in response to inflammation) was very high. The doctor diagnosed possible cholangitis and decided that he should be admitted to hospital.
48. He was taken to the infirmary by ambulance at 3.45pm the same day, 16 December, due to his high temperature and abdominal pain. When prisoners leave a prison, a risk assessment is undertaken to decide on the level of supervision needed. He was restrained by single cuffs and an escort chain.

He was to be accompanied by two prison officers 24 hours a day whilst in hospital and they kept a log, known as a bedwatch log, which was regularly updated. He was diagnosed with severe infective endocarditis (an inflammation of the innermost layer of tissue that lines the chambers of the heart). The Governor gave permission for the cuffs to be removed, and for him to be restrained only by the escort chain.

49. At 1.00am on 17 December, he transferred to the intensive care unit (ICU) where his condition remained serious and unstable. A consultant examined him at 7.20am, and concluded that he needed to have a heart valve replacement. Later that morning, at 9.40am, he was transferred to the ICU at a hospital under the care of a consultant cardiac surgeon.
50. That afternoon, at 1.45pm, he was taken to the operating theatre where an operation showed extensive destructive endocarditis. This was treated with an aortic valve replacement (a cardiac surgery procedure in which a patient's failing aortic valve is replaced with an alternate healthy valve) and repair to the tricuspid valve (a valve on the right side of the heart). He was not restrained during the operation.
51. Following the operation, he was moved back into the ICU at 7.15pm. His temperature continued to rise and fall, and he was bleeding after the operation. He remained critically ill, and was fitted with an external pacemaker (a medical device which uses electrical impulses to regulate the beating of the heart). At 10.00pm, he went into cardiac arrest when his pacing wire moved, but he was resuscitated by nursing staff and was stabilised ten minutes later. He was treated for his bleeding and this stopped overnight.
52. On the morning of 18 December, he was taken off his ventilator and was breathing independently. The pacemaker remained in place and he was told he may require a permanent internal pacemaker in the future. He received a visit at 6.00pm from a friend. As his condition had improved, a further risk assessment regarding his restraints was carried out. The hospital staff confirmed that the restraints would not restrict medical care, and so prison staff decided that the escort chain should be used.
53. The following day, he had a chest x-ray and his chest drains were removed (used to remove air, fluid or pus). He was able to get out of bed and sit on a chair, but the external pacemaker was still necessary as, although he had some independent heart rhythm, it was not enough to support him. At 11.15am, he was moved from the ICU to a ward, and at 6.00pm, received another visit from his friend.
54. At 8.40am the next morning, a consultant told him that he had an infection in his heart valves and would require antibiotics for six weeks, with at least two weeks in hospital. At 6.10pm, his friend came to see him again.
55. On 23 December, the hospital doctors noted that a permanent pacemaker could not be fitted yet because, despite his improvement, he was still not fit enough for further surgery. He received communion from the hospital chaplain

on Christmas Eve, and at 3.55pm, he telephoned Jamaica to speak to his daughter. He made a further call to his daughter on Boxing Day.

56. The external pacemaker's rate was decreased slightly on 27 December, but he remained in complete heart block (a problem that occurs with the heart's electrical system, which controls the rate and rhythm of heartbeats). The cardiologist and microbiologist liaised regarding further treatment. It was anticipated that he would require six weeks of treatment, which is the standard procedure following this type of surgery. It was noted that there were no plans to discharge him from hospital at that time.
57. At 9.45pm on 29 December, it was noted that he might have had an infection in another heart valve requiring another operation. The next day, following a scan, he was informed that further surgery to replace a valve in his heart was necessary, but the cause of his infection needed to be established before this could happen, due to the risk from surgery. The infection appeared to be from an aortic route abscess (a collection of pus usually caused by bacteria or parasites). The medical plan was to treat the abscess with an aggressive course of antibiotics. If this was unsuccessful, then surgery might be re-considered. Once the infection was under control and blood results were stable, the permanent pacemaker could be fitted.
58. During his time at hospital, the healthcare staff at Gartree telephoned the hospital regularly for updates on his condition. The Clinical Team Manager visited him several times. Following a visit on 6 January, she noted that he continued to be paced at 65 beats per minute (bpm), and despite having three different intravenous (IV) antibiotics, he continued to show signs of ongoing infection, with pyrexia (fever) and raised CRP and white cell count (this can indicate illness). He was being regularly screened for infections by way of urine and blood tests and swine flu screening. He was taking dalteparin to prevent a deep vein thrombosis (blood clot in a vein) and pulmonary embolism (blood clot in an artery). It was still anticipated he would require an internal pacemaker to be fitted. He was also anaemic (a decrease in number of red blood cells), being treated with ferrous sulphate (an iron compound to treat anaemia). He remained very unwell, with no plans to discharge him from hospital.
59. On 8 January, an update in his prison medical record noted that he was still quite poorly. He continued to take three different antibiotics intravenously and was still suffering on and off from high temperatures. His white cell count was stable. Several blood tests had been undertaken but nothing had shown up. On 12 January, he had another scan and he continued to receive visits from his friend.
60. At 10.31am on 14 January, the Head of Healthcare at Gartree visited him. She noted that he had a scan that morning to see whether the continuous infection was due to abscesses or pericarditis (inflammation of the pericardium, the fluid sac surrounding the heart). Another operation was being considered. His CRP and temperature continued to spike, making his condition less stable. His mood was fairly low, he was breathless and

complaining that he felt sore from lying in one position. She encouraged him to move around to alleviate this. The dietician visited to discuss his nutrition as he was not eating the food provided. Extra supplement drinks were given to him.

61. It was noted, following a telephone update at 2.48pm that afternoon, that he remained unstable, was not responding to the intravenous antibiotics and his blood test results were abnormal. The operation planned to repair or replace the mitral valve (in the heart) and aortic root (part of the aorta, the largest artery in the body) was being brought forward to the next day. The prison was told that he was first on the list to go to theatre and, should any of his family wish to visit beforehand, then they should visit this day.
62. On 15 January, he was reviewed by the consultant anaesthetist, the consultant cardiac surgeon and the acting consultant cardiac surgeon responsible for him. Due to his extremely poor clinical condition, they decided that surgery was no longer a viable option. His temperature had fallen to 33 degrees. A hot air blanket was placed on him at 7.20am due to his extremely low temperature, and he was to be taken back to the ICU.
63. At 8.30am, the duty governor at Gartree that day telephoned the hospital for an update of his condition. Hospital nursing staff told him that the operation had been cancelled and the move to ICU was not going to happen. A nurse confirmed that his condition was terminal and he was likely to die soon. The duty governor then kept a log of events and completed a 'change in circumstances' document. He noted that, as the man had moved into the final stages of life, his restraints should be removed again, and staff should be sensitive regarding the situation.
64. Shortly afterwards, at 8.35am, the duty governor spoke to Officer A. (Officer A and Officer B had taken over the bedwatch at 7.30am.) He told the officers to remove the restraints. Officer A informed the governor that the consultant had told her that the man had deteriorated and surgery was not a possibility. He had also said that he was in the end stage of his life and had less than 24 hours to live.
65. The bedwatch officers reported that they had not managed to contact his friend so the governor spoke to three prisoners, who were his friends, at 9.15am. He told them about the man's condition and, from their information, he was able to contact the friend, advising her to visit him as soon as possible.
66. The man was given a cold wash at 10.30am by the nurses as he said that he felt very hot. His temperature was 34.5 degrees. His friend arrived soon afterwards at 10.40am. When he said that he was very hot, Officer A, together with a nurse, helped him to sit up and the officer noticed that he was cold to the touch.
67. The governor arrived at the hospital at 1.00pm where he met the man's friend. The governor checked that both officers were okay and confirmed that the restraints had been removed. By 2.00pm, the man's breathing was shallow

68. At 3.25pm, his breathing was a little laboured whilst he was sleeping. About 90 minutes later, at 5.10pm, Officer A asked a nurse to attend to him as she had seen that his breathing had become irregular and he did not look as if he was breathing any longer. Another nurse also attended and she checked his breathing which appeared to have stopped.
69. A doctor was called and cardiac surgery registrar at the hospital examined him and declared at 5.20pm that he had died. She recorded that he died as a consequence of blood poisoning (a severe illness in which the bloodstream is overwhelmed by bacteria) secondary to endocarditis. The cause of death was septicaemia secondary to infective endocarditis. His friend was given some time alone with him.
70. Officer A immediately informed the duty governor of the death and shortly afterwards the prison activated its death in custody contingency plan. Leicestershire Police, the Governor, and the Independent Monitoring Board were informed. The governor was appointed as the prison's family liaison officer. The police visited the hospital as is customary whenever a prisoner dies, but they found no suspicious circumstances. At 6.00pm, the governor informed the prisoners on the man's wing of his death.
71. At 10.30am on 16 January, a well attended memorial service was held in the prison chaplaincy.

Liaison with the man's family

72. Following the man's death, Gartree sought to inform his next of kin as soon as possible. However, the telephone numbers for his daughters which were held by the prison were not answered or went straight to the answer machine. The duty governor sought the help of the British High Commission in Jamaica and the Jamaican Embassy in the UK. However, on 24 January, the governor received a telephone number for the family from another prisoner. The news of his death was broken to them, and assistance offered with the funeral arrangements. His funeral took place at 2.30pm on 27 January.

ISSUES

Clinical care

Standard of care

73. The clinical reviewer was provided with the man's prison medical record and spoke to the Head of Healthcare at Gartree regarding a number of questions. He also had sight of the records pertaining to his time in hospital. In his report he writes:

"I believe the standard of clinical care provided to the man was very good. Healthcare staff responded to his symptoms, arranged early consultations with prison doctors and sought the advice of the out-of-hours doctor as required. During the last four days he spent under the care of the HMP Gartree healthcare team, he was seen on 12 occasions, blood tests were arranged and he was admitted to hospital for further investigation and management."

74. I have seen no evidence to the contrary, and I endorse the clinical reviewer's findings.
75. Following the publication of the draft report, the man's family asked if a blood test was ordered when he became unwell with a flu-like illness in November 2009. The clinical reviewer writes in the revised clinical review:

"There is no blood test result in the prison medical records relating to that date. I would not expect a blood test to be requested under these circumstances."

Diagnosing the man's illness

76. The clinical reviewer explains in his review that the man's symptoms did not immediately suggest that he was suffering from infective endocarditis. He includes a reference from one of the doctors in the hospital who told him that:

"The man's clinical presentation was not typical of the very rare condition of Infective Endocarditis and that the progression of the illness was rapid."

77. The clinical reviewer writes that the surgical findings indicated that the heart infection had already begun before he first suffered from a high temperature. Although he was poorly for four days before being taken to hospital, I believe that prison doctors, nurses and wing staff monitored him closely and offered what they thought was the appropriate treatment. He was treated in hospital from 16 December and at first the hospital doctors expected that he would recover. He died a month later despite what I believe to be the expert advice of several specialists. It does not seem to me that prison healthcare staff could have done any more to diagnose his condition, which even a hospital doctor described as untypical.

78. The family responded to the draft report and said that they were concerned that blood tests should have been carried out more quickly. The clinical reviewer responds to this in the revised clinical review:

“The man was seen by healthcare staff or a doctor on 02.12.10, on 03.12.10 and on 07.12.10 with symptoms related to his abdomen. I would not expect a blood test to have been performed at that time with regard to the documented presenting symptoms and the signs found on examination. He was documented by healthcare staff to have a high and rising temperature on 12.12.10 in association with a rising pulse and falling blood pressure. He was seen by a doctor on 13.12.10; blood tests were ordered on that date and were taken from him on 14.12.10. I would have expected blood tests to be ordered at this stage in order to look for normal and abnormal results related to specific organs and conditions; and also to assist with the differential diagnosis of his clinical condition.”

79. The family were also concerned that a number of different medications were used to treat his symptoms. The clinical reviewer writes in response to this in the revised clinical review:

“The man’s documented medical records show that from 02.12.10 until 13.12.10 his symptoms were primarily abdominal in origin. It was initially considered that his symptoms were consistent with the potential stomach side-effects of medication prescribed to treat his musculoskeletal symptoms as presented on 25.11.10. In consideration of the presumed cause of his abdominal symptoms at that time, I believe that stopping the relevant medication and initiating other medication to treat the presumed stomach symptoms were the correct actions. The medications prescribed in December 2010 would not have affected his underlying condition of Infective Endocarditis.”

80. I note that the staff attempted to manage his illness and, due to the atypical symptoms, would not have expected him to be suffering from infective endocarditis.

Liaison between Gartree and the hospital

81. The clinical reviewer writes of the good communication between the prison and the hospital:

“During these last four weeks of the man’s life, HMP Gartree’s healthcare staff maintained regular contact with the hospital regarding his condition and progress. He was visited by a member of the healthcare staff on 31.12.10, on 06.01.11 and on 14.01.11.”

82. The prison medical records include information that staff at Gartree obtained from contacting the hospital. I am pleased to see this level of continuity of care, and to see that conversations with external hospitals were recorded. He

Use of restraints

83. The man was a serving prisoner and so the prison had a duty to prevent his escape. The risk to the public was assessed according to the standard procedures when he went into prison. He was accompanied by two bedwatch officers throughout the month that he spent in hospital and, at first, an escort chain was used as a further safeguard. The chain was removed for surgery the following day and restored when he began to recover. His condition deteriorated in the New Year and, on 15 January, the hospital doctors concluded that he was likely to die soon. On receiving up to date information about his condition, a prison governor decided that the restraints should be removed straightaway. He died later that day.
84. Restraints are a difficult issue as there is a balance to be drawn between the dignity of the individual and the safety of the wider public. I recognise that the risk assessments were reviewed when his condition changed, and on occasion his restraints were removed where they would otherwise have interfered with his treatment. I am pleased that the restraints were removed when he reached the end of his life I believe that, in this instance, Gartree balanced his dignity and their security responsibilities well, and encourage them to continue this approach.

Liaison with the man's family

85. The prison told my investigator that they found it very hard to contact the family to break the news to them. The telephone numbers they had were not answered. It was only from another prisoner that they were able to get a number with which they could speak to his family in the Caribbean. The family told my family liaison officer that they did not think it should have taken so long to inform them of his death.
86. It appears that the prison only attempted to contact the family once he had died. Given the severity of his condition with major heart surgery on 17 December and reliance on an external pacemaker whilst waiting for another operation, I think that the prison should have contacted them at an earlier stage. I accept that the prison had telephone numbers for his next of kin. Nevertheless, the problems they had subsequently should act as a reminder of the importance of keeping up to date next of kin contact details. This is particularly important for foreign national prisoners who, like the man, have next of kin who live overseas.

CONCLUSION

87. The man did not come to the attention of the prison healthcare staff for any serious illnesses until he began to complain of stomach problems at the end of November 2010. The clinical reviewer explains that the symptoms presented by him were not typical of his eventual diagnosis, and he finds no fault with Gartree's attempts to treat him in prison. Once it became clear that he required further treatment, he was transferred to hospital. Unfortunately, he did not recover and he died before returning to prison. I am satisfied that the prison sought to care for him the best they could, but remind them of their responsibilities to remove restraints when a prisoner is gravely ill and to consider informing the family at an earlier stage.