Investigation into the circumstances surrounding the death of a man at HMP Garth in December 2007

Report by the Prisons and Probation Ombudsman for England and Wales

October 2008

This is the report of an investigation into the circumstances of the sudden death of a man in December 2007 at HMP Garth. The man was found dead in his cell in the healthcare unit by nursing staff. A post mortem found that his death was due to natural causes. The man had been in prison for 37 years and was 70 years old.

Sadly, the man had neither identified next of kin nor any close friends. Nevertheless, my colleagues and I would like to extend our condolences to all those touched by his passing.

The investigation was led by one of my Fatal Incident Investigators. An independent review of the man's medical care in prison was commissioned from the Programme Manager for Health Standards at the Primary Care Trust, and carried out by the Deputy Director of Public Health. I am most grateful for their assistance. I would also like to thank the management and staff at HMP Garth for their co-operation during the course of this investigation.

The man was convicted of arson in 1971, and sentenced to life imprisonment. In 1993 whilst on a temporary day release, he committed an identical offence at the same location and was sentenced to a further minimum term of 15 years. He remained in good health throughout most of his sentence, save for a heart attack in 1995 from which he recovered.

In August 2007, the man was diagnosed with bladder cancer for which he received surgery followed by radical radiotherapy. Thereafter, his condition appears to have deteriorated suddenly and rapidly.

It is clear that the man received good and timely care and that his death was not preventable. However, I have made two recommendations about reporting irregularities and record keeping. The second of these is about keeping accurate next of kin details. This is a matter on which I have made similar recommendations to prisons in the past. On this occasion, the recommendation is to the Prison Service nationally with a view to establishing a clear process for maintaining up to date information.

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

CONTENTS

Summary	4
The investigation process	6
HMP Garth	7
Key events	8
Issues considered during the investigation	16
Recommendations	19

SUMMARY

The man, a prisoner at HMP Garth, died on the morning of 13 December 2007 in his cell in the healthcare centre of the prison. He was 70 years old. He was serving a life sentence imposed in 1971 for arson.

The man was never granted release on life licence. In 1993, whilst on a day release from prison, he went back to the scene of his original offence and committed an identical act of arson for which he was sentenced to a further minimum term of 15 years. As a result, he lost the support of his family and they ceased communication. He was transferred into HMP Garth in June 2000 from HMP Blundeston.

The man smoked, but for most of his sentence he was fit and in good health except for minor ailments. However, in December 2005 he had a heart attack and spent some time in hospital. He made a good recovery and remained on medication until his death. With the help of staff, he tried to stop smoking but was unsuccessful.

In August 2007, the man was diagnosed with invasive bladder cancer for which he underwent surgery followed by a course of radical radiotherapy. Diarrhoea, one of the known side effects of lower bowel radiotherapy, was persistent and troublesome for him but not debilitating.

During the early morning of 13 December 2007, the man reported to the duty nurse that he had a severe bout of diarrhoea. He was given medication and referred to see a doctor later that day. Although alert and cheerful after breakfast, he reported that he felt tired and was allowed to remain in bed in his cell. Staff were aware that he was poorly and monitored him. Thereafter, his condition appears to have deteriorated suddenly and rapidly and he was found dead in his cell at 10.50am by nursing staff. No attempt at resuscitation was made and the Prison doctor certified his death at 10.55am.

The man had been seen by the chaplain at around 10.40am whilst on his rounds. However, because of the condition the man was in and to save embarrassment, the chaplain did not speak to him or enter the cell. The chaplain believes that the man was probably already dead when he visited.

Following the discovery that the man had died, the prison's death in custody contingency plan was activated. The police were informed and visited the healthcare centre. They found no suspicious circumstances. The man's body was therefore released to the undertakers who removed him to the mortuary for post mortem examination. The Coroner's officer informed the nominated liaison governor dealing with the man's death, that he had died from natural causes.

The nominated liaison governor, the police and the man's home probation officer tried unsuccessfully to contact any remaining family to inform them of his passing. The nominated liaison governor contacted two friends (ex-prisoners) with whom the man had corresponded to inform them of his death.

As the man had no family or friends to organise a funeral, the responsibility fell to the prison. The nominated liaison governor registered the death, coordinated

arrangements for the funeral and ensured that the man's property was catalogued and put into central storage. The chaplaincy arranged the funeral service which took place on 17 January 2008 in the prison chapel and was well attended. The nominated liaison governor contacted the man's friends to invite them to the funeral but they were unable to attend. The cremation took place at the local crematorium later on the same day where the chaplain officiated. The funeral was attended by the three members of the chaplaincy team and the Nominated Liaison Governor. The man's remains were left at the crematorium where the location of ashes is recorded.

I make two recommendations and am pleased that HMP Garth has accepted the first and has made a positive response to the second.

INVESTIGATION PROCESS

1. My colleague visited HMP Garth on 2 January 2008. He met the nominated liaison governor who gave him a full briefing about the circumstances surrounding the man's death.

2. My investigator offered to meet representatives of the Prison Officers' Association and the Independent Monitoring Board. Notices to staff and prisoners were also published inviting anyone who might have information relating to the man to make themselves known to the investigator. Four prisoners spoke to the investigator; two were interviewed formally. The investigator also met relevant prison staff including members of the chaplaincy and medical departments. Garth did not have a complete prison record for the man but copies of relevant parts of what was available were provided. The police were involved briefly but decided at an early stage that the circumstances surrounding the man's death were not suspicious.

3. The Programme Manager Health Standards for the Primary Care Trust, commissioned a clinical review. The report of the review was received on 2 May 2008.

4. One of my Family Liaison Officers was briefed regarding the man's family circumstances. However, she was unable to contact anyone as enquiries by HMP Garth, the police and the man's home probation officer had all failed to trace family members or friends.

HMP GARTH

5. HMP Garth is a purpose built prison near Leyland in Lancashire and was opened in 1988. It is a category B training prison holding convicted adult male prisoners serving four years or more and can accommodate up to 100 life sentence prisoners. Garth has an operational capacity of 633.

6. Since April 2004, healthcare at Garth has been provided by the local Primary Care Trust. There are eight inpatient beds in the healthcare centre. Medical services are provided Monday to Friday between 8.00am and 5.00pm by a full time doctor, and out of hours cover is provided by Care UK, a locum service. Special sick and treatments are managed by nursing staff. Between 8.00am to 8.00pm, daily nursing cover is provided by two nurses; at night one nurse is situated in the healthcare centre. All clinical staff are appropriately qualified.

KEY EVENTS

7. The man was first received into prison on 7 December 1970, having been convicted of arson at a farm. He was subsequently given a discretionary life sentence. He appealed against the sentence but on 21 September 1971 at the Court of Appeal the appeal was dismissed. The man then spent the next 22 years in various closed prisons, before transferring to an open prison. Because of his attitude to his offence and the danger of re-offending, he was never released on life licence.

8. The man's health seems to have been good. In 1984, he had an operation to correct hammer toes but his medical records for the next six years are missing having been burnt in a fire at HMP Haverigg.

9. Throughout this part of his sentence, the man enjoyed the support of his brother and sister-in-law, as well as that of a sister who vigorously campaigned for a move to an open prison and eventual release. The man was sent to open prison conditions at Rudgate and in 1993 was allowed to go on an unsupervised visit to Leeds for one day. During that visit, he returned to the farm where he had committed the first offence and set fire to the same building. He was arrested on the same day.

10. On 4 February 1994, at Crown Court, the man was sentenced to a further period of at least 15 years in prison. Soon after his conviction for the repeat offence, he lost the support of and contact with his family. He subsequently corresponded sporadically with former prisoners. In addition, for many years he had been visited by a volunteer prison visitor. However, the prison visitor eventually retired, and consequently stopped visiting and writing to him. In 1997, his Probation Officer asked if he wanted another volunteer to visit, but he declined.

11. In December 1996, a doctor at HMP Wakefield wrote that the man was totally institutionalised but was physically and mentally well. He was receiving no treatment and had no alcohol or drug use issues. Around the same date, the Education Officer reported that the man had no interest in attending any education sessions.

12. In June 1999, the Medical Officer (MO) at HMP Blundeston reported that the man was receiving no treatment for physical or psychiatric illnesses but that he had some arthritic changes in his neck that occasionally made him feel giddy. In March 2000, the man went to the hospital for an x-ray on his right foot. The x-ray showed some degenerative changes for which he saw a chiropodist.

13. The man transferred from Blundeston to HMP Garth on 8 June 2000. His healthcare reception screening shows that he was fit and well, but was suffering from corns on his feet. It was also recorded that he had no history of self-harm. The man remained in good health, suffering only from indigestion and other minor ailments for which he received appropriate treatment. He was also given an annual flu jab.

14. On 17 August 2000, it was noted in his annual sentence plan that the man had never completed any offending behaviour work or courses in prison. This was discussed with him and a plan was formulated to address the shortcoming. The review board noted that the man had no family support and that he felt that he would never be released from prison.

15. An entry in the man's continuous medical record, dated 26 July 2001, reads "Depression – refer to [the Senior Clinical Nurse]". On 31 July he was referred by the Garth MO, to the Senior Clinical Nurse – mental health at a district hospital for long term depression. On 20 August, a letter was sent to the prison explaining that the psychiatrist no longer visited Garth, and no alternative appointment was made.

16. In May 2002, the man's personal officer wrote in his annual assessment that he had retired but helped out in the prison laundry. He was eager to secure a move from Garth to HMP Kingston to take up residence in the elderly prisoners' wing. This request was supported by the Lifer Review Board but was unsuccessful because the man did not fit the criteria required by Kingston. Having seen him in May, his home probation fficer, submitted a report to the Lifer Review Board in June. She wrote that the man showed no motivation to alter his attitude to his offences and that his view was limited to obtaining a transfer to a prison with facilities for elderly prisoners.

17. The man's first significant medical problems came to light in August and September 2003 when he reported episodes of dizziness when standing up and night cramps. After investigation, including an electrocardiogram (ECG), a diagnosis of postural hypotension was made. The man was given advice on increasing his fluid and salt intake, as well as lifestyle choices in respect of smoking and caffeine. He was prescribed quinine sulphate for the cramps and continued to receive medication for his indigestion.

18. In March 2004, the Personal Officer wrote in the man's annual assessment that he helped out in the prison kitchen. She also wrote that he had not completed any accredited offending behaviour courses. Given his age and growing infirmity, it was difficult for her to recommend his involvement in any courses or work at Garth.

19. The man again suffered dizziness on 11 October 2004, reporting to medical staff twice that day. He received treatment and was referred for an electrocardiogram which took place on 19 October. His medical record shows that the man again complained of dizziness on 9 November but there was no chest pain associated with this episode. He was referred to the prison doctor for a review.

20. At around 9.00pm during the evening of 12 December 2005, medical staff examined the man in his cell in A wing after he reported that he was short of breath. His medical observations were normal, he was not suffering with dizziness and his chest was clear. He was advised to rest and it was noted that he was to be seen by a doctor for a review the following day. The man's

medical record shows that on 13 December 2005 he reported that he had centralised chest pain which had developed at around 8.30pm the previous evening. Associated with this was numbness in his hands and he had vomited about eight times, after which the pain subsided. On that morning he was pain free and his observations were normal. He was referred for an ECG. At around 1.15pm, he was admitted to the local hospital where a diagnosis of inferior myocardial infarction (heart attack) was made. The man remained at the hospital receiving coronary care until 30 December.

21. The man was discharged with hospital prescribed medication, but on his return to Garth was reluctant to be admitted to the healthcare centre. He discussed the matter with his doctor who allowed him to return to his own cell but instructed him not to work or walk long distances. He was also told by nursing staff that it was important to report his symptoms, although at that time he was symptom free. He then made a good recovery and no outside hospital follow up was required. Staff at the prison worked with him to encourage him to stop smoking, but he found this difficult.

22. The man was monitored and prescribed medication for his heart condition and cholesterol levels throughout 2006. In January, he told nursing staff that he wanted to stop smoking and he discussed this with the nursing sister. During the same month, he told a Probation Officer at Garth, that he had had no contact with his family for many years but occasionally wrote to two old friends. In February, he was helping A wing cleaners occasionally. His Lifer Review Board report, dated 9 February, indicates that his attitude to his offences had not altered and he had not undertaken any offending behaviour work. In view of his advanced age and failing health, the man was referred for transfer to HMP Norwich's elderly prisoners' unit.

23. The man reported sick on 20 September, complaining of a stomach upset. With treatment, the illness had resolved itself two days later. However, in October 2006, he reported that he had suffered from sickness and constipation for the previous three weeks and complained that his lower abdomen on the left side was painful. He was treated with a laxative. In November, he requested an appointment with the General Practitioner with the aim of being passed fit to resume work as a cleaner in the prison kitchen. (The man had stopped work after his stay in hospital.) On 8 December 2006, he was passed fit for work but restricted to light duties only.

24. Having noticed blood in his urine (haematuria), the man reported sick on 1 March 2007. It is confirmed in his medical record that traces of blood and protein were present. He was prescribed trimethoprim, an antibiotic used to control bacterial infections of the bladder and urinary tract, twice daily for seven days. On 27 March, a report by Garth's Deputy Healthcare Manager noted that the man was not under the care of the local coronary care services and was managing his own medication quite competently. A further episode of haematuria followed on 5 April when the man reported that he had been suffering for the previous five days. He was given antibiotics twice daily for five days, to be reviewed in two weeks.

25. On 11 April, the Continuous Clinical Record contains a stamp indicating that an Assessment, Care in Custody and Teamwork (ACCT) document was opened and closed. (ACCT is a monitoring and support process for prisoners considered to be at risk of self-harm or suicide.) There is no indication why this document was opened and enquiries of the safer custody officer, the duty ACCT assessor on 11 April, and head of healthcare have been unable to establish any supporting documentation. There is a possibility that it was opened in error.

26. Later in the month (27 April 2007), a urine sample was sent for analysis but, because of an error at the laboratory, further samples were requested on 4 May. On 11 May, the man noticed that blood was still present in his urine two days after the course of antibiotics had finished. On examination his left lower abdomen was tender but his back was painless. Antibiotics were again prescribed twice daily, iron tablets were given for anaemia and a further sample of urine was sent for analysis. The man attended his annual cardiovascular disease review on 15 May where his medication was reviewed and observations taken. According to the review document he still smoked.

27. The results of the man's blood tests were received on 18 May. They showed some abnormalities and so, on 7 June, he was referred by the prison doctor at Garth, to the Urology Department at the local general hospital for an urgent appointment. He was seen on 2 July and referred for a day case cystoscopy and ultrasound which took place on 2 August. The Consultant Urological Surgeon, wrote that the man almost certainly had an invasive bladder tumour. She requested that any planned prison transfer be deferred until after treatment and that his Plavix (blood thinning) medication be stopped. On 7 August the Clinical Fellow in Urology at CDH, wrote to confirm that the man had an extensive tumour. Consequently, on 20 August the Consultant Clinical Oncologist, operated to remove the tumour and take biopsies. The treatment was to be followed by a course of radiotherapy.

28. Prior to starting his course of radiotherapy on 5 October, the possible side effects were explained to the man and, by letter, to the prison doctor. The radiotherapy treatment consisted of 20 sessions at the cancer centre based at an outside hospital. The sessions took place between 6 November and 3 December, with weekly review clinics. The man developed diarrhoea, a recognised side effect of lower bowel radiotherapy, which was managed with medication. He was admitted to healthcare ward C2, a cell in the healthcare centre, on 6 November, as an in-patient for observation during his treatment. A care plan was written with the aim of observing and monitoring the symptoms of the radiotherapy.

29. The subsequent nursing records show that the man was monitored regularly and, although the diarrhoea was troublesome, it was not incapacitating. The records also show that he was settled and slept well, his medication was taken regularly and his food and fluid intake was acceptable. He was in good spirits and interacted well with staff and other in-patients during his stay in healthcare. On 30 November 2007, the original care plan was endorsed and continued, following a review. The record of nursing care indicates that the

man continued as before, except on 3 December when, after a night during which he had had a bout of diarrhoea, he refused to attend outside hospital for his final radiotherapy treatment. The healthcare manager, attempted to persuade him to attend but he was adamant in his refusal. The medical Officer attended and prescribed more medication for his diarrhoea. By 4 December, the diarrhoea had responded to treatment and the man was noted as being active having spent long periods assisting in the healthcare dining room. On 5 December, he attended hospital for his final radiotherapy treatment. His follow up appointment was set for six months later.

30. The man remained in the healthcare centre because of his physical condition. The record of nursing care shows that he continued to be settled and was sleeping well, he was taking his medication regularly and his food and fluid intake were good. A care plan review took place on 9 December which noted that he was in good spirits and interacting well with staff and other prisoners. He did, however, suffer from recurrent bouts of diarrhoea which were to be monitored and the original care plan was to be continued.

31. On 12 December, the man's record of nursing care shows that he was concerned about his bowel movements and was seeking advice from staff about his diet and medication. He was reported as having eaten little of his food and was therefore referred to the doctor for possible dietary supplements. The night report for 12/13 December indicated that he took his medication and appeared to have slept well.

13 December 2007

32. At 6.50am on 13 December 2007, the man rang the cell call bell in cell H1-04 and reported to the duty staff nurse that he was experiencing another bout of severe diarrhoea and was passing blood. He was given 20ml of kaolin, observed regularly and referred to the medical officer later in the day.

33. The RMN staff nurse at Garth, was on duty in the healthcare centre at 7.45am. Between that time and 8.00am, he took a handover report from the duty nurse. The duty nurse remembers briefing staff about the man but the RMN staff nurse does not remember that briefing. At 8.00am, he and the duty nurse went down to the in-patient area, checked on the resident prisoners and unlocked them for breakfast. The man was in his cell and nothing out of the ordinary was noticed.

34. Between 8.30 and 9.00am, the RMN staff nurse and the duty staff nurse dispensed medication from the treatment room on H1 landing. As the man did not arrive to collect his medication (a painkiller and an anti-emetic), they took it to his cell. On arrival at the cell, the man was sitting in bed smoking and drinking tea. The RMN staff nurse asked if he was alright. He replied that he was feeling tired and asked to be allowed to remain in bed. The RMN staff nurse agreed and asked if the man wanted some breakfast, which he refused. The RMN staff nurse then left the cell and returned to the healthcare office where he told the duty staff nurse that the man was staying in bed and that they should keep an eye on him during the morning. The RMN staff nurse

believes that the duty staff nurse had checked on the man at around 9.45am. The Duty staff nurse believes that the RMN staff nurse also looked in on him.

35. The co-ordinating chaplain at Garth visited the healthcare centre at about 10.20am as part of his rounds. At about 10.30am, he went to the man's cell. He pushed the door partially open and saw the man kneeling by the side of his bed, which was alongside the left wall of the cell, with his torso across the bed and naked from the waist down. The chaplain noticed a smell of faeces and, knowing that the man had a bad stomach as a result of his illness, closed the door to save him embarrassment. He then left to attend an appointment outside the prison. He did not speak to any healthcare staff as he left, but the RMN staff nurse saw him leave and estimates that it was around 10.40am.

36. At around 10.50am, The RMN staff nurse and the duty staff nurse made a routine check of all healthcare in-patients. During the check, the duty staff nurse found the man kneeling by his bed with his torso across the top of the bed. His head rested on the bed and he was turned to the left facing towards the door. The duty staff nurse went to the man, called and shook him but he was motionless and rigid. She felt his carotid artery, found no pulse and called to the RMN staff nurse. When he arrived outside cell H1-04, she told him that she thought the man had died. The RMN staff nurse went to the man and checked for a pulse in both his left wrist and the left side of his neck but found none. He noted that the man felt cold and slightly stiff. He formed the opinion that he had died and had been dead for some while.

37. The RMN staff nurse and the duty staff nurse left the cell, locking it behind them, and returned to the healthcare office where the RMN staff nurse telephoned the Deputy Integrated Services Manager, to tell her that the man had died. The duty staff nurse went to the treatment room to collect surgical gloves to be used if resuscitation attempts were made. In turn, the healthcare manager asked the deputy healthcare manager, to contact the prison medical officer. She then left her office immediately to attend the cell. On arrival, the healthcare manager instructed that the other prisoners in the area be locked into their cells. She too checked for a pulse in both the man's neck and wrist, but was unable to find one. She examined his face to see if his airway was obstructed. It was not. She also noted that the man's body was cool and that he had a mottled appearance. She concluded that he was dead and a decision not to attempt resuscitation was made. The prison doctor arrived soon afterwards and confirmed the man's death at 10.55am.

After the man's death

38. Following confirmation of the man's death, the healthcare manager immediately instructed the deputy healthcare manager to contact the duty governor and the security officer, to inform them of the death and request their attendance at the In-patients' Department. She did this via the prison control room.

39. On receipt of the telephone message, control room staff initiated the contingency plan for a death in custody. As the man had been confirmed as dead, they did not call an emergency ambulance. At about 11.00am on the way to in-patients, the security officer met the chaplain who was leaving the prison and told him what had occurred. The chaplain was unable to attend himself and asked that the security officer inform one of the other chaplains.

40. On arrival at the cell, the security officer met the duty governor and the orderly officer. The duty governor instructed the security officer to secure the cell. The security officer tasked an officer to act as log keeper at the cell. His log of people accessing cell H1-04 was maintained from 11.05am until the man's body was removed by undertakers at 1.50pm. The orderly officer continued to implement the Garth contingency plan.

41. As noted earlier, the man had lost touch with his family many years before his death and no current next of kin details were available. The police were informed of the situation and made attempts to trace his family. The man's home probation officer was contacted and also made attempts to find family members. The nominated liaison governor at Garth contacted friends who appeared on the man's telephone list. Unfortunately, despite the various attempts, no family were traced and the man's friends were unable to assist.

42. At 11.10am, two members of the chaplaincy arrived at the man's cell to give support to prisoners and staff. At 12.11pm, the Coroner's officer and police officers entered the cell, leaving at 12.19pm. The police had no concerns about the circumstances of the death. The Coroner's officer interviewed the staff who discovered the man. He also arranged for undertakers to collect the man's body. At 1.38pm, undertakers and the Coroner's officer attended to the man and removed him from the cell to a room where the duty chaplains said prayers for him. A member of staff from Garth's Independent Monitoring Board (IMB) was also present.

43. At 2.05pm, on the instructions of the Coroner, the man was removed from Garth to the local mortuary for post mortem examination. At that time, the Coroner's officer informed managers at Garth that police were satisfied that there were no suspicious circumstances surrounding the man's death. Consequently, the prison released the cell for clearance by staff. Soon after the man's body had been removed, the duty governor held a debrief for staff who had been involved. He reported to the governing governor, that no issues of concern had been raised in relation to the actions taken. The care team staff spoke to and supported all staff involved following the man's death.

44. The man's death was from natural causes which were noted as:

    1) Peritonitis due to a perforated ischaemic small intestine.
    2) Ischaemic heart disease and atheroma.
    3) Bladder cancer (treated).

45. As the man had no family or friends to organise a funeral, the responsibility fell to the prison. The nominated liaison Governor registered the death,

coordinated arrangements for the funeral and ensured that the man's property was catalogued and put into the Prison Service central storage facility. He and the local chaplaincy arranged the funeral service which took place on Thursday 17 January 2008. The service was held for prisoners and staff in the prison chapel and was attended by 42 people. The nominated liaison Governor contacted the two friends for whom he had telephone numbers and invited them to the funeral, but they were unable to attend. The man's cremation took place at the local Crematorium later the same day. The Prison chaplain, held a service attended by the chaplaincy team and the nominated liaison governor.

ISSUES CONSIDERED DURING THE INVESTIGATION

Medical care

46. A clinical review was commissioned from the Programme Manager Health Standards, Primary Care Trust. It was received on 2 May 2008.

47. The man had been in prison custody continuously since the end of 1970. He was fit and well on reception at prison and remained physically well for the next 30 years, suffering only minor ailments. As he became older the ailments varied and were commensurate with his advancing years.

48. In December 2005, the man had a heart attack and was admitted to hospital. He remained in hospital for several weeks before being discharged back to Garth where, with appropriate medication, he made a good recovery. He required no hospital follow up. To aid his recovery, prison staff encouraged him to stop smoking but he was unable to do.

49. During March 2007, the man was treated with antibiotics for blood in his urine. Further bouts were similarly treated in April and May. This then led to an urgent referral to a urology specialist in June. The man was seen in early July and referred for a cystoscopy which took place in early August. The results of the tests showed a large bladder tumour which was subsequently treated by surgery and a course of 20 radiotherapy treatments. Prior to his radiotherapy, medical staff explained to the man the side effects of the treatment. Radiotherapy was administered between 6 November and 3 December 2007 at a cancer centre, with weekly review clinics during that time. The man was nursed in healthcare cell H1-04 while he was receiving his radiotherapy treatment. He developed side effects, the most recurrent being diarrhoea, a recognised complication of lower bowel radiotherapy, which was managed with medication. The nursing records show that the man was regularly monitored and that, although the diarrhoea was troublesome, it was not incapacitating. His food and fluid intake were monitored and were recorded as acceptable.

50. On the morning of 13 December 2007, the man was seen by nursing staff after he rang his cell call bell at 6.50am. He complained to the duty staff nurse of severe diarrhoea in which there was some blood. He was given kaolin, and referred to a doctor. He then returned to bed and staff observed him regularly. After the man failed to collect his medication from the treatment room on H1 landing, nursing staff delivered it to him at around 9.00am. The man was in bed drinking tea, smoking and was generally in good spirits. He refused breakfast but asked to remain in bed for the morning as he was feeling tired. He was observed regularly by nursing staff.

51. During a routine check of all healthcare in-patients at around 10.50am, nursing staff found the man kneeling by his bed. They were unable to get a response by calling and shaking him. After finding no pulse and noting that his body was cool, the nurses concluded that the man was dead and decided not to attempt resuscitation. The prison doctor confirmed the man’s death at

10.55am.

52. The clinical reviewer has concluded:

> "[The man's] bladder cancer was advanced at the time of diagnosis and the likely outcome of his condition was poor, even with treatment. From my review of the medical records I am of the opinion that the treatment he received, and the timeliness of that treatment, was on a par with what would be available to other members of the general population outside of the prison setting. The post-mortem results confirm that his death was due to natural causes and I have no specific recommendations to make with regard to the care he received."

From the evidence available, I concur with the clinical reviewer's view.

Official visitors to the healthcare centre

53. As part of his normal prison rounds the prison chaplain, visited the healthcare centre on 13 December. At around 10.30am he went to the man's cell, pushed the door partially open and saw the man kneeling by the side of his bed with his torso across the bed. The chaplain noticed a smell of faeces and was aware that one of the side effects of treatment for cancer was a bad stomach. He therefore closed the door to save the man embarrassment and left the healthcare centre at around10.40am without speaking to any staff in the unit. Later that afternoon, after speaking to other members of the chaplaincy, he realised that the man had died in the same position he had seen him in when he visited the cell. With hindsight, he believes that the man was probably dead when he saw him.

54. The man's condition appears to have deteriorated suddenly and rapidly on the morning of his death. There is no evidence to suggest that, had the chaplain drawn attention to the man's predicament when he visited the cell, it would have made any difference to the outcome. However, it is unfortunate that he did not do so and this is something I understand he regrets.

The Governor should remind official visitors to the healthcare centre and all other units or departments of the importance of reporting irregularities promptly to relevant staff.

Information about the man's next of kin

55. The man's prison records show his widowed sister-in-law as his next of kin. However, he had lost contact with her in or around 1994 and had since cited no alternative. The man became institutionalised and had no prospect of being released back into the community. Prison was his home and was likely to remain so for the rest of his life. The friends with whom he had corresponded and his telephone contacts were all former prisoners he had met within the prison system. Efforts were made by HMP Garth, the police and the man's home probation officer to contact someone in his family to

inform them of his death, but with no outcome. As a result, his funeral and cremation were organised and conducted by staff at HMP Garth.

56. Although the man had lost contact with his relatives and the prison was not responsible for the fact that they could not be traced, it might relieve the burden on prisons in emergency situations if more efforts were made to encourage prisoners to keep next of kin details up to date. I have commented on this and made recommendations to this effect in previous investigation reports. As there appears to be no standard guidance, I am directing this further recommendation to the Prison Service.

The Prison Service should provide guidance to prisons on adopting a formal process to ensure that the accuracy of next of kin data, particularly that of long term elderly prisoners, is maintained throughout a prisoner's sentence. It is suggested that, as a minimum, an annual check of the information held by the prison is carried out as the same time as the sentence planning process.

RECOMMENDATIONS

I make two recommendations:

The Governor should remind official visitors to the healthcare centre and all other units or departments of the importance of reporting irregularities promptly to relevant staff.

HMP Garth accepted this recommendation and responded that:

“A notice has been issued to all staff (visitors to Healthcare) reminding them of the importance of reporting any irregularities to the healthcare staff as soon as possible.”

The Prison Service should provide guidance to prisons on adopting a formal process to ensure that the accuracy of next of kin data, particularly that of long term elderly prisoners, is maintained throughout a prisoner’s sentence. It is suggested that, as a minimum, an annual check of the information held by the prison is carried out as the same time as the sentence planning process.

HMP Garth made a response to this recommendation that:

“The man had been in prison custody for a significant period of time during which he had lost contact with his family and in this case they appeared to have ceased communication with him. In these situations, therefore, it is doubtful whether a prisoner could provide appropriate next of kin details if those members of his family have effectively ceased to be in contact, and if there is no one else who could be appropriately nominated. Nonetheless, it is important that processes are maintained to ensure next of kin details are reviewed and HMP Garth has taken steps to implement such processes accordingly.”