Investigation into the circumstances surrounding the death of a man in March 2009, in hospital, whilst in the custody of HMP Gartree

Report by the Prisons and Probation Ombudsman for England and Wales

February 2010

This is the report of an investigation into the death of a man who died in March 2009, in hospital, whilst in the custody of HMP Gartree. He was diagnosed and treated for lymphoma (cancer) in 2006, when he was at HMP Swaleside. The man was assessed by a forensic psychiatrist in February 2009, and was waiting to move to a medium secure unit nearer to his family in London. He was taken to hospital two weeks before he died at the age of 74 years old.

A post mortem was not held into the man's death at the request of HM Coroner for Leicestershire and South District. He died from natural causes resulting from pneumonia and renal failure probably secondary to the lymphoma. I extend my sincere condolences to his family and friends.

This investigation was undertaken by one of my colleagues. In addition, a review of the man's healthcare was commissioned from the local Primary Care Trust. I am grateful to the clinical reviewer who carried out the review. I would also like to thank the then Governor of Gartree and her staff for their help and assistance. I am particularly grateful to the prison's liaison officers.

I make four recommendations for the attention of the Governor. The first recommendation relates to visiting orders and three recommendations acknowledge the exceptional care of the man by healthcare and prison staff at Gartree.

In this final report the Governor has accepted the recommendation in relation to visiting orders and the care afforded to the man by healthcare and prison staff.

The man's family engaged solicitors to act on their behalf and the draft report was sent to their offices. On receipt of the draft report, his family solicitor wrote a lengthy response to the Ombudsman's office, in which they raised issues relating to his time in custody and his care. We have responded to the families concerns and a copy of that letter has been forwarded to the Coroner. I apologise for the delay in issuing this final report however, to address family issues further investigation was undertaken.

On page 28 I have responded to some of the family's concerns rising from the draft report and also amended two factual inaccuracies in relation to the man's birthplace of Egypt and the family noting that their father did not receive low key chemotherapy. Two more annexes are added to this final report.

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 **February 2010**
Deputy Prisons and Probation Ombudsman

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SUMMARY

The man was sentenced to life imprisonment in August 2004 at court for the murder of his wife and taken to HMP Belmarsh. His medical notes state that he had undergone major bowel surgery. In January 2005, he transferred to HMP Swaleside and later to HMP Elmley. Whilst at Swaleside and Elmley it was noted that he had been a challenging prisoner. He complained about his diet of kosher meals and failed to adhere to prison rules.

The Head of Jewish Chaplaincy for the Prison Service and a chaplaincy rabbi advised the man about acceptable behaviour and his diet. Whilst at Swaleside and Elmley, he was subject to some hostility from other prisoners as his behaviour disrupted the wing.

In 2006, the man was diagnosed with a lymphoma. He was treated at hospital and accompanied to some of those appointments by a Hebrew interpreter. The hospital ensured that he was fully aware of his treatments. However, he often chose not to attend his appointments if an interpreter was not present, he had a visit, or for religious reasons. In time the consultant discharged him as he failed to attend his follow up appointments after his cancer treatment was completed.

In December 2008, the man transferred to Gartree where he was to address his offending behaviour. It was noted on his arrival that he was elderly, and had a history of lymphoma. From his second day on B wing he presented with challenging behaviour. He refused or complained about his diet, despite a discussion between himself, the catering manager and prison staff.

In February 2009, the man was placed on an Assessment, Care in Custody and Teamwork (ACCT) plan. (An ACCT plan is a document used to care for prisoners at risk of self harm and suicide. The plan sets out actions, observations and reviews by prison and healthcare staff to monitor the prisoner and their wellbeing.) He had been refusing to eat his kosher meals and wing staff had become increasingly concerned about his fragility.

A forensic psychiatrist saw the man in February and referred him on to be admitted to a medium secure unit, nearer to his family in London. Whilst he was not deemed ill enough to be sectioned under the Mental Health Act, there were some concerns over his mental health.

The man's physical and mental health deteriorated and he was taken to the healthcare unit in February. Despite twice refusing to be taken to hospital, he was admitted to hospital in March. His health deteriorated and he refused to take his medication if he was unfamiliar with the brand name. He assaulted two healthcare nurses.

The man's family were allowed to remain at his hospital bedside 24 hours a day. His behaviour continued to be erratic with some bursts of energy which included violence towards prison escort and hospital staff and so restraints were used.

In March, a hospital doctor spoke to a senior manager at the hospital. As a result the man‘s restraints remained in place despite his continued deterioration and very poor health. He died three days later at 12.54pm with his family at his bedside. Restraints were removed ten minutes before he died on the order of the duty governor.

Whilst I can fully understand the man’s family’s distress at his imprisonment and subsequent poor health, I judge that he was well cared for by prison and healthcare staff at Gartree. I make one recommendation for assistance to be offered to prisoners who are unwell, physically or mentally, with their visiting orders. Three other recommendations reflect the exceptional care by prison and healthcare staff.

THE INVESTIGATION PROCESS

1. In April, the investigator visited Gartree to review the man's prison files. The Ombudsman's notice of investigation and terms of reference had been sent to the prison in advance of her visit. The investigator requested copies of documents to be collected by her at a later date. The man's security file was sent to her office.

2. Later, the investigator met with the Chair of the Independent Monitoring Board (IMB) and a member of the IMB. There have not been any responses to the notice of investigation from prisoners or staff.

3. A clinical review of the man's medical care was commissioned with the local Primary Care Trust (PCT). The clinical reviewer carried out that review on behalf of the PCT.

4. The investigator visited Gartree in April to collect copies of the documents. She visited B wing and spoke to the SO. Whilst on B wing, she saw the man's cell. Later, she spoke to the Head of Healthcare.

5. In April, one of the family liaison team spoke to the man's son by telephone and informed him of our investigation. His son said he would speak to his family, so she wrote to him enclosing details of any assistance the family may need and her contact details. Later, the man's family referred their concerns to solicitors to act on their behalf. Those issues related to their father's care in Gartree, his failing mental health, his diet, visiting orders and hospital appointments.

6. The investigator visited HMP Elmley and spoke to the Healthcare Principal Officer in May. The following day, she visited Gartree and spoke to an officer from B wing and the Jewish chaplain. She returned to Gartree in June to interview prison staff and prisoners and met with the Chair of the Prison Officer's Association.

7. In July, the investigator spoke to the Head of the Jewish chaplaincy for Her Majesty's Prison Service by telephone. A week later, she interviewed the Jewish chaplain.

8. The investigator returned to Gartree in September to collect visiting records. She made contact with a rabbi to arrange an interview, but he declined to be interviewed.

9. The investigator and Family Liaison Officer interviewed a prison doctor in February 2010.

HMP GARTREE

10. HMP Gartree opened in 1966, originally as a category C prison. Within a year, it was converted to a high security dispersal prison and maintained this function for approximately 25 years. In the early 1990s, Gartree was re-categorised as a B category training prison for adult male life sentenced, and now indeterminate sentenced, prisoners. Typically, it holds prisoners in the early stages of their sentence for up to five years and has operational capacity of 575.

11. The prison's purpose is to help prisoners come to terms with their sentences, assess their individual needs and provide specific interventions, such as offending behaviour programmes.

12. Gartree has four residential wings (A to D) with B wing being the induction unit. There is a therapeutic community unit, a healthcare unit and a supervision and assessment unit.

13. Her Majesty's Chief Inspector of Prisons carried out an unannounced inspection at Gartree in April 2008 as a follow up to a full inspection in. August 2005. She noted that a healthcare recommendation made in 2005 had been achieved. The recommendation said:

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

14. This had been achieved by:

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

15. In her summary of the unannounced inspection, the Chief Inspector commented:

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

16. The man questioned his kosher diet throughout his prison sentence. The diet supplied to the Prison Service for Jewish prisoners is prepared in specialised kitchens under Jewish law. The meals are sealed into

Healthcare

17. Gartree delivers both primary and secondary healthcare services, akin to a doctor's surgery and an inpatient facility. The healthcare centre is over 40 years old and somewhat tired in appearance. The IMB commented in 2006/07 that refurbishment plans were currently under discussion at senior and area management level. Despite appearances, the IMB report said that the healthcare centre delivered an "excellent service".

18. When new prisoners arrive, they are seen by a member of the healthcare team in reception and a needs assessment is carried out in the healthcare centre. The healthcare centre and employs registered mental nurses, general nurses, one counsellor and a visiting psychiatrist who carries out, on average, one session every two weeks.

19. The inpatient facility consists of 14 cells, one of which is reserved for continual observation and is fitted with Closed Circuit Television (CCTV) and is a gated cell.

20. The IMB commented that numerous prisoners in the inpatient wing should be accommodated in more appropriate accommodation, such as secure hospitals, where the necessary treatment could be provided.

21. There have been six previous deaths at Gartree since 2004. Some of those deaths are similar to the man's by the fact that they were elderly prisoners with long term illnesses. Some were also challenging prisoners with complex healthcare needs. One recommendation relating to restraints has been considered as part of this investigation and is referred to in the issues section of this report.

KEY FINDINGS

22. In January 2003, the man was remanded into Belmarsh following a court appearance for the alleged murder of his wife. It was noted that he had recently under gone a colostomy (a surgical procedure where part of the bowel is removed and a bag sited externally for the collection of bodily waste). Information was later received that he was under the care of a hospital. Arrangements were made for him to continue his treatment at the hospital and from healthcare staff. Between his first reception into Belmarsh and his conviction, he underwent surgery to reverse his colostomy. He was convicted and sentenced to life imprisonment at Court in August 2004.

23. The man transferred to HMP Swaleside in January 2005. His medical history and on going abdominal pain were recorded in his reception health screen document. In May 2005, he transferred to HMP Kingston and returned to Swaleside in August 2005. Throughout this time he regularly rejected his meals, despite a kosher diet being provided. His general attitude raised difficulties with prisoners and staff, resulting in many adjudications against him for poor behaviour and disobeying orders.

24. A mental health assessment was undertaken by a registered mental health nurse who noted that the man was not suffering from any form of mental disorder or dementia. In addition, it was further noted that he often refused to see healthcare staff or take his medication.

25. In 2006, the man was diagnosed with a lymphoma in his groin. (Lymphoma is a form of cancer in the lymph glands.) He was treated with radiotherapy at Medway Hospital. It was noted that he was accompanied to his first appointments by a Hebrew interpreter, so that he was fully aware of the diagnosis and treatment procedures for his medical condition. However, for subsequent treatments an interpreter was not always present as he already knew of the processes to treat his medical condition.

26. The man's medical notes and wing records refer to frequent refusal to go to hospital appointments if an interpreter was not present, he was having a family visit, it was the Sabbath, or it was a religious holiday.

27. In June 2007, the man was transferred from Swaleside to HMP Elmley following his continued poor behaviour which had resulted in him becoming a victim of hostility from other prisoners. It was agreed that a transfer to Elmley would be in his best interests and that of prisoners in Swaleside. However, he continued to be a challenging prisoner for staff and prisoners at Elmley.

28. In March 2008, a consultant from Medway Hospital wrote to the medical officer at Elmley. The man had refused to undergo a minor surgical procedure, that is a lymph node biopsy, despite special

29. The man complained about the diet he was given by saying it was not Hermolis kosher food. (Hermolis is a brand name.) It was noted that he was receiving the prison standard brand of kosher food, and extra protein of turkey and salmon was provided. A rabbi, a member of the chaplaincy team, also brought food for him, provided by the Jewish community.

30. An Elmley Healthcare Principal Officer (HCPO) told the investigator that the man continued to be demanding of healthcare staff time. He refused medication and was unwilling to cooperate with doctors and nurses even though he was given every opportunity to access services. She added that he was able to understand English and could construct an argument in the language. The HCPO said that the man needed to progress, in terms of addressing his offending behaviour and programmes. Elmley did not provide the relevant courses for him and so he transferred to Gartree where appropriate programmes would be available.

31. In December 2008, the man was received into Gartree. He was seen by a doctor at reception, who wrote in his medical notes that he had a history of lymphoma. A medication sheet was complied and the doctor arranged to see him in a weeks' time. The man was placed on the induction wing (B wing), in a single cell.

32. The following day, a Senior Officer (SO) wrote in the man's personal record that, although he told her he could not understand English, he had already complained to staff and demonstrated a good understanding of the language. Later that day, another SO wrote in the personal record that the man demanded that his food should be changed. The SO asked him to adopt a more polite and acceptable manner of behaviour on the wing.

33. The SO wrote in the man's personal record in December that he complained about his food and was taking up staff resources by his poor behaviour and attitude. The SO advised him on the complaints system procedure should he wish to raise issues about his food. Two days later, the SO contacted the Head of Jewish Chaplaincy to confirm aspects of Jewish customs for the Sabbath and kosher meals. The rabbi told the SO that he knew the man and the issues around his management and meals. The rabbi advised the SO on Jewish laws.

34. In December, the SO met the man and Catering Officer. Despite some debate over the diet provided and advice from the Catering Officer, the man refused to accept his help and arrangements were made for him to receive salad trays and eggs every Tuesday and Friday. (This food

35. The man saw the doctor in January 2009, as his right leg was swollen. The doctor referred him to a consultant in an outside hospital for a review of his lymphoma. Later, the SO issued him with a verbal warning for failing to keep his cell clean and his lack of personal hygiene. The SO noted that he refused to put his clothes into the laundry and prisoners were complaining of an unpleasant smell from his cell.

36. An entry was written in the man's personal record in January by an officer. The officer had received complaints from prisoners on the wing that the man was peering through the observation panels in their cell doors whilst they had free time. (Free time or association is a period of the day when prisoner's cells are unlocked and they can access communal areas on the wing.) One of the prisoners told the officer that, if he continued with his current behaviour then an assault would be inevitable. The officer told the man to stop this behaviour as it was upsetting prisoners; however, he denied the allegations. The officer reported this to the duty SO for wing staff to be aware of the situation.

37. In January, the man refused to change his clothes. It seemed that he was under the impression that he had to pay for a change of clothes although the SO had advised him that this was not the case. He still regularly refused his kosher meals each day, despite encouragement from staff. The following day, the SO asked him to come to the wing office so she could speak to him about his diet, refusal to take meals and general poor behaviour. The SO noted that he did not engage with her and referred him to the healthcare unit for a mental health assessment.

38. The man was seen in healthcare in January by the triage nurse. He complained of pain in his leg and the nurse wrote that his leg was still swollen. He refused to take prescribed pain relief by saying it was not the correct brand. The nurse explained that it was the same prescription but in a different package. He was insistent that he would only take a specific brand.

39. The next day, the man had a mental health review with a mental health nurse. The nurse wrote in his medical notes;

> "Unable to fully communicate with the man but no answers were related to the questions asked. He continually asked about his medication but when I tried to explain I was here to ask about his mental health he reverted back to a list of medication. Difficult to determine if it is a language barrier or reluctance to talk with myself – will refer to MHT [Mental Health Team] to have reviewed by another member of staff."

40. In January, a Principal Officer (PO) wrote in the man's personal record that he had seen him and was concerned about his health. The PO noted that his leg was swollen. The PO contacted healthcare staff to report his concerns over the man's medical condition. He was due to see the doctor the next day.

41. The following day, the man was examined by the prison doctor. She wrote in his medical records that the swelling to his right leg had increased and there was further swelling to his scrotum. The doctor arranged for him to be admitted to a hospital. A risk assessment was completed and he was escorted to hospital by two officers with an escort chain. (An escort chain is a 1.8 metre length of chain with one cuff attached to an officer and the other to the prisoner.)

42. On arrival at the hospital at 5.30pm, the man was admitted to a ward for observation. At 8.30pm the officer wrote in the bed watch notes that the man had refused to have a catheter inserted, or pads placed on his bed to absorb urine. (A catheter is a tube inserted externally into the bladder to drain urine.) It was further noted that he was argumentative with hospital staff. He refused to walk to the toilet as he would not use slippers provided for him, and he would not use a urine bottle. It was thought that he was deliberately urinating on to his bed, so that the nurses had to constantly change his sheets.

43. At 10.10pm, the man refused to take his medication stating that it was not his. When the nurse explained it was the medication prescribed by the doctor he used a dismissive gesture and shut his eyes. He continued to urinate in his bed, became increasingly argumentative and rude to both escort and nursing staff. At one point, he threw the slippers at the bed watch escort and she issued him with a warning about his poor behaviour.

44. The following day at 6.30am, the man was placed on a discipline report for further poor behaviour towards a nurse and the bed watch escort. She noted that his rudeness and aggression continued. At 7.05am she made contact with the SO at Gartree to report the situation.

45. At 7.30am two further officers took over bed watch duties and they recorded that the man's poor behaviour continued. He refused to be taken for an ultrasound scan (a procedure to examine the internal body) at 10.00am. A short while later, he declined to take a hospital's consultant's advice and discharged himself from hospital. He arrived back to Gartree at 12.30pm.

46. In January, it was written in the man's personal record that he smelt strongly of urine and was walking on the wing with wet trousers. Wing staff contacted the healthcare unit and the prison doctor went to his cell to examine him. The man refused to see the doctor.

47. A Mental Health Nurse saw the man in February. She wrote in his medical notes:

> " Seen today following a request for a second opinion. The man appeared to understand adequately what I was asking of him in respect of his mental health and wellbeing. He choose however not to answer any of my questions, preferring to ask his own about his physical needs, his medication and getting an appointment with a doctor. I declined to enter into a discussion about any issues other than his mental state therefore the interview was a short one."

48. The man went to the healthcare unit in February for an emergency appointment and demanded to see another prison doctor. The nurse told him that he had been offered several appointments the previous week and declined to attend them. The nurse discussed his demand with that particular doctor who said that the man should see a doctor the next day.

49. At 11.33pm, a nurse was called to see the man in his cell as he was complaining of stomach discomfort. The nurse examined him and recorded, low blood pressure of 110/70 (the average reading is 130/80), a pulse rate of 82 (the normal reading is between 70-100) and a temperature of 36.5 (a normal reading). He was given some medication relieve his discomfort and the nurse noted that he was due to see the doctor the next day.

50. In February, a prison doctor wrote in the man's medical notes that he refused to see him. The man refused to go for an out patient hospital appointment the following day. An officer wrote in his personal record that, despite encouragement from wing staff and prisoners, he consistently refused to be taken to hospital, and also declined to sign a disclaimer form.

51. The SO wrote in the man's personal record that on four consecutive days starting from February, she was concerned about his aggressive and non compliant behaviour. He was still rejecting some of his meals, his personal hygiene was poor and his cell was dirty. In February, he saw a doctor in the healthcare unit. The doctor wrote that his legs were still swollen and he became aggressive during the consultation after demanding to be transferred away from Gartree.

52. In February, the SO wrote in the man's personal record:

> "The man had a visit booked with his family this afternoon he was unlocked and reminded about the visit but failed to get there. When an officer checked on him he had fallen asleep, uncharacteristically. He did not seem concerned that he was late for the visit. The officer escorted him to visits and he again stated that the prison was trying to kill him and he cannot eat the food because it is poison."

53. The Head of Healthcare in February wrote in the man's medical notes that she discussed his deteriorating health and lack of engagement with nursing staff, wing staff, the rabbi and Governor. A case conference was to be scheduled to put in place arrangements for his ongoing care. Later, a nurse visited him in his cell as he told wing staff he was unwell and refused his medication. He ignored the nurse and declined her assistance.

54. An Assessment, Care in Custody and Teamwork (ACCT) plan was opened in February by the SO. The SO wrote that her concerns focused on the man's refusal to take meals and medication. In addition, the SO included information about his failure to engage with staff. He refused to go to his ACCT review. A plan of his care noted that officers should regularly talk to him when his cell was unlocked, to monitor his food intake, and make hourly observations.

55. In February, the man was seen in his cell by a Forensic Psychiatrist. The doctor managed to engage, for a short time, with him and they discussed his food and medication refusal. The doctor noted that he looked gaunt, his legs were swollen and his health was poor. He told the doctor that staff at Gartree and Elmley were trying to kill him by poisoning his food. However, as the interview progressed he became non co-operative and aggressive.

56. The doctor wrote:

> "Given his [the man's] apparently delusional beliefs about his food being poisoned and the serious impending complications of his physical health, discussed with the prison doctor today, it is necessary to seek a full assessment of his mental state. In my opinion, he will require conditions of medium security and I will refer him to the appropriate unit."

57. The mental health nurse saw the man in February to check his fitness to go to two adjudication hearings. (An adjudication is an internal discipline hearing for failure to comply with prison rules.) He denied that he had two adjudications, although staff had presented him with the paperwork the previous day. The nurse offered him some respite care in the healthcare unit which he declined. An hour later, he was seen in his cell by another nurse who judged that he was not fit for the hearings.

58. In February, the SO wrote in the man's personal record:

> "The man has been told several times he has a visit this afternoon from his family. He was unlocked for this but did not come down for the visit. I went to his cell and tried to speak to him. He was sat with a blanket over his head (possibly a prayer blanket). He refused to speak to me or look at me. I made it clear he had a visit from his family and he needed to make his way there. I left him for

10 minutes, then returned to speak to him in the presence of two officers. The man again ignored me. I again told him his family were here to see him. I said that ignoring me and refusing to attend visit I could only conclude he did not want to go to his visit this was his one chance to tell me. He remained silent so informed i/c [officer in charge] visits he had refused to attend."

59. In February, the man transferred to the healthcare unit on the order of the Governor. At first he refused to go, however after some persuasion, he eventually agreed to go with the support of staff. He was reviewed later by a prison doctor, who wrote that he looked clinically dehydrated and had lost weight. The doctor noted that he needed another psychiatric review and a fluid chart was established to monitor the amount of liquids taken.

60. Later that day, the man was assessed by another doctor. This doctor wrote that he still looked dehydrated and unwell. His clothes were wet with urine and he would not allow the doctor to approach him. The doctor contacted the forensic psychiatrist, the Head of Healthcare and healthcare staff. The forensic psychiatrist told the doctor that a place in a medium secure unit would take at least two to three weeks, as one closer to his family in London was desirable. The doctor then made the decision to admit him to hospital.

61. At 5.00pm, an ambulance arrived to take the man and his escort of two officers to hospital. He refused to go and help was offered by the paramedics. He said he was not ill. He became aggressive to towards staff and told them to leave his cell. The ambulance left the prison and he remained in the healthcare unit. A daily care and nursing plan was started and it was noted that should he become poorly and unresponsive, then an emergency ambulance should be summoned.

62. The doctor reviewed the man in February. The doctor wrote that he refused to engage with him but he did look more hydrated than previously. Later an ACCT review was undertaken by two nurses. The review noted that that he had taken a shower and seemed a lot brighter. The rabbi and the man's family had brought food into the prison for him, which he seemed to have eaten.

63. In March at 00.22am, a nurse wrote in the man's medical notes that he had fallen in his cell. His trousers were around his ankles and fluid was on the cell floor and his bedding. As staff tried to help him and clean his cell, he lashed out at the nurses. An ambulance was requested as staff were unable to assess any injuries to him. When the paramedics arrived, he refused to be examined but they were able to lift him back into bed. Later that day, an ACCT review noted that his physical and mental health needs were being monitored along with hourly observations.

64. The nurse wrote in the man's medical notes that he assaulted two members of healthcare staff in March. He was in a poor physical state and, although there were empty food containers in his cell, he appeared to have lost weight. There was also a strong smell from his cell. He agreed to have a shower and wet clothing was taken from his cell.

65. Two days later, the prison doctor wrote that the man refused to acknowledge her when she went to his cell to examine him. The doctor noted that he had been verbally abusive to staff. She concluded her entry in his medical notes by adding that he was waiting for a transfer to a secure unit for a psychiatric review.

66. In March, a healthcare officer noted that the man had bathed in the morning following some resistance. The officer wrote that he was unsteady on his feet and looked dehydrated. Later, he was seen by a prison doctor. The doctor wrote that he was frail, the observations of his blood pressure were recorded as 115/69 and his pulse rate was 102. The doctor encouraged him to drink more and advised staff to closely monitor his fluid intake. At 7.40pm it was noted that he had been abusive to staff and kicked a nurse.

67. Another doctor assessed the man in March. The doctor wrote that he had accepted food and fluids, but there was some uncertainty as to whether he had eaten or flushed the food away. The doctor noted that he looked dehydrated and still refused to let staff near him. The doctor arranged for him to be admitted to hospital for observation and assessment. An escort of two officers was arranged and he was transferred to hospital, arriving at 11.00am on an escort chain was in place. His family were contacted and advised of his admission to hospital. His ACCT plan was taken to the hospital and remained in place.

68. The man was placed on a side room in the clinical assessment unit. At 4.00pm his daughter and son arrived to visit him, leaving at 6.00pm. (His family then remained in the local area of Leicester so they could visit their father and spent all their days at his bedside.) At 9.00pm, he transferred to a side room of a ward.

69. The following day at 6.20am, it was noted that the man had hit out at hospital and escort staff. An hour later, it was written in the bed watch notes that he had exposed himself and threw a towel at one of the escort officers. At 9.00am, he was noted to have wet his bed and attempted to urinate over an officer.

70. The record for March at 7.10am, states that the man continued to urinate over his bed and floor and was aggressive to staff. At 8.10am, bed watch staff telephoned the Orderly Officer at Gartree for advice on how best to manage his behaviour. It was agreed that he should be placed on a double cuff restraint should his aggression continue. (A

71. At 8.25pm, the Night Orderly Officer (NOO) at Gartree agreed to a hospital staff request that the man's family be allowed to bring him food. The next day at 11.25pm, the hospital doctor informed the bed watch staff that his restraints could be removed as he posed little threat to staff and himself. The doctor wrote this comment on the bed watch notes. One of the escort officers telephoned the duty governor to inform her of the doctor's comments. The governor agreed that the escort chain should be removed.

72. Less than two hours later, the man seemed to be brighter but became aggressive towards a nurse, attempting to lash out at her. The escort officer re-applied the escort chain and telephoned the Night Orderly Officer (NOO) at Gartree to inform him of his actions. (A NOO is a senior member of staff on duty during the night.) The NOO confirmed that restraints should be applied. The officer spoke to the man in Hebrew and was able to calm him. The officer also told the investigator at interview, that whilst he was weak and frail he did have short bursts of energy when he became physically aggressive. An SO wrote in the bed watch notes at 9.30am that the man had lashed at a nurse and dug his nails into his hand.

73. The bed watch notes record that at 5.05pm, following a routine check by prison managers, the duty governor's permission should be sought if the doctors advised that restraints are unnecessary. (A routine management check is carried out daily by senior prison staff to ensure the safety and security of the prisoner, staff and public.)

74. The man had become calmer after sedation had been administered. The presence of his family, who were staying by his bedside around the clock, also had a soothing effect. However, the bed watch notes say that his family challenged the use of restraints. It was explained that this was prison procedure and management checks were carried out every day to confirm that the use of restraints was appropriate. It was further noted that his family were able to manage the man's aggression.

75. The bed watch notes indicate that the man was showing signs of improvement and was communicating with his family. Additionally, his sons helped and prison escort staff with their father's personal hygiene and changing his bed.

76. A bed watch escort wrote that one morning there were concerns about the amount of family intervention with the man's care. They spoke in Hebrew to their father and so the escorting officers did not understand what was being said. The family asked the officers to be quiet when

77. The following day the bed watch notes record that the man was again showing signs of improvement. At 6.10pm a bandage was placed on his wrist to protect it rubbing against the restraint.

78. The governor carried out a management visit to the hospital and he had a conversation with a hospital doctor. The doctor raised concerns regarding the man's safety, his security and public protection issues. Although his condition was deteriorating the doctor felt the restraints were still appropriate. On his return to Gartree, the Governor completed a Security Information Report regarding what the doctor had told him and updated the man's risk assessment.

79. The man's condition continued to deteriorate. Hospital staff were unable to place an intravenous line (a drip to provide fluid) into a vein. Later a nurse explained to his family that their father was nearing the end of his life. At 12.30pm the following day, a nurse alerted bed watch staff to his poor medical condition and that he was near to death. The bed watch escort contacted the duty governor who authorised the immediate removal of restraints. The man's family were present at his bedside when he died. His death was confirmed at 12.54pm.

80. The man's family were seen at the hospital by the duty governor shortly after their father's death. The duty governor conveyed his condolences and offered any assistance they may need. A few days later, family liaison officer telephoned the man's son. She was unable to speak with the family as they were in a period of mourning. She told the investigator that she has since made several attempts to contact the family to which they have not responded. A letter of condolences was sent to the man's family by the Governor. The prison offered financial assistance towards his funeral and the offer was declined.

ISSUES

81. The man's family made a statement to their solicitor commenting on their father's care whilst at Gartree. Their concerns included his diet, mental health, physical care by healthcare staff and visiting orders. A review of his clinical care was undertaken by the clinical reviewer on behalf of the local PCT.

The man's use of English

82. It was sometimes recorded in the man's medical notes and personal file that he might be unable to understand English and so wanted an interpreter. He had lived in London for over 40 years and been a business man. During his cancer treatment at hospital an interpreter was used at appropriate appointments. However, the HCPO told the investigator that the man was able to use English and understood what said to him.

83. At interview the rabbi further told the investigator that the man could understand English. He spoke to the rabbi in Hebrew, and the rabbi replied in English.

84. From evidence provided in interviews with prison staff, prisoners and the rabbi, it would seem that the man was able to understand spoken English.

Hospital appointments

85. For security reasons prisoners are not told the times and dates of their hospital appointments. Likewise, families are also not informed of dates of hospital appointments and are therefore unable to be present. However, I am pleased that the prison allowed the man's family to remain at his bedside from the time he was admitted to hospital until his death.

Diet

86. Whilst at Elmley, the man was given extra meals of turkey and salmon as he refused to accept the choice offered in the menu of kosher food sent to the prison. It was felt that this was due to his personal preferences rather than any other reasons. There was no record of any medical reason for foods that he should avoid, although reference is made to his food preferences and the need for extra protein.

87. The SO arranged a meeting between the catering manager and the man shortly after his arrival at Gartree. Following that discussion he was given salad trays and eggs twice a week, to store in the wing refrigerator and supplement his diet. Despite encouragement from wing staff and prisoners, he regularly refused to accept his hot kosher food. The rabbi told wing staff that if he refused his lunch then he

88. The clinical reviewer noted in the clinical review that the man was unhappy with the food supplied to him. The doctor was unable to verify from the medical notes that the man was told not to eat certain food types. However, it was recorded that he had regularly asked prison doctors to do this whilst at Swaleside. There is no record of the man raising this issue with the prison doctors at Gartree.

89. Both Jewish chaplains arranged for kosher food to be brought into the prison for the man. This is not a usual arrangement and I note the sensitivity of the managers of Gartree and Elmley in agreeing to this.

90. The clinical reviewer noted:

> "I can find no evidence that HMP Gartree failed to supply sufficient food of the correct type to the man, rather it appears he did not eat the food supplied."

Care by wing staff

91. The man presented challenging behaviour from the time of his reception into Gartree and his location on B wing. Both Senior Officers managed to ensure that he remained safe and constantly offered support, which he declined. I believe the high standard of the entries in the wing history sheet and his personal file reflect the quality of care by wing staff.

92. One SO opened an ACCT for the man following his rejection to take the kosher food ordered for him. Whilst it was not thought that he refused food for reasons of self harm, his refusal of his meals was impacting on his physical health. Virtually every day, and sometimes twice a day or more, his personal record held entries of the interaction between him and with staff.

93. Concerns about the man's behaviour and attitudes led him to be referred for a mental health assessment. It was identified that his behaviour was so fixed that it was thought to be beyond normal and acceptable. However, from his first reception into the prison system he had displayed similar behaviour albeit not so intense.

94. I believe that wing managers and the staff of B wing largely accepted the man's behaviour and recognised that, whilst he was difficult to manage, he was an elderly man likely to have mental health problems. He was treated equally with other prisoners and subject to prison discipline rules, although he was judged unfit to attend his adjudications.

95. As well as considering whether the man's lack of cooperation might be a result of his mental health needs, wing staff also ensured that they took advice from the Jewish chaplain to ensure that his cultural and religious beliefs were considered.

96. I acknowledge the compassion, support and assistance provided by B wing staff in caring for the man in what were complex circumstances.

I commend both SOs for their management of the man and ensuring that B wing staff were kept informed of the issues around his behaviour. I also note the high standard care by B wing staff in their day to day involvement with him.

Visits

97. The man would have been allowed two visits a month plus two privilege visits. It seems that there was some breakdown in communication in arranging visiting orders for him when he was taken into the healthcare unit and was seemly unable to make his own applications.

98. His family commented on problems they experienced receiving visiting orders. From records at Gartree the following visits were arranged; December 2008, January 2009, February 2009 and March 2009. Four visiting orders were issued to his family in March 2009, however he was admitted to hospital.

99. A prisoner on B wing told the investigator that he helped complete the man's visiting orders when he first arrived at Gartree. In February 2009 he had to be persuaded to go to a visit to see his family and declined to attend a later visit.

The Governor should ensure that prisoners who are unwell are helped to apply for visiting orders.

Healthcare

100. The man transferred to healthcare on the specific order of the Governor. His behaviour had become difficult to manage on a normal wing. In addition, his physical health had deteriorated to the extent that there were serious concerns about his well being.

101. The man was allocated a single cell on healthcare. His ACCT document remained open and a care plan was introduced, which included a chart to track his fluid intake. However, he remained aggressive towards staff and frequently failed to engage with them.

102. In February, the prison doctor arranged for the man to be admitted to hospital but he refused to go. Three weeks earlier, a forensic psychiatrist had referred him to a medium secure unit. Although the

103. The man stayed in the healthcare unit being cared for and closely observed by nursing staff. He seemed to have been a difficult patient, he kicked and hit nursing staff on several occasions and did not take care of his personal hygiene.

104. Healthcare staff and the doctors continued to care for the man to the same high standard as that of wing staff. They tried to encourage him to eat, take fluids and wash, but he failed to engage with the staff and they found his aggression was hard to manage.

105. The clinical reviewer noted that referrals were made appropriately and appointments re-booked where possible.

I note the high standard of professionalism by all members of staff in the healthcare unit caring for the man.

The man's mental health

106. The man's mental health was a concern for his family and wing staff. His family referred to his distressed state when they visited him Gartree and his unhappiness at being transferred there. Whilst Gartree is some distance from the family home in London, the distance is not dissimilar to that to Elmley. Gartree is designated for prisoners serving a life sentence with programmes to address their offending behaviour.

107. Many assessments were made of his mental state, including two assessments by mental health nurses in Gartree and one by a forensic psychiatrist. They were difficult to undertake given that the man did not cooperate. The forensic psychiatrist thought that transfer to a medium secure unit would best serve his mental health issues and a place was being sought in a unit nearer to his home in London. At no time was it thought that he was a risk to himself or others, and so he could not be detained under the Mental Health Act.

108. The clinical reviewer noted that a CT scan (taken whilst he was in hospital) did not show any evidence of a physical lesion in his brain or the progress of a dementia which might explain the development of his personality behaviour. A formal assessment of his mental health was not possible and the identification of a mental health disorder, such as depression of paranoid psychosis, remained a possibility.

109. There was no evidence to detain the man under the Mental Health Act. He could not be compelled to accept treatment and so he could make decisions about his care which may not have been in his best interest.

"I conclude that the Prison Service and particularly HMP Gartree, did all they could to consider both the man's physical and mental health appropriately."

Bed watch

110. The man was admitted to hospital for less than 24 hours in January. His conduct in hospital was disruptive and the bed watch escort issued a formal warning. The bed watch notes were well written and recorded in great detail his challenging behaviour towards prison and hospital staff.

111. In March, the man was admitted to hospital. His family were told and travelled from London to be with their father. They were granted permission to stay at his bedside throughout his illness. I note this sensitive decision by managers.

112. The bed watch notes indicated that the man's behaviour remained disruptive throughout his time in hospital.

113. Bed watch staff assisted hospital staff and the man's family in caring for him. The bed watch notes include entries referring to the practical help officers gave to ensure he was kept in a hygienic environment whilst his bodily functions were deteriorating. Again, the bed watch notes were well written with clear informative entries.

114. The man was also visited every day by senior prison managers, who spoke to his family and ensured that the bed watch officers were supported and the security issues were constantly assessed.

115. A bed watch escort told the investigator that when he carried out bed watch duties, he spoke to the man in Hebrew. This calmed him as did the presence of his family. However, the officer said the man had short bursts of energy and quickly became aggressive. The officer was able to interact with him using his language skills and cultural knowledge.

    I acknowledge the professional care and practical support afforded to the man and his family by bed watch officers, especially one bed watch officer, when he was admitted hospital.

Restraints

116. The man's family questioned the use of restraints which they thought was excessive. However the information in the bed watch notes about his behaviour and attitude towards prison and hospital staff indicate that they were appropriate. Daily management checks were carried out by senior prison staff and the use of restraints were reviewed daily.

117. A report into a death of another elderly man at Gartree in 2006 raised concerns about the late removal of restraints from a seriously ill prisoner. A recommendation regarding the excessive use of restraints was. The man was restrained until ten minutes before his death. Whilst I am uneasy that the restraints were not removed earlier, I acknowledge that hospital staff raised their concerns to the governor three days before the man died. Their anxieties related to the security of him, his safety and that of hospital and escorting staff.

118. The clinical reviewer also notes in the clinical review that the man was restrained up to the final moment before his death. The doctor said;

> "In view of his [the man] violence to NHS staff, despite his frailty, this was appropriate."

119. It is always difficult to balance the use of restraints with the care and dignity of the prisoner. Indeed, I have had cause to make many recommendations regarding this issue. The man was an elderly man, his prognosis was poor and he was bed ridden. However I accept the reasons why the restraints were not removed until minutes before his death.

Cause of the man's death

120. The clinical reviewer examined the man's medical notes, his CT scans and considered the issues raised by his family. The clinical reviewer noted that he received radiotherapy for lymphoma which was diagnosed in 2006 whilst he was in custody at Swaleside. He had been offered treatment but only attended his radiotherapy sessions on an intermittently despite efforts to ensure that his requests for an interpreter were met. In July, his treatment was cancelled as his failure to attend the appointments meant the treatment would not be effective. The clinical reviewer said:

> "It is possible that treatment which was more in line with the usual plan for this type of illness would have prolonged the man's life but the prognosis with the type of lymphoma (a follicular lymphoma) he had has to be guarded."

121. A CT scan in March 2009 indicated that the lymphoma had enclosed the main artery taking blood to the body and legs. The man had urine collecting in both kidney areas with stones. The scan showed patches of pneumonia and an area of abnormal bone density in his pelvis. This could have been part of his Lymphoma.

CONCLUSION

122. The clinical reviewer concluded in his review that the man's circumstances made getting his cooperation particularly hard. The doctor said:

> "The man's care was at least equitable with that in the wider community as he was referred appropriately for various medical problems that needed specialist help and when he declined to attend the out patient visits arranged for him return visits were arranged on his behalf. It is also clear from the records that he was aware of the potential disadvantages of not attending these appointments as exemplified by the entry in March 2007. This might not have been the case if he had lived in the community, particularly if he was alone. I appreciate that he had a family who would have been able to help in these circumstances but not everyone is that fortunate."

123. From all the evidence in the man's prison records and interviews with staff and prisoners, it seems that he did not conform to prison rules and often challenged the regime. He was offered kosher meals and it was his decision to refuse to take the food. As his physical health and mental wellbeing deteriorated I believe that he was cared for by both wing and healthcare staff. Whilst I understand his family's distress at seeing their father become increasingly frail whilst he was at Gartree, I am satisfied that he was well looked after despite his failure to accept advice and support.

Family response to draft report.

124. In November 2009, solicitors acting on behalf of the man's family wrote a lengthy document to the Ombudsman's office, raising concerns over the draft report, its findings and conclusions. As a result of those concerns two of my colleagues interviewed the forensic psychiatrist in February 2010 to clarify some of the issues the family have raised. I have dealt with some of those concerns below and further issues are dealt with in response letter to the family.

Interview with the forensic psychiatrist

125. The forensic psychiatrist told my colleagues that he had assessed the man in February 2009, in his cell at Gartree. The doctor said the assessment was hindered by the man's insistence that he only wished to talk about his prison categorising rather than his mental health.

126. As result of the assessment, the doctor made a referral for the man to be transferred to a medium secure unit in London. There are set timescales for referrals and as far as he was aware the referral was progressing within the timescale. The referral was not urgent as his mental health, whilst concerning, did not warrant immediate transfer.

Common Law powers

127. The doctor noted that patients can be forced to accept medical intervention except where religious or cultural issues prevail.

128. The draft report noted that when the man was taken to hospital in January 2009, he discharged himself the following day. However, doctors at the hospital did not regard his mental health to be of concern, for him to make that decision.

129. Furthermore, in February, a prison doctor arranged for the man to be admitted to hospital. He refused to go with the ambulance service saying he was not ill and it was noted that he was aggressive. He was frail and realistically to forcibly remove him from his cell may well have resulted in him being physically injured. The decision was made for him to remain in the healthcare unit, under nursing supervision, with a note that should be become unresponsive then an emergency ambulance would be summoned.

130. Taking into account these circumstances it is understandable that force was not used to remove the man from his cell for a transfer to hospital under common law power.

Restraints

131. We recognise and acknowledge the distress of the man's family in relation to the late removal of restraints. The reasons for restraints being used until he was close to death have been previously discussed. For security reasons we are unable to disclose as to why this decision was made. Nevertheless, it was extremely stressful and upsetting for his family.

The man's family's contact with Gartree

132. The man's family made contact a senior member of staff at Gartree, on many occasions prior to him being admitted to hospital in March. That contact was to raise their concerns over their father's welfare and his mental health.

133. It has already been discussed that his referral to a medium secure unit was already being processed, within the structures as set down by the Department of Health. The staff at Gartree could only re-assure his family that their father's care was of great concern to them however, procedures were in place and the correct protocols were being followed. The rabbi was visiting him on a regular basis to provide spiritual and emotional support.

134. The ill health of a family member who is held in custody is traumatic for families. Again, I empathise with the family's distress over their father's ill health whilst he was in custody. Gartree could only act within the confines of prison regulations and did allow the man's family to remain at his bedside, from the time he was admitted into hospital until his death.

RECOMMENDATIONS

For the Governor at Gartree

1. The Governor should ensure that prisoners who are unwell are helped to apply for visiting orders.

   Accepted – "Head of Residence to instigate a system to ensure that any prisoner who is unable, or has difficulty through illness or infirmity in completing Visiting Orders is provided with assistance. Pending this, temporary arrangements have been put in place immediately."

2. I commend both SOs for their management of the man and ensuring that B wing staff were kept informed of the issues around his behaviour. I also note the high standard care by B wing staff in their day to day involvement with him.

3. I note the high standard of professionalism by all members of staff in the healthcare unit whilst caring for him.

4. I acknowledge the professional care and practical support afforded to the man and his family by bed watch officers, especially a particular bed watch escort, when he was admitted hospital.