Circumstances surrounding the death of a man at hospital, In June 2008 while in the custody of HMP Belmarsh

Report by the Prisons and Probation Ombudsman for England and Wales

March 2010

This is the report of the investigation into the circumstances surrounding the death of a man in hospital, while in the custody of HMP Belmarsh. He died from natural causes at hospital in June 2008. He was 67 years old.

One of my investigators has undertaken the investigation. I would like to thank the Governor of Belmarsh and his staff for their participation. Particular thanks go to the liaison officer at the prison for making all the practical arrangements and providing the necessary documentation.

The local Primary Care Trust was commissioned to undertake a review of the man's clinical care. A team undertook this review.

I would like to add my condolences to those already expressed by the investigator and the Family Liaison Officer to his family and friends. I apologise for the delay in publishing this final report.

The man who died was placed in the healthcare wing of Belmarsh prison when he arrived into custody and remained there throughout his sentence. In April, he began to refuse his medication and food, which this resulted in him being taken to hospital to be rehydrated on 9 May. On 22 May, a multidisciplinary review concluded that he did not have the mental capacity to make decisions about his intake of food and fluids. The following day, he was re-admitted for observations. While in the care of the hospital, medical staff noted a problem with his left leg and, following assessment by a surgeon, the decision was taken to amputate the leg. The operation was carried out on 29 May. Following the amputation, his condition deteriorated and he was located in the hospital's high dependency unit where he later died.

I make no recommendations in relation to prison procedures but I endorse the recommendations made by the clinical review team relating to various aspects of his medical care at Belmarsh and note their view that the delay in referring him to hospital between 21 and 23 May might have contributed to the events, which led to his death.

The man's family were concerned not to have been told of his deteriorating health. It was said that he was reluctant to have contact with them and it seems that the prison did not tell them that he had been admitted to hospital because of security considerations. I have asked the prison to consider how information is shared with the families of those with deteriorating mental health.

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
Deputy Prisons and Probation Ombudsman **March 2010**

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SUMMARY

The man was sentenced to 18 months imprisonment on 4 January 2008 and taken to HMP Belmarsh. He was 66 years old and had never been in custody before.

When he arrived at Belmarsh, a nurse conducted a medical health screening. During this assessment, the nurse identified that he had problems with walking and had for some years had been diagnosed with mental health problems. As a result, she recommended that he be located in the healthcare unit so that a further assessment of his medical condition could take place. No other referrals were made at this time.

The man remained in the healthcare unit between January and April 2008 apart from one night on a residential wing. On that night he had a panic attack and was moved back to healthcare. During this time, the prison's mental health team, who had obtained his previous treatment history, saw him regularly. He was given his medication daily and complied with the regime. He would often move around the unit with the aid of a Zimmer frame and talked openly with staff.

However, in mid-April, the man began to refuse his medication and also declined food and fluids. This continued over time, in spite of frequent staff encouragement to eat, drink and take his medication. He complained of deterioration in his physical health, telling staff that he was constipated, unable to swallow and that his body was shutting down. The mental health team also saw him on a regular basis and, as his condition became worse, they referred him to an outside psychiatric hospital in an attempt to obtain a bed for him. He continued to refuse his medication and food and his physical health deteriorated further. It is recorded that he drank small amounts of water or tea with the encouragement of staff but would then continue to refuse.

On 9 May, the man was taken to the hospital to be rehydrated, returning to the prison the same day. At the hospital, he was also diagnosed with acute tonsillitis and prescribed a course of antibiotics. However, on his return to the prison he again refused all medication, food and fluids. The mental health team attempted to get a bed for him under the Mental Health Act but were informed that further information was required before anything could be offered.

Blood tests taken on 21 May indicated that, because of the man's continued food and fluid refusal, his renal function had become worse. The following day, a multidisciplinary review was held and staff concluded that he did not have sufficient mental capacity to take decisions regarding eating and drinking. On 23 May, he was again sent to the hospital for dehydration and, after assessment by a doctor, was admitted. The doctor told escort staff that he expected him to be in hospital for at least a few days.

While giving the man a bed bath on 25 May, a nurse noticed that his left foot appeared bruised and that he had no sensation in it. The duty doctor diagnosed an acutely ischaemic (poor blood supply owing to the blockage or narrowing of the arteries) left leg which required amputation.

While he was in hospital, the man continued to refuse food, fluids and his condition deteriorated. He was moved to the critical care unit as his condition became worse

and was heavily sedated. On 29 May, he underwent the operation to amputate his left leg. Nursing staff reported that he recovered better than expected, although he remained unconscious and sedated.

Over the next few days, the man's condition remained stable and he was moved from the critical care unit to the high dependency unit. On the morning of 1 June while a nurse was attending to him, he went into cardiac arrest. An emergency team arrived immediately and they were able to stabilise him before moving him back to the critical care unit.

The man's condition did not improve and he did not regain consciousness. At 8.35pm, on 2 June, the heart monitor attached to him revealed there was no output and at 8.40pm, a nurse informed the escort that he had sadly died. A doctor confirmed his death at 8.45pm.

The clinical review team have made eight recommendations on healthcare matters at Belmarsh, with which I concur. In particular, they concluded that the healthcare provided to the man at Belmarsh was not equitable to that which he might have received in the community and that the delay in referring his to hospital might have contributed to the events which led to his death. One of the recommendations relates to the concerns of his family that they were not told of his deterioration in health and subsequent admission to hospital.

THE INVESTIGATION PROCESS

1. Notices informing both staff and prisoners of the investigation were issued on 4 June. They invited anyone who had information about the man's death to contact the investigator. No responses were received to the notices.

2. The investigator telephoned the prison on 10 June and arranged for the man's prison and medical record to be made available to him. The investigator then reviewed all the available documentation.

3. Greenwich PCT was commissioned to conduct an independent review of the medical care that the man received in custody at Belmarsh. This was carried out by a team led by a clinical reviewer. She was asked to consider all the clinical issues, including those raised by the family. She visited Belmarsh on a number of occasions in late 2008 and early 2009 to interview healthcare staff and managers who had been responsible for the man's care. Although the delay in completing the clinical review is regrettable, I would like to thank the clinical reviewer and her team for their report, which is attached in full as an annex.

4. The man's wife contacted the Prison Reform Trust to ask for my office to speak to her. After several unsuccessful attempts to get in touch by telephone and letter, the Family Liaison Officer contacted HM Coroner, who told her that the family had engaged a solicitor and required all correspondence to be directed to them.

5. The Family Liaison Officer contacted the family's solicitor, who explained that the family wanted to meet her and the investigator and that she was happy to facilitate this at her offices. The meeting could not be held until September 2008, but in the meantime, the Family Liaison Officer asked the solicitor to outline the family's concerns. These are listed below:

    - The failure of the prison authorities at HMP Belmarsh to inform the man's next of kin and family members of his decline in health.

    - The failure to inform his family members that he was in hospital until several days after he had been admitted.

    - The healthcare that he received at Belmarsh.

    - The delay by the prison in taking him to hospital for treatment.

6. The investigator visited Belmarsh on 18 September and interviewed six members of staff who had dealt with the man prior to his death. Transcripts of these interviews are attached as annexes to this report.

7. On 7 October, the investigator along with the Family Liaison Officer and the clinical reviewer, met with the man's wife and son, who were assisted by their solicitor. The purpose of the investigation and the role of the Ombudsman were explained. In addition, the investigator and clinical reviewer explained the

areas that they would be examining and their initial concerns. The man's family reiterated their previous concerns.

8. The investigator contacted HM Coroner to inform him of the nature and scope of the investigation and request a copy of the post mortem. The post mortem concluded that the man's death had been as a result of bilateral pneumonia, pulmonary oedema (swelling) and acute renal failure following amputation above the knee of his left leg. A copy of this report will be sent to the Coroner to assist his enquiries.

HMP BELMARSH

9. Belmarsh is a local prison located in Thamesmead, South East London. Opened in 1991, it is one of three local prisons managed within the high security prison estate. Along with remand and lower risk prisoners serving relatively short sentences, Belmarsh also holds category A prisoners.

10. HM Chief Inspector of Prisons carried out a full inspection of Belmarsh in October 2007. Following her inspection, she said of the healthcare at Belmarsh:

> ”Health services were commissioned by Greenwich Primary Care Trust (PCT) and, in the main, provided by the Prison Service through a prison health delivery plan. A health needs assessment had been conducted in February 2007. Clinical leadership was poor in some areas, infection control was inadequate and there was lack of training in resuscitation. Documentation and record keeping were inadequate. Most primary care services were wing based and of a good standard but prisoners complained that getting to see a GP was difficult. Mental health services were good with excellent clinical expertise and leadership and prisoners with primary mental health problems were well served by the in-reach team. Inpatients all had care plans, time out of cell for patients was good, but was dependent on the number of discipline staff on duty. There were too few nursing staff to provide a full range of therapeutic interventions.”

11. The Independent Monitoring Board (IMB) at Belmarsh published their annual report in June 2007. (The IMB are volunteers who monitor the day-to-day life in their local prison to ensure that proper standards of care and decency are maintained. Prisoners can make confidential complaints. The IMB members visit the prison regularly and require responses from Governors on any points raised by prisoners.) The Board considered the prison to be performing well and said of healthcare:

> “The healthcare improvements continue through the NHS partnership arrangements and the determination on the part of the staff to create a hospital environment, although there have been some serious shortcomings on occasions due to staffing problems.”

12. Since the Ombudsman took responsibility for investigating deaths in prison custody in 2004, there have been five previous deaths attributed to natural causes at Belmarsh. Following these deaths, a number of recommendations were made. One of these is repeated in this report and relates to medical record keeping not being consistent with recognised standards.

KEY FINDINGS

13. The man who died was sentenced to 18 months imprisonment on 4 January 2008 and taken to HMP Belmarsh. On arrival, he, who was 66 years old at the time, was assessed by a nurse in order to complete a first reception health screen. He told the nurse that this was his first time in custody. When asked about outstanding medical appointments, he told the nurse that he had mental health problems and had been seeing a doctor at the Priory Hospital, Hayes. He also said that he had an appointment booked for 16 January. He revealed no other medical problems but did mention that he suffered from claustrophobia. The nurse recorded that he also appeared to have some mobility impairment. However, the form does not state whether he had any other concerns about his physical health.

14. The health screen went into more depth about the man's mental health and he confirmed that he had previously been admitted to a psychiatric hospital for treatment in 2006. He also told the nurse that he was receiving medication for these problems and this was also recorded. Although the nurse completing the health screen identified his immediate needs, sections of the screening forms were incomplete.

15. The prisoner escort form (PER) completed by court staff was given to reception staff at Belmarsh and indicated that the man had claimed to be feeling suicidal following his court appearance. It also showed that an Assessment, Care in Custody and Teamwork (ACCT) document had been opened as a result. (ACCT is a process to identify, monitor and support prisoners at risk of self-harm or suicide.) This document was not provided to the investigator and when he enquired with reception and nursing staff he was told that one had never been received. During the health screen, the nurse asked him if he had ever tried to harm himself outside of prison. He said that he had attempted suicide in 2006 but had not since. The nurse indicated on the screening form that he had answered yes to feeling as if he might harm himself. However, conversely, it is then written that he had no thoughts of self-harm or suicide at that time but was concerned about his claustrophobia. No referrals were made to any other services as a result of the reception screening. It was also noted that the nurse completing the health screen referred to his appearance as "mad professor". (Although the nurse might not have intended this to be derogatory comment, I do not consider it to be appropriate.)

16. The man's concerns over his claustrophobia were shared with the discipline department at Belmarsh who informed the escort service that he would require special transport to attend any future court appearances.

17. Following the health screen, the man was located on the healthcare wing to allow further information to be obtained from his community general practitioner (GP) and the Priory Hospital in relation to his health needs. He was also referred to the prison GP for further assessment.

18. Once in the healthcare centre, the man was spoken to again by a nurse who completed an in-patient's admission form. (It has been impossible to identify the nurse who completed this process as the forms were not signed.) As well

as recording his mental health problems, the nurse recorded an assessment of how he appeared at the time of his admission:

> "… Appears low in mood, poor eye contact, states due to the shock of being in prison especially being first time his appetite is currently poor. Denies any self-harm or suicidal ideation. States he sleeps about four hours a night. Describes visual and auditory hallucinations, hears voices from his former employee who was murdered …"

19. The nurse also recorded that the man's blood pressure was 151/94; the normal range is 120-140/80. His physical illnesses were recorded as asthma, heart disease, high blood pressure, high cholesterol and joint problems on his right hip. Although not registered disabled, he had special requirements and used walking sticks to aid his balance.

20. As part of the man's reception onto the healthcare wing, a nurse produced a care plan on 7 January, outlining the reasons for his admission. The plan also set out the goals for both the nursing staff and himself and the interventions required. They were:

Goals

- To be nursed in a safe environment.
- To reduce or prevent the risk of self-harm and or suicide.
- To carry out a holistic individual assessment and risk. Reduce anxiety and establish rapport with him and optimise his physical and mental health.

Intervention

- Clinical staff to establish a therapeutic relationship with him.
- Clinical staff to encourage one to one interaction with emphasis on allowing time for him to ventilate his feelings/anxieties in a safe environment.
- Clinical staff to offer support and adopt a non judgemental approach.
- Clinical staff to administer medication as per prescription chart, record and observe for any side effects.
- Staff to encourage participation in constructive activities i.e. association/exercise.
- Any violence or aggression must be dealt with as per prison service management of violence procedures.
- Regular blood pressure checks and regular reviews by GP.

21. A psychiatrist working at Belmarsh assessed the man later that day. He recorded that he had a history of severe depression and the first recorded instance was in 1962. The man confirmed that he had been seeing a doctor at the Priory Hospital privately since September 2007. He had last seen him on 21 December and was due to be seen again on 16 January. When the psychiatrist asked about thoughts of self-harm or suicide, the man said that he had no such current thoughts. The psychiatrist concluded that he presented as a softly spoken elderly man who was mobile with walking sticks and a bent posture. He complained of asthma during the assessment and also requested earplugs as he would usually sleep for a few hours during the day. The

psychiatrist recorded that he should remain in the healthcare centre and his outside GP should be contacted for his previous medical notes.

22. A nurse recorded in the man's medical notes that, during the afternoon of 7 January he appeared isolated and withdrawn, sitting separately on the ward and not talking or interacting with other prisoners. He was eating and drinking. Over the next few days, he continued to settle into the regime, collected his meals and medication as required and began interacting a little more. On 9 January, he was prescribed a nasal decongestant after being diagnosed with chronic rhinitis.

23. On 10 January, the psychiatrist received a letter from the doctor at the Priory Hospital. The letter set out his contact with the man and provided some background and medical history. He concluded that:

> "... Diagnostically I think he probably has what would be classified as a personality disorder with recurrent adjustment difficulties. His presentations with the latter include quasipsychotic symptoms. Throughout his contacts with NHS mental health services a diagnosis of a psychotic illness has never been made ..."

24. The psychiatrist assessed the man again on 15 January. He spoke about the spirit of an ex-colleague that had been visiting him before and after he came into prison. He said that he found his talks with his ex-colleague both comforting and supportive. However, he asked the psychiatrist whether he could have his evening medication later, explaining that he slept better and the spirit of his ex-colleague did not appear. The psychiatrist noted that he should be assessed for a Zimmer frame to aid his mobility. He also referred to his appearance. The man submitted a letter which said:

> "... I would hereby wish to notify your presence that all my life it has been my ambition to grow and sport a bushy beard. But unfortunately due to a busy working life style in my herbal practices I had not been able to do so.
>
> Hence I am now serving at HM Belmarsh for the first time in my life ever. I feel that I have my opportunity to fulfil my wish ..."

25. The man also asked for permission to alter his appearance. He gave the letter to an officer who explained to him that he was at liberty to do so. He told him that, although there are restrictions on prisoners who are subject to the higher levels of security, they did not apply to him.

26. The Zimmer frame was provided on 18 January and the man became more mobile with the aid of this and his walking sticks. During the remainder of January, he raised no cause for concern amongst staff and the entries in his medical record refer to him being stable in mood, taking his medication as required and sleeping well. He also attended association periods (part of the day when prisoners are unlocked and are able to make phone calls, or play games such as pool, board games or just watch television) but it was recorded that he kept to himself.

27. During a review on 30 January, the man told the psychiatrist that he spent his time reading books from the library and writing. He also said that the officer had encouraged him to ask for categorisation. (All sentenced prisoners are given a security category assessed on the offence and risk they pose to the public. There are four security categories, A, B, C and D with A being those prisoners considered to pose the greatest level of risk and D being those suitable for open prison conditions.) He said that he hoped to move to an open prison. However, due to outstanding court appearances, which the investigator was told were in relation to a confiscation order, he was categorised as C and therefore remained in closed conditions. He had submitted an application form on the same day to support his request to be considered for open conditions. The psychiatrist concluded that in his opinion he was suitable to be located on a residential unit, but the GP should be consulted first regarding his fitness to move.

28. A prison doctor saw the man on 4 February. She recorded that he had undergone some investigations into a heart complaint at St Thomas' Hospital, four years earlier, but had been discharged back into the care of his own GP. She recorded that his main problems now appeared to be anxiety and panic and was happy for him to be monitored by the mental health team at Belmarsh. The doctor saw no medical need for him to remain in the healthcare centre. Following his assessment by the GP, a nurse recorded in his medical record that he was to be discharged to a houseblock but would require a cell on the lower level due to his mobility difficulties and either a nurse or officer to take his medication to him.

29. The man moved to a houseblock on 5 February. However, during the early evening on 6 February, wing staff became concerned as he appeared to be experiencing a panic attack. A nurse went to the wing and assessed him in his cell. She recorded that she was unhappy for him to remain on the wing and explained this to the prison doctor. As a result, he moved back to the healthcare centre for overnight observations.

30. The following day, a second psychiatrist reviewed the man. He told the psychiatrist that he had had a panic attack in the houseblock the previous night. He described how his cell mate had gone out and he had felt very anxious. He said that everything had gone dark, he was gasping for air and could feel his heart racing. He added that he had also had the same symptoms the previous night (5 February) but with less intensity and that he had slept very little while on the houseblock and found it difficult to breathe. The psychiatrist spoke at length with him about the visual apparitions he had experienced. He told the psychiatrist that he wished to be in the healthcare centre if possible but he did not want to come across as someone who was not "compliant" with authority.

31. The psychiatrist explained that admittance to the healthcare centre was for prisoners who were severely unwell, or had a mental illness. He told the man that the first psychiatrist would be asked to review him but he would remain in the healthcare centre for the time being.

32. Over the next month, the man's mental state was recorded as settled and he complied with his medication regime. The GP prescribed a course of antibiotics in mid-February for an infected toe but no other issues were recorded. At the end of February, he reported that he had had a migraine for three days. His symptoms were recorded as throbbing temples and nausea but he said that he had no visual symptoms. He told the nurse that he regularly suffered from migraine particularly when stressed, and he had been feeling stressed since being on the houseblock. He went on to say that he felt better on the healthcare centre. Paracetomol and diazepam were prescribed for the next two days. His headaches improved and, apart from being prescribed some cream for dry skin, no further problems were reported by him during February.

33. The second psychiatrist conducted a further assessment at the end of February. He recorded that the man had said that he had been experiencing anxiety symptoms such as sweating, butterflies in his stomach and his heart was racing. He said that he had not had any further panic attacks since returning from the houseblock. He told the psychiatrist that before he came into prison he had been prescribed paroxetine (an anti-depressant drug) but was now receiving fluroxetine (another anti-depressant) that did not agree with him. He agreed with the psychiatrist that he would only take diazepam at night for seven nights and the psychiatrist arranged for a course of paroxetine to be started. He also recorded that the man should be encouraged to go to the day centre to increase his interaction with others.

34. In March, the man was reviewed by the psychiatrist but apart from continued concern about being located onto a houseblock no other issues were raised. He told the psychiatrist that he was hoping to be released on Home Detention Curfew (HDC) in May. (HDC allows prisoners serving between three months and under four years early release from prison to serve a maximum of 90 days in the community, subject to a curfew, wearing an electronic tag.) Although he did not go to the day centre, he regularly attended association and interacted with fellow prisoners.

35. On 17 March, the man submitted an application for the foreign national co-ordinator at Belmarsh to visit him. He said that he required advice on his immigration status and residence in the UK. The application form notes that he was seen on 18 March, but does not indicate by whom or what advice was provided. When the investigator asked the discipline department at Belmarsh about immigration issues, he was told that nothing had been recorded. He had not at this time had any correspondence from the UK Border Agency (UKBA).

36. At the end of March, the man was seen by a nurse after reporting further headaches for which he was prescribed paracetomol. He also saw a nurse in relation to passing blood for two or three days. He told the nurse that he had been diagnosed with haemorrhoids in the past and was taking lactulose (an oral medication used for treating constipation). He said that he had been constipated over the last few days but was no longer so. The nurse advised him to continue with the lactulose and referred him to the doctor the following day. However, there is nothing to indicate that the follow up appointment took place.

37. On 2 April, the man asked to see the doctor as he had abdominal pain. The nurse recorded that he had asked for Gaviscon (indigestion treatment) and lactulose recently. He told the nurse that he had previously been taking omeprazole (used to treat heartburn and other gastric problems). He was seen the same day by the GP who gave instructions for omeprazole to be added to his medication.

38. The first psychiatrist also saw the man on 2 April for a further psychiatric review. He recorded that he was coping well on the ward but still felt anxious at times and had difficulty sleeping. He told the psychiatrist that he had been seen by a probation officer who was working on his HDC and that he would be eligible on 22 May or sooner. He asked the psychiatrist if he could continue to take diazepam and the other medication until his release and they discussed the risk of becoming dependent. The psychiatrist concluded that he should remain in the healthcare centre as he was unlikely to cope on the houseblock.

39. For the next few days, the man was recorded as being settled and taking his meals and medication as required. On 5 April, he refused his aspirin and asked the nurse to check his cholesterol levels. The nurse advised him to discuss his medication with the doctor. On 7 April, the prison doctor explained the risks and benefits of taking aspirin and omeprazole and he agreed to resume taking it. Over the next couple of days, it was recorded that he had been asleep in the evening when his medication was due; therefore it was given to him by the day staff to avoid him missing his dose.

40. The discipline department at Belmarsh received a letter on 10 April from UKBA who asked for a form to be passed to the man to provide information on his immigration status. Staff passed the letter to him the same day. He completed it as required and added a detailed, six page letter setting out his reasons for coming to the UK and why he considered he should be given leave to remain. He explained that his permanent home had been in the UK since November 1960. Also, he was likely to face persecution if returned to Iran and he had no family living there. His response was faxed to UKBA on 11 April.

41. On 11 April, the man asked to speak to the psychiatrist as he felt as if he was having panic attacks at night. He also asked for medication to relieve irritable bowel syndrome (IBS). The first psychiatrist saw him the same day and recorded that he was complaining of claustrophobia at night. He told the psychiatrist that when he was at home he would often go to his garden to relieve these symptoms. He asked to continue taking diazepam and the psychiatrist agreed.

42. The man's abdominal discomfort continued and the prison doctor examined him on 16 April. The doctor recorded that he was experiencing bloating and pain especially after eating anything apart from potatoes and bread. He told the doctor that this was a recurring problem and he did not feel that the medication was effective although his bowels were working properly. Over the next few days, he continued to take his meals and medication but spent resting on his bed. On 20 April, a nurse recorded that he did not appear very alert. His blood pressure and pulse were taken and he was advised to drink fluids. The nurse

discussed his condition with the doctor who advised that he should be seen at the surgery the following day.

43. A doctor saw the man the next day. He said that he had not felt well for around two weeks and had a poor appetite. The doctor recorded that he had "very retarded and slow speech", looked depressed and was experiencing other symptoms such as headaches and anxiety episodes. The doctor advised that his weight should be checked weekly, prescribed medication for his bowel problems and noted that the outcome of blood tests was awaited. He also commissioned a review of the severity of his depressive illness.

44. A nurse recorded that the man was feeling ill on 22 April. He told her that he felt rather low, isolated and lonely since he was not receiving visits from home. The nurse reassured him and made him comfortable. The following day a Senior Nurse recorded that he had refused his treatment and was offered medication to relieve his constipation but he replied that no treatment was effective for him.

45. Later that afternoon, another nurse found the man kneeling on the floor. At first, he would not speak. Eventually, he said that he felt unwell but said little else. He told the nurse that his "tongue had dropped" but the nurse recorded that his tongue appeared normal and he was able to speak. He refused to allow the nurse to check his blood pressure, saying that he was not well enough. The nurse offered to help him onto his bed but he declined any help. The nurse recorded that he did not complain of any other pains but had been refusing his medication. A message was left for the doctor.

46. The doctor assessed the man later that day, noting that he was sitting on the floor and refusing to move. He told the doctor that he could not swallow and his bowels were still not moving. The doctor recorded that he was depressed and believed that he was dying. His throat was red and he had not taken any medication (including that provided to relieve his constipation) for the previous two days. The doctor wondered whether he was dehydrated and if he had been taking fluids. He therefore instructed that his fluid intake be monitored over the next few days; blood tests carried out and referred him to a psychiatrist.

47. Later that evening, the man told nursing staff that he had a diazepam tablet in his possession. He was asked to find it and, after checking through his property, he produced eight tablets which were disposed of. It was recorded that he should be given diazepam in liquid form in future. His medical notes indicate that he would occasionally make a noise to gain the attention of staff and asked for diazepam and paracetomol. These requests were refused.

48. The psychiatrist saw the man the following day. He told the psychiatrist that he had been storing his medication so he could take it when he needed to help him sleep. He also said that he needed six milk drinks a day and the psychiatrist suggested that he should eat normal food. The psychiatrist recorded that he appeared rather confused and slow during the assessment.

49. The same evening, nursing staff recorded that he appeared confused and was not responding to verbal discussion. He was given his evening medication. During the night he was observed sitting on his toilet for long periods and hanging his head over his sink. It was recorded that he was very unsettled, unable to sleep and looked very distressed.

50. The following morning, 25 April, a nurse recorded that the man seemed confused and slow when being spoken to. He appeared distant and unable to comprehend what was being said. Nursing staff attempted to take a blood sample but he would not allow them to do so. They continued to encourage him to allow the test to be done. He eventually agreed, but in spite of attempts the nurse was unable to take any blood. He declined his medication during the morning despite nursing staff encouraging him to do so. The doctor was informed. A urine analysis was also carried out that indicated no glucose in his urine and a trace of ketones (when fat is broken down by the body, for example if there are no carbohydrates or the individual has been fasting).

51. A nurse spoke with a doctor later that afternoon and gave him the results of the urine analysis and the observations taken earlier. The doctor told the nurse that he would prescribe some lactulose as the man had said he had been constipated for about a week. It was recorded that his blood pressure should be monitored over the weekend and he should be reviewed on Monday 28 April at the surgery. An enema was prescribed later that day.

52. On Saturday 26 April, a doctor assessed the man and recorded that treatment with the enema should continue for the next two days. The next day, the GP was able to persuade him to have his third prescribed enema and he also took his medication. Despite this, his medical notes show that he was still confused and not eating or drinking adequately. At 5.00pm, a nurse recorded that he seemed very confused, repeatedly banging on his door and taking out bits of food from his bin to feed imaginary birds. The nurse also recorded that some of the other prisoners on the ward tried to help him into bed. Nursing staff were able to persuade him to take his medication and he had two cups of water. The night staff noted that he did not sleep at all that night, became increasingly agitated and confused and should be seen by the doctor first thing on Monday morning.

53. The following morning the man was reportedly very lethargic and unable to move without assistance. The doctor saw him later in the day and recorded that he was confused. With encouragement, he took his medication as prescribed on that and the following day.

54. During the course of the investigation, the investigator interviewed a number of staff who had known the man, including a HCO. The investigator asked the HCO about the decline in the man's health during April and whether it was apparent. She replied that the decline had been "very rapid" and there were occasions when staff were able to encourage him to take his medication. However, this was not easy and she and other staff would also spend time trying to persuade him to sip water. She said that when he first came onto the unit he would attend the chapel regularly, but he suddenly stopped and he

seemed to take to his bed. He would not talk to anybody, take his medication or care for himself.

55. Another Healthcare Officer (HCO) recorded that on 30 April, despite persistent offers of help and persuasion, the man continued to refuse his medication. In view of this, as well as his refusal of food and drink and his continuing confusion, a care plan was put in place to minimise the risk of dehydration. The interventions planned were for staff to monitor his dietary intake, using a fluid and diet chart, for him to be encouraged to eat and drink and for the seriousness of poor diet to be explained to him.

56. The food and fluid chart indicates that over the next two days the man continued to refuse all meals and medication, spending the majority of his time lying on his bed. He told staff that his organs were shutting down and that he could not swallow. He was assessed by a doctor on 2 May. He told the doctor that "my organs have wrapped around my spine, everything has shut down." The doctor assessed that he was not dehydrated, his throat was alright and blood samples taken appeared normal. He concluded that he was suffering from a depressive illness.

57. A visiting consultant forensic psychiatrist reviewed the man later that day, during which he told the psychiatrist that he was "severely depressed", his muscles had seized up, he had painful kidneys, acid in his stomach and was unable to talk. He told the psychiatrist that the psychiatric medication was making him worse. He also told the psychiatrist that he was "shocked about my life" and "about my sentencing". He said that "I got 99 years for something as I am a foreign national" and mentioned that he was to be deported. (It is not clear what he had based his views on, but I have found no evidence that he had received any further correspondence from UKBA other than the initial letter mentioned earlier.)

58. The psychiatrist concluded her assessment by recording in the man's medical notes:

> "... the man appears to be depressed. An organic cause has been excluded by the GPs but in view of his age I am concerned that there may be an organic component to his presentation. He is unwilling to have psychotropic medication at present but is willing for physical monitoring and energy drinks in the meantime ..."

59. Later that afternoon, the man drank 200mls of water but continued to decline all food and medication. On 4 May, a nurse recorded that he continued to refuse his medication despite encouragement from staff. The nurse said that he was offered a nutrition drink but said he was unable to swallow it. She noted that she was very concerned about his appearance and presentation and would ask the GP to see him. The GP assessed him during the afternoon and had a discussion about his reasons for not eating or drinking. He is recorded as replying"what's the point". The GP explained that because he was unable to provide a urine sample to check his renal function, a blood sample was needed. Again he replied "what's the use". The GP asked him to consider allowing a

blood test. Over the following few days, he continued to refuse both food and medication in spite of encouragement.

60. On 7 May, the man was continuing to refuse his medication, food and fluids and he was assessed by the first psychiatrist. He told the psychiatrist that he had not eaten for three weeks and was only drinking water. He said that the medication gave him stomach cramps. He told the doctor that he was worried about moving to a houseblock. He had recently been advised that he was ineligible for Home Detention Curfew (HDC) and was therefore likely to remain in prison for more than 18 months. (Without HDC, his release date would have been October 2008.) He also discussed his concern that he was likely to be deported, although no such decision had been made. He was encouraged to drink fluids, which he agreed to, and the chart shows that he drank 750mls over the remainder of the day.

61. The following day, 8 May, a healthcare management review took place, attended by a number of doctors and nursing staff. The man was not present. The review recorded that his thoughts about deportation had had a detrimental effect on his mental health. It seems that the prison made no attempts to clarify his immigration status. Information supplied to the investigator shows that the UKBA had proposed on 22 April that he should not be deported, taking account of the grounds submitted by him in his earlier supporting letter. This recommendation had not been communicated to him.

62. The man agreed to allow nursing staff to take blood samples and they were sent for analysis on 9 May. He was also seen by the GP who recorded that, due to his continued refusal of food and almost all fluids, he required rehydration. He was therefore taken later that afternoon to the emergency department at hospital where he was given one litre of saline over a two hour period. He was also diagnosed with acute tonsillitis and prescribed a course of penicillin before being discharged back to the prison.

63. The food and fluid chart is not completed for 10 May but it shows that the man ate some ice cream on 11 May and also accepted 500mls of water. There are also no entries on the chart for 12 and 13 May. However, the medical record states that he had refused meals and medication. He was seen drinking water from his sink. On 13 May, staff managed to encourage him to have porridge and also his morning medication. The psychiatrist spoke with him later in the morning after a visit with his solicitor. He told the psychiatrist that his solicitor had said his case was difficult with reference to deportation, but he did not clarify what he meant. When the psychiatrist asked about his refusal to eat or drink he replied,"it doesn't matter" and that food got stuck in his throat.

64. The following day, the psychiatrist wrote to the ward manager at Chelsham House, Bethlem Royal Hospital. He explained about the man's past mental health problems and his more recent behaviour. He expressed his concern about the man's mental health and asked the hospital to assess him with a view to admission to the local mental health inpatient unit.

65. The man continued to refuse food but did tell nursing staff that he was drinking and was observed doing so. He also continued to refuse his prescribed

medication. Although spending much of the time lying on his bed, he was also seen walking around the ward and standing for long periods. On 16 May, he told a nurse that he had chest pains. The nurse examined him and recorded that the smell of his breath indicated that he had not been drinking enough. (When someone has not been eating or drinking enough, ketones produced by the body can be smelt on the breath.) The nurse contacted the doctor, who had seen him at lunchtime and would review him again the following day. The visiting consultant forensic psychiatrist also attempted to review him later that afternoon but he refused to be seen. The psychiatrist recorded that there were ongoing concerns regarding his physical state, particularly his level of hydration.

66. On the morning of 17 May, the man refused to go to a family visit and also refused food and medication. When the doctor reviewed him later, he recorded that he remained convinced that his "body is not working". The doctor recorded that he was becoming dehydrated again following his rehydration at hospital eight days earlier. Over the next three days the pattern of refusing fluids, food and medication continued. The doctor also continued to liaise with Adult Social Services in the community to try and have him assessed.

67. A nurse assessed the man on 20 May. She recorded that, despite encouragement, he continued to refuse all efforts to get him to eat or drink. He agreed to have his blood pressure taken, but he declined to have his weight checked. The nurse advised him to think about having intravenous fluids administered in the healthcare unit. He replied that he would refuse to agree to this.

68. The nurse and doctor discussed the blood results sent back from hospital. The doctor said that she was not satisfied with the sodium levels and had spoken to a specialist at hospital. The doctor asked for a further blood test as a matter of urgency the following day and said that, if the sodium levels did not improve, the man would need to return to hospital. The nurse explained to him that he would have to make the effort to drink fluids. He is recorded as taking 150mls of water that evening, but continued to refuse food and medication.

69. During the early morning of 21 May the man was observed urinating on the floor of the ward. Staff gave him a bath and changed his clothing. Blood samples were also taken and sent to hospital as instructed by the doctor. The nurse recorded that staff should follow up the results as soon as possible and report them to the doctor.

70. The psychiatrist received a message on 21 May stating that the man had not been allocated to a named hospital consultant as there were discrepancies with his address. The doctor spoke with him that afternoon and confirmed his address details.

71. At 7.45am on 22 May, the man was found on the floor in a sitting position. Nursing staff recorded that he had no apparent injuries and did not complain of any pain. He walked to his bed with assistance. (There are no incident reports relating to this event in his medical record.) The psychiatrist was informed later that morning that his referral for him had been forwarded to Gresham

Psychiatric Intensive Care Unit. A multidisciplinary meeting between the mental health team and the doctors took place later that day. They concluded that the man did not have the mental capacity to make decisions about food and fluids. They also recorded that "matters are in hand to transfer him under the Mental Health Act as soon as possible". Any psychiatric treatment provided was likely to require him to be in a good physical condition and therefore his physical health would be their initial priority.

72. At 2.00am on 23 May, night staff saw the man lying on the floor near his bed. The staff member acting as Oscar 1 was notified and the ward was opened to allow access. (During the night, Oscar 1 is the radio call sign assigned to the person in sole charge of the prison, who carries keys and has access to all areas of the prison.) Staff went into the ward and helped him back onto his bed. They recorded that there was a strong smell of ketones and they tried to engage him in conversation, but he did not respond although he was conscious. He was checked for any injuries but nothing was observed. (Again, there are no incident reports or injury report forms relating to this incident.)

73. Later that day, the man was taken to hospital again to be rehydrated. He was initially seen in the emergency department where it was confirmed that he had acute renal failure secondary to dehydration. He was admitted for observation. As with his previous admittance to hospital, he was escorted by two members of staff and "double cuffed". (Double cuffing refers to two sets of handcuffs being used. One set is applied to the prisoner's wrists and one cuff of the second set is attached to the prisoner and the other to one of the escorting officers.)

Treatment at hospital from 23 May until 2 June 2008

74. After the man's admission to hospital, a doctor told the escort staff that he was likely to remain in hospital until at least Monday 26 May. He was moved to a ward at 11.10pm and had a settled night. Restraints remained in place although they were reduced to an escort chain. (An escort chain is used when a prisoner is confined to bed or if they require the use of a toilet while on escort. A single handcuff is attached to the prisoner and a length of chain connects this to another worn by an officer. The escort chain allows more freedom of movement for the prisoner and makes it easier for nursing staff to administer treatment.)

75. The following day, the man continued to refuse food. He would not respond to questions form doctors, nursing staff or the escort officers. The consultant treating him confirmed to the escort staff that he thought it likely that he would remain in hospital for three or four days.

76. During the morning of 25 May, the man continued to ignore the escort officers' questions as to whether he wished to have any water or food. At 10.40am while a nurse was giving him a bed bath, she noticed that his left foot was swollen and appeared bruised. She told the escort staff that it felt cold and that he had no sensation in it. The nurse brought this to the attention of the senior nurse on duty who said that she would notify the doctor. The escort staff recorded that during the bed bath the man was very resistant to the efforts of

the nurses and told them to leave him alone. During the afternoon, a doctor examined his foot and told the escort staff that he might have a blood clot. He did not cooperate during the examination. A blood sample was also taken.

77. The investigator interviewed an officer who had been part of the escort on 25 May. The officer said that the doctor had asked the escort staff how long the man's foot had been in that condition. The officer told the doctor that they were unaware of any problem until the nurse had examined him. The officer told the investigator that the man had not mentioned any problems with his foot prior to the nurse examining him. He said that he had continuously encouraged him to eat and drink but he did not respond to his requests. During the night, he remained settled and staff recorded no concerns.

78. The following day, the officer was on duty again and continued to encourage the man to take food and fluids. He explained the consequences of refusal but he still had nothing to eat or drink. The second officer recorded on the bedwatch log that both bedwatch officers spoke to the nurse to express their concerns for the man. When the investigator asked the first officer about their concerns, he said that both officers felt that staff were not being proactive in deciding what was going to happen to him. He told the investigator that nursing staff had mentioned the possibility of amputating his leg. However, when they asked about it, the nurses said that the decision would be made by a doctor and that, due to the bank holiday weekend, only locum doctors were on duty.

79. During the afternoon, a duty doctor examined the man and told the escort staff that no decision about the amputation or a mental health admission would be made until at least the following day. He remained settled during the day but continued to refuse food and fluid.

80. On 27 May at 10.00am, a nurse was again giving the man a bed bath. She told the escort staff that she was concerned about his left foot which appeared to have changed colour from the previous day. The nurse reported her concerns to the senior nurse. A doctor assessed his foot and diagnosed acute ischemia of his leg. Escort staff were told that his leg would require amputation above the knee as soon as possible. The operation could not be carried out until he was assessed by the intensive care doctor and anaesthetist to ensure that he was fit enough. The escort staff reported to the prison that they had been asked whether his next of kin would be able to attend the hospital to sign the consent forms.

81. One of the escorting officers, a Senior Officer (SO), recorded that medical staff had been with the man for most of the morning carrying out various tests to prepare him for the operation, although there was still no indication when it would take place. At 12.45pm, the duty governor at Belmarsh took the decision that all restraints were to be removed from him. The investigator asked the SO why the restraints were removed at this point. The SO explained that when he arrived on duty the man was still attached to the escort chain and he felt that it was hindering the nurses in their attempts to administer treatment. The SO contacted the prison to obtain permission for the restraints to be removed.

82. At 5.40pm, nursing staff told the SO that a woman was outside the ward and asking to speak with prison staff. The SO went to the visitors' room and was introduced to the woman, who showed identification that she was the man's wife. The investigator asked the SO to give details of their meeting. The SO said that he explained that she would be allowed to see her husband. He wanted to make her aware that his appearance might have changed from when she last saw him. The SO said that she was very upset. He told the investigator that she explained that she had attempted to see her husband three times while he was at Belmarsh, but he had refused to have visits, which was why he felt it was important to tell her that his appearance might have changed. He asked her to place all the items in her pockets into her handbag and accompanied her to the ward.

83. The SO told the investigator that as the man's wife entered the ward she shouted something like "that's not my husband". She fell backwards, but he caught her and nearby nursing staff gave assistance. They sat her on a chair next to her husband's bed and gave her some water.

84. The SO also told the investigator that the man's wife took his hand but he tried to pull his arm away and get out of bed. The SO told him to stay in bed but he continued to become more agitated. He explained that after about six minutes he asked the man's wife if she would leave the room while they spoke to her husband, which she agreed to do. He and the other officer then asked him if he was happy for his wife to be present. The SO told him to signal to them if he could not speak. He indicated that he did not wish his wife to stay. (The investigator asked how he was to signal and the SO told him that he moved his hands once for 'yes' and twice for 'no'.

85. Once the man had indicated that he did not wish his wife to remain in the room, the SO went outside and told her that they felt she might be causing her husband distress. He asked if she wished to return to the visitors' room and offered to ask the surgeon to come and speak with her. The surgeon, in the presence of the SO, told her that her husband's leg would have to be amputated. The SO said that he had not given her this information as he did not feel it was his place to do so.

86. The man's wife then left the hospital. The SO told the investigator that when he returned to the ward, the man was still attempting to get out of bed. Nurses were asked if any medication could be provided to calm him down but they said that there was nothing they could give him. The SO said that he decided to place the handcuffs back on him to prevent him from hurting himself in his attempts to leave his bed. He said that they remained on for around one and a half hours until the night staff came on duty and he was placed on an escort chain. At 10.45pm, he was moved to the critical care unit where he was assessed by a doctor in order for a central line to be inserted into his neck. (The line enables medication and fluids to be administered.) Following this procedure he had a settled night.

87. When the escort staff changed the following morning, 28 May, the restraints were not reapplied to the man because of his location in the critical care unit

and his poor condition. During the morning, a nurse passed a message to him from his wife who had telephoned the ward.

88. Prison staff told the UKBA on 28 May that the man was seriously ill and had been admitted to hospital. The UKBA senior caseworker began to work on a proposal to support the earlier recommendation not to deport him whilst waiting for further medical information to strengthen the case.

89. A doctor told the escort staff that the man would be taken to the operating theatre as soon as the clot in his leg had cleared. The doctor asked the officers whether details of his previous medical history and any current medication could be provided. The escort staff telephoned the prison and a little later, a Senior Nurse went to the hospital and spoke with medical staff in the critical care unit about his previous history.

90. At 10.25am, the Governor told the escort staff that, following a request from the nursing staff, they could leave the man's bedside. They went to a side room where they were still able to see him. At around 1.00pm, a nurse told the officers that he had opened his eyes but appeared to be unaware of his surroundings. Shortly afterwards the staff asked the nurses to attend as he had become aggressive and had to be restrained to prevent harm to himself. A doctor administered medication to calm him down. He was visited by his wife and son later in the afternoon and the son discussed his father's prognosis with nursing staff.

91. On 29 May, the escort staff were told that it was hoped that the man would be taken to theatre for his operation before lunch. He remained unconscious and heavily sedated. He was initially taken to the theatre at 11.40am but returned to the ward as the medical team were not ready. He went back to the theatre at 1.50pm, had the operation and returned to the critical care unit at 4.00pm. Nursing staff told the officers that he was doing better than they had expected, although he remained on a ventilator and unconscious. His wife telephoned the hospital during the evening and was reassured by a nurse that her husband was doing well.

92. It is recorded on the bedwatch log that the man had a settled night after his operation. His condition remained the same the following morning and at 4.40pm he was moved from the critical care unit to the high dependency unit. He remained unconscious and nursing staff provided constant monitoring. The escort staff remained away from the bedside but were still able to see him. At 7.48pm, the escort staff moved back to the side of the bed at the request of the nursing staff.

93. Over the next couple of days, the man's condition remained stable. His family telephoned the hospital on a number of occasions for updates on his condition and he continued to receive constant care from nursing staff. On 1 June, a ventilator was attached to help remove carbon dioxide from his body. It remained in place for around two hours during which time he woke up briefly. In the afternoon, the doctor placed him back on the ventilator and he remained unconscious.

94. During the evening, the ventilator remained in place and nursing staff monitored the man constantly. The ventilator was removed at 11.30pm and a doctor attended but was unable to gain any response from him. The ventilator was re-applied at 2.00am. At 7.24am, he went into cardiac arrest while being attended by a nurse. An emergency team and doctor arrived and they were able to stabilise him at 7.38am.

95. At 8.40am on 2 June, the man's son came to visit along with his wife and daughter-in-law, but his father remained unconscious. He was moved back to the critical care unit at 12.20pm and again attached to a ventilator. A nurse told the escort staff at 6.44pm that his condition had not improved since his cardiac arrest earlier in the day and that he might die soon. The nurse contacted his family at 7.50pm to tell them that he had been placed on dialysis as his kidneys had stopped functioning properly.

96. The escort staff changed shift at 8.00pm and at 8.35pm, the officer recorded that the heart monitor attached to the man showed no electrical activity in the heart. At 8.40pm, a nurse informed the escort that he had died. A doctor confirmed his death at 8.45pm.

Events following the man's death

97. Nursing staff telephoned the man's wife to break the news of his death. She arrived at the hospital, along with her son and daughter-in-law, within 30 minutes.

98. The man's wife had written to the prison on 31 May when it became clear that her husband was going to have his leg amputated. She asked what care the prison would be able to provide for her husband following his operation and asked about the treatment he had received at Belmarsh.

99. The Head of Healthcare at Belmarsh received the letter on 3 June, the day after the man's death. He responded in writing offering his condolences. He indicated that it would be inappropriate to respond to her questions as a review of her husband's medical care would now take place.

100. The Governor also responded to the letter on 5 June. He again expressed his condolences and reiterated the points in the earlier response from the Head of Healthcare. The Governor advised the man's wife that the prison would be able to assist with financial support for funeral costs if she wished, and provided contact details.

101. The man's son contacted a governor at Belmarsh, who had been appointed as the prison family liaison officer, to discuss financial support. The governor reaffirmed that the prison would like to contribute and thanked the man's son for providing the costs from the funeral directors. He explained that it was normal practice for the prison to contact the funeral directors to confirm the costs before payment could be made. The man's son told the governor that it was his family's wish that the prison did not contact the funeral directors as the family did not want them to know that his father had been in custody. He said that if the prison had to confirm the costs with the funeral directors, then he

would rather the prison did not contribute. The governor said that he understood their concerns and agreed that the prison would therefore not provide any financial assistance. The governor told the man's son to contact him if they changed their mind.

102. The family told the investigator of their discussion with the prison regarding financial assistance. He spoke with the Governor who explained the situation regarding costs but agreed that the prison would be willing to contribute without the need to contact the funeral directors. The Governor asked the investigator to pass on this offer to the family which he did during his meeting with them on 7 October 2008. Following the issue of my draft report I was informed by the prison that a payment was made to the man's family on 31 October towards the funeral costs.

ISSUES

Clinical care

103. A review of the man's medical care was undertaken by a team led by a clinical reviewer, of the local PCT and a comprehensive report produced. I have summarised the team's findings below and endorse the recommendations, which have been slightly recast.

Reception screening

104. The clinical review found that the medical screening process had been inadequate and ineffective in establishing the man's past and existing physical and mental health problems.

105. Large parts of the First Reception Health Screen form were incomplete, including the disability questionnaire. The inpatients admission form was unsigned and undated. The clinical reviewer says in her report that this raises particular concerns about the section of the form that the patient is supposed to sign to give their consent to treatment. She also highlighted the inappropriate description of the man during his screening process and considered it could be viewed as derogatory.

The Prison Service in partnership with Department of Health should review the First Reception Health Screen form and amend it as necessary to make it more precise.

Offender Health should introduce a single assessment process for older people following the guidance in 'A pathway to care for Older Offenders' (Tool kit for Good Practice).

In response to my draft report, the Prison Service highlighted that the First Reception Health Screen is a national document in use across the service. In response, I have recast the recommendation as an issue to be dealt with nationally.

Mental health

106. The man had a long history of mental health problems. The psychiatrist obtained a summary of his previous history and treatment and made a referral to Bethlem Royal Hospital to admit the man under the Mental Health Act.

107. The clinical review confirms that the man was reviewed by the mental health team at Belmarsh on a weekly basis and that the assessments were thorough. I endorse the following recommendation in relation to mental health referrals:

The Prison Service and Department of Health should review the process for transferring a patient to a secure mental health unit. At present, an outside assessment is required which might delay the process considerably.

In response to my draft report, the Prison Service said that it was not clear what concerns had led to the above recommendation being made. The recommendation was made as a result of the clinical review and the team's full report was attached to my draft report. In addition, the Prison Service said that the problems with transferring under the Mental Health Act are a national one. I acknowledge this and have recast the recommendation as an issue to be dealt with nationally.

Physical health

108. Thamesmead Medical Associates provide the primary and general medical care at Belmarsh. The clinical review found that there was no clear evidence that an adequate and effective physical history had been obtained. It also established that while the man's food and fluid intake was being monitored, the charts were not completed in full every day.

109. The clinical review team interviewed the Head of Healthcare, who explained the difficulties in monitoring such aspects of health care. He told them that "health care staff could not always gain direct access to a prisoner over the 24 hour period".

110. In relation to the man's moves to hospital, there was no evidence of any delays on either occasion. However, although the blood tests taken on 21 May were reported back later that day and indicated that his renal function was worsening, he was not referred to hospital until two days later on 23 May. The clinical review team concluded that the delay referring him might have contributed to the sequence of events that followed, resulting in his death in June. This is clearly a matter of great concern and the Governor and Head of Healthcare will wish to ensure that no other prisoners suffer as a result of delayed responses to medical tests.

    The Head of Healthcare should review the procedures for receiving and acting on urgent medical test results.

111. The review team said that there is evidence that healthcare staff assisted the man with his personal hygiene, yet they did not report anything unusual about his physical or mental health while they were assisting him.

Equitable care

112. The clinical review team did not comment on the care provided to the man while at hospital as this was outside the remit of the investigation.

113. The team found no evidence of any appointments being cancelled by either the prison or external care providers. However, given the inadequacy of the initial screening as well as the subsequent monitoring of his food and fluid intake; and the delay in sending him to hospital following the deterioration in his renal function, they concluded that some of the care that the man received in the prison was less equitable than that which he might have expected in the

community. (Recommendations on these matters have been made within the report.)

Documentation/standards of record keeping

114. The clinical records presented to the clinical review team did not appear to consistently meet recognised standards and they were concerned to read inappropriate comments entered on the First Reception Medical Screening form.

The Governor and Head of Healthcare should introduce a computer based record keeping system to ensure that information is available to all relevant staff, can be easily read, and that the person entering the records can be identified.

Communication

115. The clinical review team found that the standard of record keeping was insufficient to ensure that effective communication took place between the different parts of the prison or the multidisciplinary team. The team were unsure whether appropriate information was passed between relevant professionals and this might hamper the work of the multidisciplinary team.

The Governor and Head of Healthcare should implement a review and update of multidisciplinary working practices and procedures where necessary.

In response to my draft report, the Prison Service asked for clarification on which multi disciplinary team and professionals are being referred to in the previous paragraph. It is my understanding from reading the clinical review that the team were referring to all staff that were responsible for the man's care when they refer to 'multidisciplinary'. In relation to 'professionals' I believe this to refer primarily to those doctors both inside and outside of the prison sharing information. The review refers to information from health care professionals outside of the prison not being acted upon thus hampering the work of the multidisciplinary team and leading to delays in treatment.

Physical environment

116. The man was 66 years old when he first arrived at Belmarsh. Both discipline and healthcare staff interviewed by the clinical review team expressed their concerns and described his vulnerability in terms of mobility, physical and mental health and how these factors contributed to the impact of his imprisonment.

117. The doctors working at the prison reported a lack of resources in terms of equipment and appropriate clinical environments to conduct medical examinations.

The Head of Healthcare should review the equipment and facilities for primary care and where necessary update them in line with 'Good Medical Practice for Doctors providing Primary Care Services in Prison.'

In response to my draft report, the Prison Service asked how the physical environment might have contributed to the man's death. While I acknowledge that, it is not possible to draw, a direct link between the two it is significant that the clinical review team concluded that his care was not equitable to that which he may have received in the wider community.

Family concerns

118. The man's family were concerned that the prison had not notified them of the decline in his health and his transfer to outside hospital. During the course of the investigation, the investigator was told by staff that he had said that he did not wish his family to be told, but there is no documentary evidence to support this. The clinical review team also reported that during their interviews with staff there appeared to be a widely held belief that he did not wish to have contact with his family or for them to be informed of his deteriorating health.

119. When the clinical review team interviewed the Head of Healthcare, he said that the decision to inform family members of a hospital stay lies with the security department due to security risks. He also said that healthcare staff are not allowed to make direct contact with prisoners' families. While I accept that the need for security is paramount, I would consider it unlikely that passing on information relating to a prisoner's health, with their consent, would pose a security risk.

The Head of Healthcare should review the policies and procedures for sharing information with families of prisoners with deteriorating mental health.

Liaison with the UK Border Agency

120. The correspondence sent to the man by the UKBA was passed to him quickly and he was able to respond accordingly. However, as his condition deteriorated during April and May, it was recorded during medical reviews that the possibility of deportation was having a detrimental effect. It was also noted on his care plan that this issue should be clarified. Despite this, there is no indication or evidence to suggest that Belmarsh contacted UKBA for an update on his case.

121. While I acknowledge that he had a number of other issues, I believe that clarification or at least an update on his immigration status would have provided reassurance. The information supplied to the investigator clearly shows that a proposal not to deport the man was made as early as 22 April. Equally, this proposal was not reported to Belmarsh by UKBA.

122. The prison updated UKBA on 28 May, reporting that the man was seriously ill and had been admitted to hospital. Unfortunately, Belmarsh did not inform UKBA of his death and they only found out in September when they contacted

the prison regarding progress on his case. I am aware that the prison has procedures in place for dealing with immigration issues and make no formal recommendation on this. However, the Governor might wish to remind staff that all relevant information should be sought from and shared with the UKBA.

Escort arrangements at hospital

123. The use of restraints when escorting sick or dying prisoners is an issue that the Ombudsman has commented on many times during investigations. The man was escorted to hospital twice. On both occasions, he was escorted by two members of staff and handcuffed to an officer. A risk assessment had been carried out which indicated that as a category C prisoner, restraints would need to be used and there were no medical objections to this. The level of restraint on the first visit to hospital seems to have been appropriate and on the second visit, the level was initially the same. When it was apparent that he was to be admitted, the escort staff reduced the level of restraint to an escort chain.

124. The escort chain remained in place until 27 May when the decision was made to remove all restraints from the man. However, after a short period they were reapplied as he became confused and attempted to get out of bed. On 28 May, the escort staff were advised that they need not remain at his bedside. They positioned themselves away from the bed, yet able to maintain security, allowing medical staff easier access and provide him with more dignity. A manager from the prison reviewed the risk assessment and staffing arrangements regularly while he was in hospital.

125. The man's family expressed some concern to the investigator about the presence of prison staff at the hospital and their conduct. I have looked at the documentation relating to the bedwatch and it appears that staff were efficient in recording all events. It is also evident from both the documents and interviews with staff that they routinely tried to engage with him, encouraging him to eat and drink and had expressed concern to the nurses about his care. From the interviews and documents available, there is no evidence to suggest that staff acted inappropriately at any time during their bedwatch duties.

Payment of funeral expenses

126. The policy regarding contribution to prisoners' funeral expenses is set out in Prison Service Order 2710. In line with requirements of the PSO, the prison offered to contribute to the costs, but this was refused as the family did not want the funeral directors to know that the deceased had been a prisoner. Given the family's reluctance for this information to be disclosed, the Governor might wish to consider whether prison staff could have been more flexible in the arrangements for payment in order to be consistent with the spirit of the PSO guidance. I am pleased that, following the investigator's interventions, the Governor agreed to take a more flexible approach.

CONCLUSION

127. The man was an older man who had been diagnosed for many years with mental health problems. It was his first time in custody and, as mentioned in the clinical review, his age and health issues made him particularly vulnerable. Although initial medical documentation was not fully completed, he was placed in the healthcare unit for a period of assessment.

128. The decline in both the man's mental and physical health appeared to be quite dramatic in mid-April 2008. While it is clear that efforts were being made to attend to his mental health and to transfer him to a suitable hospital, the clinical review team considered that his physical needs were not adequately addressed. Although there were no delays in taking him to hospital, there were delays in actually deciding to do so.

129. The healthcare provided to prisoners should always be equitable to that which they would have received in the wider community. The clinical review team concluded that the man's care did not meet this standard and, on the evidence provided, I concur with their view.

130. In response to the draft report, the man's family said that they were happy with the investigation process, and were keen for the inquest to take place. The family added that they still felt, the actions of staff on the bed watch and the levels of restraints used on him were of concern to them. The family acknowledged that the investigation had raised these issues but would like these matters considered during the inquest process.

RECOMMENDATIONS

1. The Prison Service in partnership with Department of Health should review the First Reception Health Screen form and amend it as necessary to make it more precise. (National recommendation)

2. Offender Health should introduce a single assessment process for older people following the guidance in 'A pathway to care for Older Offenders' (Tool kit for Good Practice).

3. The Prison Service and Department of Health should review the process for transferring a patient to a secure mental health unit. At present, an outside assessment is required, which might delay the process considerably. (National recommendation)

4. The Head of Healthcare should review the procedures for receiving and acting on urgent medical test results.

5. The Governor and Head of Healthcare should introduce a computer based record keeping system to ensure that information is available to all relevant staff, can be easily read, and that the person entering the records can be identified.

6. The Governor and Head of Healthcare should implement a review and update of multidisciplinary working practices and procedures where necessary.

7. The Head of Healthcare should review the equipment and facilities for primary care and where necessary update them in line with 'Good Medical Practice for Doctors providing Primary Care Services in Prison.'

8. The Head of Healthcare should review the policies and procedures for sharing information with families of prisoners with deteriorating mental health.