Investigation into the circumstances surrounding the death of a prisoner at HMP Gartree in February 2007

Report by the Prisons and Probation Ombudsman for England and Wales

September 2008

This is a report into the circumstances surrounding the death of a prisoner who died at HMP Gartree in February 2007, having been taken ill earlier in the day whilst his partner was visiting him. He was subsequently admitted to the health care in-patient centre and that evening was discovered dead from a heart attack. The man was 40 years of age.

I wish to extend my condolences to the man's long-term partner, together with his other friends and family. To lose a loved one at any time is difficult, but especially so when they are relatively young, die suddenly and are in custody.

This investigation was carried out by one of my colleagues. A clinical review was undertaken by a doctor from the local Primary Care Trust (PCT) for which I am most grateful. I included the clinical review as an annex to earlier versions of this report and I would urge the PCT to consider its findings as well as my own recommendations.

I am indebted to the Governor of Gartree for her support and attention to my investigator's early concerns regarding clinical practice at the prison. It is rare that I feel the need to be critical of an individual staff member's practice, but in this instance I have felt it necessary. It is evident from my investigation and from the clinical review that, had this man received more appropriate treatment (referral to outside hospital), he would have stood a much better chance of being alive today.

I make nine recommendations and one point of good practice in this report.

Stephen Shaw CBE
Prisons and Probation Ombudsman **September 2008**

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SUMMARY

The man died in February 2007 at HMP Gartree.

The man was convicted of murder at Crown Court on 5 December 2005, and received a life sentence. He was transferred to HMP Gartree on 13 July 2006 from HMP Woodhill.

During the man's early days at HMP Gartree, the priority for both him and staff at the prison was to assess and manage his mental health. The man was diagnosed, not with a mental illness, but with an 'emotionally unstable personality disorder'. The treatment was to be cognitive support, counselling and an adjustment of his medication.

There were times of emotional distress for the man, and he was assisted through these crises by prison staff, the Assessment, Care in Custody and Teamwork (ACCT) process, and by mental health in-reach staff.

On an afternoon in February, 2007, the man went to the visits area in the prison to meet his partner and a friend. During this visit, the man felt unwell and was suffering from chest pain. Healthcare staff were called to assess and treat him. The nurse who saw the man believed him to be suffering from stress and anxiety as the following day was an anniversary date of some significance for him. The man was reassured and continued his visit.

After his visit, the man returned to his residential unit. He again felt unwell and nursing staff were called to see him. Once more he was experiencing chest pains, but nursing staff continued to believe this was due to anxiety and indigestion. However, he was admitted to the healthcare unit in order for his condition to be monitored.

At approximately 8.45pm, when the night staff for the healthcare unit arrived, the man was discovered dead from a heart attack.

THE INVESTIGATION PROCESS

1. One of my investigators made initial contact with HMP Gartree to ensure that Notices to Staff and Prisoners were issued for display. My investigator also made arrangements for prison papers to be sent to this office and made contact with the prison's liaison officer and family liaison officer.

2. Another of my investigators visited HMP Gartree on 30 March 2007. He met the Governor, members of the healthcare team, the family liaison officer and the prison liaison officer. My investigator was shown around the prison and saw the healthcare centre where the man died, together with the visits area and residential accommodation where the man had been unwell on the day he died. My investigator was also introduced to members of the local branch of the Prison Officers' Association, but no members of the Independent Monitoring Board (IMB) were available on this occasion. I am grateful to the Governor and her staff for the consideration and assistance given to my investigators throughout this investigation.

3. The local Primary Care Trust (PCT) was asked to undertake a clinical review of the care the man received while in custody. A doctor who works as a GP undertook this review on behalf of the PCT. The doctor was asked to look at the entries in the man's clinical record and the quality of such entries. The doctor was also invited to judge whether the care the man received while at Gartree was appropriate and of equal standard to that that he might have expected had he been at liberty. In particular, the doctor was asked to consider the response of healthcare staff to the man's three presentations of chest pain on the day he died.

4. On various dates between June and August 2007, my investigator and the doctor undertook interviews of staff at HMP Gartree. The doctor also spoke with the man's next of kin, to gain information about his visit to the man that took place on the day the man died.

5. On 5 March 2007, one of my own Family Liaison Officers, spoke with the man's partner on the telephone. She explained the investigation procedure and invited him to raise any questions. He raised a number of issues of concern. Chief amongst these was the man's care under the mental health services whilst at HMP Gartree, a matter dealt with in the clinical review. The man's partner also asked why the healthcare team had not been able to identify the seriousness of his partner's condition on the day he died. I hope this report goes some way to addressing these concerns.

HMP GARTREE

6. HMP Gartree is located three miles north of Market Harborough in Leicestershire. It opened in 1966 as a category C prison. It was upgraded to form part of the high security group of prisons in the 1980s, but in the early 1990s it was re-graded to a category B training prison for adult males. It holds life sentenced prisoners in the first and second stages of their sentence. Gartree has an operational capacity of 577 prisoners. Two new units were added in November 2006.

7. Ms Anne Owers, Her Majesty's Chief Inspector of Prisons, last reported on Gartree in May 2005 when she found the prison wanting in its delivery of lifer services. She described Gartree as 'showing all the signs of a prison that had been drifting …' She described healthcare services as giving her cause for serious concern. She was particularly worried that staff shortages, coupled with inappropriate use of healthcare staff for discipline roles, were leading to poor service delivery. There were 14 beds within the healthcare centre, but only two of these beds were allocated to clinical need. This meant that healthcare staff were used to supervise non-patient prisoners, thereby detracting from their clinical duties. This situation continues to date.

8. One of the other serious failings identified by the Chief Inspector was the use of nurse triage without any formal training – a feature in this man's death. However, I am pleased to report that there have been significant steps forward at HMP Gartree from the time of the Chief Inspector's report and the man's death. There are now some 15 members of the healthcare team (a Band 8a leader, with two Band 7s – one for primary care one for mental health care; six RMN Band 5s including two HCOs with mental health qualifications; three RGN band 5's plus two HCO's without qualifications) leaving just one post currently vacant. The action plan from the 2005 Inspection report has largely been implemented with just the one major area of concern outstanding. This is tied up with the number of places Gartree can offer to the Prison Service and means that, for the time being, the inpatient unit has to continue to provide cell spaces for non-patient care.

9. This man's death was one of eight deaths that have occurred at Gartree since I began investigating all deaths in custody in April 2004. In one of my earlier investigations (2006), I made similar recommendations to those contained in this report. Although Gartree has only had two months to implement those recommendations, I am told they have already done so. I hope this will leave the prison better able to deliver healthcare to the prisoner patient population.

KEY FINDINGS

10. The man arrived at HMP Gartree on 13 July 2006. He appears to have settled in quite well, although he liked to largely keep himself to himself. He struck up good relationships with some staff, particularly his personal officer and one of the chaplaincy team. He also underwent some psychological and mental health nursing interventions to help him with his coping skills.

11. The man had a number of episodes of self harm or cause for concern from staff such that he was put onto an ACCT document. (ACCT is a flexible, prisoner centred assessment and care planning system, which aims to identify individual needs and offer personalised care and support before, during and after crisis, in a safe and caring environment.)

12. During the man's relatively short time at Gartree, he engaged with the healthcare team and the psychology department, in respect of issues relating to his offence and his continued personality disorder. He worked on a one to one basis and had considered asking for a trial at HMP Grendon (which operates as a therapeutic community). It was agreed in one of his sessions that he should find out more for himself about Grendon, and then apply to go there when he felt ready. At the time of his death, he had not made a formal application to transfer.

13. The man had contact with his outside probation officers and regular visits from his partner and friends throughout his time in prison. In fact, it was on one of these visits, in Sunday February 2007, that the man first felt unwell in the episode that led to his death.

14. That afternoon the man was being visited by his partner and their friend. The man arrived at the visits hall with chest pain and his visitors noted that he was clammy to the touch when they hugged him. Nevertheless, he wanted to proceed with his visit. After approximately half an hour of feeling uncomfortable with his chest pain and having restless arms, the pain intensified to such an extent that the man had to stop his visit and request the assistance of staff.

15. Discipline staff on duty at the time summoned the assistance of healthcare staff. A male nurse arrived and, according to his interview, started to make an assessment of the man in the privacy of a back room off the main visits room. The nurse (who is general nurse qualified) made an assessment and took a clinical history from the man. The nurse felt certain that the man was having an anxiety attack because the man seemed pre-occupied with the fact that the following day was an anniversary date of his index offence. According to the nurse, most of what the man was talking about was this forthcoming anniversary. The nurse was keen to reassure the man and suggested that he use the coping skills he had acquired to distract him from self harming behaviour and as a means of relieving stress.

16. The man resumed his visit, apparently having declined any medication (according to the nurse he had offered him some relief from his pain which the

nurse thought may have been related to indigestion). The man's visitors left at their due time without further interruption to the visit.

17. When the man returned to his living unit (G Wing) at approximately 4.15pm, the female officer who supervised his entry to the unit recalls seeing and speaking to him. She asked the man if he had had a good visit. He replied 'yes but I had a panic attack and they came over from healthcare and they gave me some indigestion tablets'. The officer reports that he then said, 'but I've still got the pain here' and patted his chest and told her that he was sweaty. When asked in interview if the man appeared sweaty or distressed, the officer said that he did not, but he was wearing a thick jumper and was his usual pale complexion.

18. The man then made his own way back to his cell after being advised by the officer to rest in his cell and see if he felt better. The officer felt that the man had accepted and agreed with the healthcare team that he was suffering from anxiety.

19. Later that evening, at approximately 6.15pm, the man rang his cell call bell for assistance. A different female officer was in charge of the unit, and she attended and discovered the man gripping his chest and complaining of chest pains and pains in his elbows. This officer had only ten minutes earlier looked in on the man (as part of his ACCT observations) and found him to be fine and sitting on his bed. She was concerned for the man because she was aware he had had problems earlier on his visit. In her opinion, he was in a lot of pain and very distressed. The officer immediately contacted the duty senior manager and healthcare using her radio, and stayed talking to the man to offer reassurance.

20. There was a ten minute delay before the duty senior manager and nurse arrived due to the fact that they had been dealing with another incident elsewhere in the prison. The man remained under constant observation by this second supervising officer during this time.

21. When staff arrived, the nurse (a female nurse who is qualified as both a general nurse and a mental health nurse) calmed the man down and took his blood pressure. According to the female officer who had been watching over him, the man did calm down somewhat and the female nurse gave him some liquid indigestion medication. The officer believes that, although he calmed down, the man remained in pain throughout the assessment by the nurse. The man described it as being a crushing pain and complained that he had pain in his elbow too.

22. The female nurse decided to admit the man to healthcare in order to further assess him and monitor him overnight. The duty senior manager, his assist (a male officer), and the female nurse then left, escorting the man to healthcare together.

23. Both the male officer and the duty senior manager said in interview that the man, on being escorted to healthcare, was clutching his chest and walking

very slowly, as though he was having some difficulty. They both recall he needed to stop at least once en route in order to sit down.

24. The man eventually arrived at the healthcare centre (it is a walk of some 600 yards from G wing) and he was admitted to a cell there. He was then examined by a Healthcare Officer (HCO) who took his pulse and blood pressure. The HCO undertook further questioning and assessment of the man and admitted him for further observation.

25. Over the next hour or so, the HCO looked in on the man two or three times, noting that he was lying on his bed and appeared to be sleeping. The HCO prepared to hand over to the night patrol at about 8.45pm (a fellow healthcare officer with a Registered General Nurse qualification). The day HCO tried to rouse the man. Due to the fact they could not wake him, they went into the man's cell and discovered he was not breathing. They immediately started cardio pulmonary resuscitation (CPR) and used the emergency radio system to call for an ambulance. The night HCO and the day HCO both used the heart start machine but it indicated no signs of life. They continued CPR until the ambulance team arrived.

26. Despite further attempts at resuscitation by the paramedic team, the man was pronounced dead at 9.15pm.

27. The man's partner was informed by the police at 3.00am the next morning that he had died. He was told to contact the prison in the morning for further details. According to the man's partner, it was at the insistence of the prison that the police broke the news of the man's death immediately and in this manner. The prison however, is quite clear that they did not request the news be broken immediately, but merely requested the police do so on their behalf. The Deputy Governor was, in fact, quite unhappy overall with the way the police handled matters relating to the man's death – a matter she thought would benefit from some joint training locally in the future.

28. The man's funeral expenses were partially met by the prison. However, the prison 'offset' part of these costs by utilising funds from the man's personal account at the prison.

ISSUES

29. The clinical review was undertaken by a doctor who was appointed by the local Primary Care Trust. In his review, the doctor deals with each presentation of the man's medical emergency in February 2007. There were no less than three opportunities for healthcare staff to have referred this man to local NHS services. Had they done so, the doctor says there would be an 80 per cent likelihood that the man would be alive today.

30. At the Coroner's inquest held in July 2008 the Coroner had asked for a report from a consultant cardiologist. The cardiologist (a professor) provided a report which I attached as a new appendix to the final version of this report. The professor was asked to comment on the likely outcome for this man, given the severe narrowing of his anterior descending artery (a main blood vessel of the heart). His report says:

    On the basis of information available to me, I do not think that it was possible to prevent the myocardial infarction [the heart attack]. Once it occurred, the risk of death was high because of the location of the occlusion of the anterior descending artery.

    The sudden occlusion of the anterior descending artery in young men carries a high risk of sudden death, particularly as it often presents with no typical angina.

    Conclusion. On the balance of probabilities I believe that even if the anterior myocardial infarction (had) been identified, the outcome would have been the same.

31. This is quite at variance with the clinical reviewing doctor's position. My investigator therefore spoke with both the doctor and the professor. The doctor feels that his use of statistics to say that this man would have had an 80 per cent likelihood of being alive today if healthcare staff at Gartree had referred him to hospital sooner was 'a little clumsy'. He stands by his point that if the man had been referred to local NHS services at any time after his first presentation of chest pain at approximately 2.30pm, he would have stood a better chance of survival. The professor agrees with this point – and both doctors say that early diagnosis and start of treatment for people with chest pain is imperative. There was much more each doctor could have said about the early treatment and referral processes, but the underlying points within this report remain unchanged.

32. In respect of the first of these opportunities (the man's examination by the male nurse during his afternoon visit), the doctor's opinion is that, the man 'presented with, if not classical symptoms, then symptoms highly suggestive of acute cardiac pain.' The fact that the nurse failed to recognise this highlights inadequate training, errors of judgement in respect of heart attacks, inadequate knowledge of the correct management of undiagnosed chest pain and, says the doctor, a pre-judged acceptance that the man's problem was attributed to anxiety.

33. The doctor says the management of chest pain of uncertain origin should result in immediate transfer to an emergency department for a more in-depth assessment using blood tests and electrocardiograph (ECG) monitoring (a tracing of the electrical output of the heart). Delays in such referrals, even by an hour, increase the chances of a patient's death, or further damage to their heart.

    The local PCT should assist the Governor in developing chest pain guidelines to ensure it provides appropriate guidance for staff who are assessing patients presenting with severe chest pain symptoms.

    Untrained (without formal minor illness training) nursing staff should not take clinical decisions in isolation and should be supported in their assessment of medical problems either by appropriately trained staff in the day, or the out of hours triage service at night.

34. When the man was seen at about 6.30pm by the female nurse (the second opportunity for transfer to a hospital), she also seems to have assumed that the man was suffering from anxiety. It is evident from her interview that, in her assessment of this man's presentation, she was preoccupied with the psychological distress he was apparently suffering rather than the physiological symptoms of acute chest pain. In interview, this nurse declared that it was difficult to obtain a good history from the man because he was in such distress. She did give medication for indigestion but failed to check if the man had ever suffered from such acute gastric pain before, or whether the medication was effective.

35. The female nurse Murphy to admit the man to healthcare so that another member of the healthcare team could continue observation of him. Unfortunately, the nurse made inadequate written records of her findings and administration of medicines. She gave an inadequate handover to an unqualified member of staff, and appears to have misjudged significantly the degree of pain the man was experiencing at the time she reviewed him. The nurse accompanied the man on his movement to healthcare. This took a long time because the man had to stop several times. He apparently clutched his chest throughout the move and complained of pains in his arms. These are classic signs of someone in acute cardiac distress.

36. The doctor says that the female nurse clearly breached her professional duties by working beyond her scope of practice. She failed to record matters adequately in the medical notes. She administered medicines without adequate training or the support of a local prescribing protocol. She delegated a task to a lesser qualified healthcare worker without an adequate handover.

    The Governor, in conjunction with the local PCT, should consider whether this nurses conduct should be referred to the Nursing and Midwifery Council (NMC).

The medicines management committee should ensure there are sufficient and appropriate Patient Group Directives to allow the administration of simple medicine remedies for patient care at HMP Gartree. There should be appropriate staff training in their use.

37. More generally, the medicines management issues caused the doctor to have very serious concerns which he raises in his clinical review. In interview, the day HCO stated that he would be happy to admit an asthmatic patient to the in-patient unit, administer medication and continue to monitor the patient overnight, even though there was no working policy to cover such eventualities at that time. Nowhere within the NHS would such clinical freedom be afforded (or expected) of an unqualified member of staff. The doctor says, 'Such a worker would be expected to be supported by robust clinical guidelines and narrow protocols, always with access to a qualified member of staff to support and guide decision making.'

38. Once the man arrived in healthcare, the day HCO reassessed his signs and symptoms and came to the same erroneous conclusion that he was suffering from anxiety. This was the third opportunity healthcare staff had to identify the seriousness of the man's condition. In interview, the day HCO described how someone would present with anxiety correctly, and recognised that these were not the signs and symptoms that this man was displaying. He was also able to describe to some degree the typical signs and symptoms of someone experiencing a heart attack, but he mistakenly believed that these would always present as a band of pain across the chest. It is likely, according to the clinical reviewer, that this inexperience is attributable to lack of formal qualifications and training in recognising the full range of signs and symptoms for heart conditions. I am particularly concerned by this HCO's assumption (to which the clinical reviewer refers) that the man's elbow pain might have been attributable to arthritis.

A full training needs analysis for staff working in healthcare should be undertaken by the PCT to incorporate an urgent review of the nursing roles at HMP Gartree.

39. The day HCO is not a qualified nurse (he has an NVQ level Three in Care which is akin to a Health Care Assistant), yet he was put in sole charge of an in-patient area over a prolonged period of time. The female nurse had clinical accountability for her patient, yet she felt able to discharge that responsibility to a non-nurse qualified member of the team and gave an inadequate handover. She failed to inform the HCO fully of what she expected of him and did not mention (or record properly) the medication she had given the man. Indeed, the HCO thought that the man had been given paracetamol by the nurse, and was unaware that she had given him indigestion medication which he ought to have been monitoring for effect.

Staff who are not qualified and registered should not take sole responsibility for delivering healthcare. Their practice should always be under the supervision of a qualified member of the healthcare team.

40. The doctor's review states that the current arrangements for the provision of healthcare at HMP Gartree are less than satisfactory. He says the, 'Primary Care Trust commission HMP Gartree to provide a healthcare service (essentially the nurses employed by the prison). The prison as the provider is responsible for the quality and governance issues of this service. I believe the necessary skills for the proper provision of this service is not currently available at the prison. There has not been sufficient engagement between the PCT and the prison to ensure that suitable systems are in place to ensure the quality of health provision and its development.'

41. When commissioning arrangements changed in April 2005, it was envisaged that there would be an improvement in systems to ensure the quality of health provision and its development at Gartree. Whilst there have undoubtedly been some improvements (as highlighted in the clinical review) in provision at Gartree, events surrounding this man's death suggest that the skills and competencies required to run a health service of this complexity are not sufficiently present at the moment.

42. The doctor also questions the healthcare service facilities, in particular the function of the in-patient unit: 'I would further question the role of the healthcare wing. Only two of the fourteen cells are reserved for healthcare and nursing staff have penal duties for all the cells. I struggle to see the medical value of an admission to these cells given the capability of the staff and the restrictions on access to the patients. The majority of prisoners housed on the unit are requiring sanctuary from bullying and could be managed elsewhere. Similarly increased vigilance for psychological distress could be managed more closely on the wings.' This echoes concerns raised by Ms Anne Owers' report (Ms Owers said, 'Prisoners should be located in the healthcare centre only if clinically indicated.')

    The PCT should review current arrangements to ensure that an effective healthcare service is being delivered at HMP Gartree. Consideration should be given to better use of the provider skills of the GPs during the current tender period, in particular to underpin clinical responsibility for the current service.

43. There was an apparent reluctance to seek additional advice or guidance from outside the prison during out of hours periods. The day HCO seemed to believe that he had two main options if he felt unduly concerned about a patient. He said in interview, 'But at night-time the only referral you've got is either get the doctor in or send them out.' Similarly, the female nurse did not consider calling for any additional help or guidance from outside services in respect of the man's chest pain because she was so convinced that his condition was that of anxiety and indigestion. If any of the three staff who saw this man on this day had sought outside guidance, there is no doubt in the reviewing doctor's mind that they would have recommended that he should be sent to hospital immediately.

44. The doctor believes that there are inappropriate attitudes to the value of an out of hours service, and these attitudes stood in the way of staff seeking help and guidance from outside the prison.

The PCT should ensure that closer working relationships are established with the medical lead of the out of hours service to develop protocols for referral, advice and requests for visits from them.

45. When the man was admitted to the in-patient unit, the prison was on 'patrol state'. This means that, except in extreme emergencies, prisoners' doors can not be opened unless there are sufficient staff present (which would usually mean at least three members of staff). If this man was admitted for further observation (as indicated by the female nurse and day HCO), his room would have had to be unlocked with additional staff having been summoned to facilitate this. There does not appear to have been any attempt by the day HCO to request attendance of any additional staff for this purpose. I believe the observations and monitoring that should have been expected for this man should have amounted to more than a verbal check from the doorway that he was alright.

The Governor should develop a protocol for managing patients who require observations, monitoring and administration of medicines or treatments during patrol state times.

46. As the clinical review makes clear, there have been some significant improvements in the care provided at Gartree over recent years. My previous reports contained relevant recommendations for further improvements, but unfortunately they would not have had time to have become established by the time of this man's death. I am confident that if the PCT and prison work together in partnership and act on the recommendations within this report and others, they will improve still further and provide a much enhanced service to their prisoner patients.

47. Prison Service Order (PSO) 2710 gives guidance and instruction to prisons on matters related to deaths in custody. In respect of notification of a death to the deceased's next of kin, it makes clear that this should be done '*in a suitable manner*'. Supplementary guidance to this PSO makes it clear that, where possible, this notification should be face to face by staff from the Prison Service. In this instance, the prison asked the local police to break the news of the man's death (a practice that is reasonable given the circumstances of distance from the prison). However, I was disappointed to learn that the man's partner was informed in the manner in which he was and hope that the prison can learn from this for the future. The man's partner has made no complaint on this matter, although he has mentioned it to my Family Liaison Officer.

48. Similarly PSO 2710, in its supplementary guidance, says that the prison should 'offer to pay *reasonable* funeral expenses'. The guide for 'reasonable' is seen to be in the region of £3,000. This man's funeral expenses were £3,210.50 (after deduction of costs for floral tributes). The prison initially

chose to reduce their contribution towards the funeral costs by deducting the man's prison cash account balance and paying 70 per cent of the remaining bill. This course of action is not in the spirit of the PSO which advises prisons not to quibble over small sums. Gartree has since returned the man's prison account money to his partner.

The Governor should review the contribution the prison has made to the man's funeral expenses.

49. In contrast, the prison were very supportive to the man's partner in many other ways. Gartree should be commended for this.

RECOMMENDATIONS

To the Primary Care Trust

The medicines management committee should ensure there are sufficient and appropriate Patient Group Directives to allow the administration of simple medicine remedies for patient care at HMP Gartree. There should be appropriate staff training in their use.

A full training needs analysis should be undertaken by the PCT to incorporate an urgent review of the nursing roles at HMP Gartree.

The PCT should review current arrangements to ensure that an effective healthcare service is being delivered at HMP Gartree. Consideration should be given to better use of the provider skills of the GPs during the current tender period, in particular to underpin clinical responsibility for the current service.

The PCT should ensure that closer working relationships are established with the medical lead of the out of hours service to develop protocols for referral, advice and requests for visits from them.

To the Governor and Primary Care Trust

The Governor, in conjunction with the local PCT, should consider whether the nurses conduct should be referred to the Nursing and Midwifery Council (NMC).

The local PCT should assist the Governor in developing chest pain guidelines to ensure it provides appropriate guidance for staff who are assessing patients presenting with severe chest pain symptoms.

Untrained (without formal minor illness training) nursing staff should not take clinical decisions in isolation and should be supported in their assessment of medical problems either by appropriately trained staff in the day, or the out of hours triage service at night.

Staff who are not qualified and registered should not take sole responsibility for delivering healthcare. Their practice should always be under the supervision of a qualified member of the healthcare team.

To the Governor

The Governor should develop a protocol for managing patients who require observations, monitoring and administration of medicines or treatments during patrol state times.

The Governor should review the contribution the prison has made to the man’s funeral expenses.

Good Practice

I am pleased to note that Gartree dealt sensitively and compassionately with a number of matters relating to supporting the man's partner. Gartree's Chaplain presided over the funeral of the man in accordance with the wishes of his partner.