Investigation into the circumstances surrounding the death of a man at HMP Gartree in May 2009

Report by the Prisons and Probation Ombudsman for England and Wales

June 2010

This is the report of an investigation into the death of a man at HMP Gartree. He was a self proclaimed political prisoner. Imprisoned in 1988 for armed robbery, he maintained that because he had not had a barrister at his trial, he was held in custody illegally. As a result of his strong beliefs he refused to participate in the parole process and therefore remained in prison many years past his parole eligibility date. In protest of his imprisonment, the man held many 'dirty' protests and periods of food refusal.

In November 2008, he transferred from HMP Wakefield to HMP Gartree as part of a normal progressive move. On the day of his arrival he commenced a new food refusal. He continued to refuse food until he died six months later in May 2009. My colleagues and I would like to extend our condolences to the man's family and all those affected by his loss.

The investigation was carried out on my behalf by two investigators from my office. A review of the man's clinical care in prison was carried out by the Clinical Reviewer on behalf of Leicestershire County and Rutland Primary Care Trust (PCT). I am very grateful to the Clinical Reviewer for his assistance. Given the length of time the man was in prison, there are considerable records. I have primarily considered the records from the man's reception into Gartree which are the most pertinent in the period before his death.

The Clinical Reviewer found that the man's care in prison was as good as, if not better, than that which he could expect to receive in the community. I make no recommendations in this investigation but highlight the Clinical Reviewer's comments about the man's treatment and care being an exemplar for other prisons when looking after a prisoner in similar circumstances.

Jane Webb
Acting Prisons and Probation Ombudsman **June 2010**

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SUMMARY

The man was in custody for a considerable length of time – over 20 years – and maintained throughout that he was a political prisoner. He claimed that he was illegally imprisoned because he had been denied a barrister at his trial. For this reason he did not engage or co-operate in the planning or work to reduce his risk of re-offending and progress towards release from prison. As a result he was still in prison some eight years after his tariff expired.

In objection to his imprisonment, the man carried out a number of dirty protests[1] and food refusals. He transferred to HMP Gartree in November 2008 and immediately started a new food refusal. It is documented several times that he believed that by dying in prison he would bring notice to his situation. Suicide and self-harm monitoring procedures were put in place.

On his reception at Gartree, the man chose to live in the segregation unit refusing to be located elsewhere. Daily segregation, self harm monitoring and medical records provide a comprehensive history of the man's life in Gartree. They describe his wish to continue his food refusal as well as the efforts of staff to persuade him to stop. He produced an Advance Directive (which I explain on page 9 of my report) giving instructions about what medical treatment he would and would not accept. His mental health was assessed by a psychiatrist and he was given access to legal advice and support. His solicitor confirmed that the Advance Directive was a legal document and any breach could result in prosecution of staff. Generally, he agreed to treatment for conditions not related to his food refusal which would not prolong his life. He also agreed to treatment which would make him comfortable and to that end transferred to the healthcare centre at the end of March 2009 which gave staff easier access to help look after him.

There were regular care plans which changed according to the man's needs and wishes at any given time. The care plans monitored, amongst other things, his breathing, mobility, eating and drinking (he took fluids throughout his food refusal), continence, washing and dressing. As he became weaker the input from staff became greater. Throughout all the care plans and other prison records it is clear that the man's dignity was considered as well as the need to respect his own wishes about medical intervention. This would not have been an easy period for medical, discipline or civilian staff who looked after and knew him and I commend their efforts. The man died on 10 May 2009.

The clinical reviewer has found the man's care and treatment to be exemplary.

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.

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[1] A dirty protest is where a prisoner has chosen to defecate or urinate without using the facilities provided. In virtually all cases the walls, floor or ceiling of the cell or room are affected. Some prisoners choose to cover their clothing and their body with faecal waste. Although their actions may be undertaken as a protest, they may also be as a result of mental health problems.

INVESTIGATION PROCESS

1. The investigation was initially opened by two Investigators of this office. They visited the prison and requested relevant prison documentation including the man's medical and core prison records. The investigation was then taken over by another Investigator (Investigator A).

2. Notices to staff and prisoners were sent to the prison to be displayed. They invited anybody with information to talk to my investigators. In this instance one person, another prisoner and friend (prisoner A) asked to share information about his contact with the man.

3. A clinical review into the man's clinical care at HMP Gartree was carried out by the Clinical Reviewer on behalf of Leicestershire County and Rutland PCT. Due to the length of time the man was in prison and the considerable amount of documentation, it was agreed between the Clinical Reviewer and Investigator A that only the care at HMP Gartree would be reviewed in depth.

4. HM Coroner for Leicester City and South District was informed of my investigation. The Coroner will receive a copy of this report.

5. A Senior Family Liaison Officer from this office was appointed as the liaison officer with the man's designated next of kin. The Senior Family Liaison Officer wrote to the man's next of kin to offer them the opportunity to be involved in this investigation and raise any concerns they might have. The Family Liaison Officer did not receive a response at the time. However, she spoke to the man's next of kin in February 2010. They have kindly shared some letters the man wrote in 2005. They relate to his case and protests and the way he felt he was treated in prison. As they do not refer to any concerns during his last food refusal and time at Gartree, I have not considered them for inclusion in this report.

6. The man's next of kin told the Family Liaison Officer that the staff at Gartree were very helpful. They added that the Head of Healthcare had been "brilliant" and kept them regularly updated about the man's condition. They were also complimentary about the regular contact by the prison's Family Liaison Officer. The man's next of kin were concerned about his tariff and that he was not released when he was critically ill. They added that he did not want to be released on licence, but wanted to be released as a free man. They would like to know why he was not released towards the end of his life.

HMP GARTREE

7. HMP Gartree is a category B training prison for adult male life-sentenced prisoners. It forms part of their progression on to category C or other prisons as appropriate. Prisoners are encouraged to address their offending behaviour to reduce their risk of re-offending and work towards parole. The prison can hold a maximum of 689 prisoners. Gartree delivers both primary and secondary healthcare services, akin to a doctor's surgery and an in-patient facility.

Her Majesty's Chief Inspector of Prisons (HMCIP)

8. Her Majesty's Chief Inspector of Prisons reports on all Prison Service establishments. The majority of inspections are pre-announced and allow the prison being reported on to prepare for inspection. However, a small number are unannounced, meaning the prison concerned has no prior knowledge that the Chief Inspector's team is visiting until they arrive.

9. The last full announced inspection by Her Majesty's Chief Inspector of Prisons, was in May 2005. A short unannounced follow-up took place in April 2008. There is little in the Chief Inspector's findings which is relevant to the man's care and treatment given his individual circumstances therefore I do not give a summary of the report here. Full details can be found on the Chief Inspector's website at www.justice.gov.uk/inspectorates/hmi-prisons.

Independent Monitoring Board (IMB) report

10. Each prison in England and Wales has an Independent Monitoring Board (IMB). Their role is to monitor the prison and to report any concerns that they have regarding the prison or how prisoners are treated. Board members are able to visit any area of the prison at any time, and have direct access to any prisoner who they wish to see or who asks to see them. The Chair of the Board produces an annual report to the Secretary of State for Justice.

11. The IMB had regular contact with the man which I refer to in my report. The 2008/2009 annual report for Gartree, as well as previous reports, can be found at www.imb.gov.uk.

Categorisation of prisoners

12. Prisoners are categorised according to their likelihood to attempt to escape and the risk they would pose to others should they do so. The categories are defined as follows:

    - Category A – prisoners whose escape would be highly dangerous to the public or the police or the security of the state, no matter how unlikely that escape might be, and for whom the aim must be to make escape impossible.

- Category B – prisoners for whom the highest conditions of security are not necessary, but for who escape must be made very difficult.
- Category C – prisoners who cannot be trusted in open conditions, but who do not have the resources and will to make a determined escape attempt.
- Category D – prisoners who can be reasonably trusted in open conditions.

A life sentenced prisoner would usually be expected to progress from either Category A or B to a Category D prison in the course of their sentence.

Mental Capacity Act 2005

13. The Mental Capacity Act 2005 provides a statutory framework to empower and protect vulnerable people who are able to make their own decisions. It makes clear who can take decisions, in which situations, and how they should go about this.

14. The Act establishes a set of key principles and provides a checklist to be used in ascertaining a person's best interests. It deals with liability for actions in connection with the care or treatment of a person who lacks the capacity to consent to what is done.

15. Under the Act, any individual has the right to refuse food and fluid. The Act states that a person is assumed to have capacity to make this decision unless it is established that the person lacks capacity. The Act informs that a person must not be considered unable to make a decision on the basis that the decision made may be an unwise one.

Advance Directive

16. An Advance Directive is a statement of instruction about how a person wants to be treated in the future should they lose the capacity to make informed decisions about their own care. Adults with the capacity to make their own decisions have the right to refuse food, fluid and treatment, both at the time it is offered, and in the future using an Advance Directive. If treatment is forced, it is a breach of the patient's right to life, self determination and liberty. It can also be considered a criminal offence to treat someone against their informed will.

17. The key characteristics of an Advance Directive under the Mental Capacity Act include:

    - That the decision and statement must be verified in writing.
    - A person can change or completely withdraw the advance decision if he or she has the capacity to do so.
    - The withdrawal or partial withdrawal does not need to be in writing.
    - An alteration of an Advance Directive does not need to be in writing, unless it applies to an Advance Directive refusing life sustaining

treatment, in which case formalities will need to be satisfied in order for it to apply.

Department of Health Guidelines

18. The Department of Health also has guidelines for the clinical management of people refusing food in immigration removal centres and prison (2008). They give information about the assessment and management of a person intent on refusing food.

19. The management of the prisoner includes:

- Establishing the primary reason for food refusal.
- Attempting to resolve the situation by developing strategies for their psychological, physical and social wellbeing.
- Consideration of opening the Assessment, Care in Custody and Teamwork (ACCT) procedures to reduce the risk of suicide and self harm.
- Deciding how to manage the person clinically, according to their wishes, if the situation cannot be resolved satisfactorily.
- The patient must be referred to a psychiatrist for a mental health assessment if the clinician has any concerns.

20. The assessment of the prisoner includes:

- A thorough assessment of nutritional status should be carried out at the beginning of the food refusal. It should include establishing the usual body weight and recent levels of food intake as well as a specific nutritional examination.
- A case conference should take place soon after a person has been identified as being on food refusal. The meeting should explore ways to try to resolve the situation and assist in care planning. Regular reassessments of the prisoner's physical and mental state should be carried out ("within limits dictated by the individual's compliance").

KEY FINDINGS

21. The man received a custodial sentence in 1988 for the offence of armed robbery. He received a 12 year tariff and was designated as a category A prisoner. Categorisation review documents show a history of disruptive behaviour in prison, including dirty protests, food refusals, threats to staff and escape attempts. They were in protest at his imprisonment, which he believed to be illegal. In 2001, the man's tariff expired and he became eligible to be considered for parole. However, he unwaveringly maintained that he was a political prisoner and refused to co-operate with sentence planning or challenge his offending behaviour. This meant that prison staff were unable to measure any reduction in his risk of re-offending. In 2006, the categorisation review team noted that the man's conduct in prison had improved but because he had not shown any reduction in risk, he remained a Category A prisoner. Throughout his prison custody, until the last six months, the man moved between numerous high security prisons.

22. The type of behaviour displayed by him in his food refusals and dirty protests led to several mental health assessments whilst he was in custody. In a psychiatric report for the Parole Board (undated) the psychiatrist concluded that there was no evidence that the man was suffering from mental illness. The report comments that there were periods when he reported symptoms of depression. They were treated with medication when the man chose to take it. The psychiatrist formed the view that he was depressed as a result of his belief about the inappropriate manner with which he felt he was being treated in prison. The psychiatrist concluded that, at the time of the report, there were no psychiatric contra-indications to parole. During at least two food refusals in 1999 and 2005, he prepared Advance Directives. The latter confirmed that his wishes as of 1999 with regards to his refusal of food and certain treatment were to remain in force.

23. In February 2007, he was re-categorised and downgraded to a Category B prisoner. In a psychology report, it was noted that this was likely to be due to his behaviour within a healthcare setting, where he was then living, and his age rather than the fact he had engaged in any reducing re-offending behaviour work.

24. The man made a last will and testament in July 2007. He left his money and personal property from prison to a close friend so that she could arrange his burial. The will was witnessed by two members of the chaplaincy team at HMP Wakefield.

25. The following year, in May 2008, he wrote to the Prisoners' Advice Service (PAS). At the time he was living in the segregation unit at his own request. He wrote to PAS seeking advice about his right to remain in the segregation unit and refuse to move to healthcare whilst he was on food refusal. He also wanted to know if prison staff could use force to move him whilst on food refusal. PAS replied in July 2008 to say that the prison could relocate him, but that to do so by force would have to be justified.

26. On 19 November, he transferred to HMP Gartree as part of a progressive move. Upon his arrival he underwent a routine health screen. He told Nurse A that he would go on food refusal as a means of ending his life. (Nurse A was the man's keyworker. She reviewed his care plans and had regular contact with him.) He said that he had no interest in parole because, in his view, his imprisonment was not legal. He therefore refused to acknowledge the parole process. He told Nurse A that he was an ageing prisoner and that, if he were to die in prison, people might take note of his situation. An Assessment, Care in Custody and Teamwork (ACCT) document was opened so that the man could be closely monitored. Managers were made aware and Nurse A referred him to the mental health team. The man refused to live on a normal residential unit or healthcare and so he was moved to the segregation unit.

27. The doctor on duty following the man's reception to Gartree, Doctor A, assessed him during the morning of 20 November. The doctor noted the man's medical history and complaints and that he had started to refuse food. The doctor wrote in the medical record that he was not depressed and seemed mentally capable of making his own decisions.

28. An ACCT assessment also took place on 20 November. The man told the assessor that he believed he was imprisoned illegally. He said that food refusal was his way of protesting and his way to get out of prison and that he was "not interested in parole". He added that he had never harmed himself and had no suicidal thoughts or intentions at the time. When they spoke about the man's current mental state, he replied that it was difficult to focus on events and put things in order. He was trying to anticipate what the Prison Service would do with him. The assessor asked him about his reasons for living and ways of coping. He replied that he had stepchildren but had limited contact with them. He told the assessor that his children would be upset if they knew about his situation and food refusal and therefore thought it better to cut contact with them. He added that the only way he would leave prison would be if his sentence was quashed and he received compensation.

29. A review took place following this assessment, which was attended by a range of staff and the man despite him initially saying in the assessment that he did not want to attend. The ACCT assessor shared information about the man's previous food refusal history and said that he would take water, Oxo and Bovril drinks, vitamins and supplements. It appears that the staff decided to close the ACCT document. However, in practice, it was not closed and the observations and monitoring continued until the man's death. Over this time the level of observations ranged between every half hour and every hour depending on his need.

30. A Nurse carried out a mental health review with the man on 22 November. The nurse wrote that he was very clear and determined and had told him that he had no mental health issues. The nurse recorded that the man said he was fully aware of his actions and the possible consequences. The following day, Nurse A wrote that the man had given her miscellaneous information including an Advance Directive regarding his medical treatment. On 24

November, the man had an appointment with the doctor on duty. (Doctor B) Doctor B wrote that the man had been referred for a psychiatric assessment.

31. A forensic psychiatrist assessed the man on 27 November. The psychiatrist concluded that there was no evidence of a thought disorder, delusional beliefs or inappropriate mood. The psychiatrist also wrote that the man understood the consequences of not eating and, although he did not want life saving or prolonging interventions, he would accept palliative care and assistance to be made more comfortable. The psychiatrist wrote that the man was adamant he did not want to be resuscitated. Various amendments were made to the Advance Directive and the man, the psychiatrist and a nurse signed it. The psychiatrist wrote in conclusion in the medical notes that he would be assisted to seek independent legal advice.

32. Shortly after his appointment with the psychiatrist, the man had another ACCT review. The Head of Healthcare at Gartree, who also attended the review, spoke to him about getting legal advice. She asked the segregation unit staff who said that they had already begun the process of arranging it for the man. He told the Head of Healthcare that he had ordered some sugar free squash from the canteen. He added that he would drink more, but would not eat. Later that afternoon, Nurse A noted in the medical record that an initial care plan had been devised which should be amended as the man's condition dictated.

33. The care plan included a routine weekday visit by the duty doctor. At weekends a nurse or healthcare officer would visit. Additional visits were to be carried out as his condition necessitated, at his request or if segregation staff were concerned about his health. If the man gave his consent, then daily blood pressure and pulse observations would be taken. His weight was to be monitored as well as urine tests twice weekly and blood tests as deemed necessary by the doctor. Medication was to be given as prescribed and it would be reviewed by the doctor. His personal care needs would be met by the healthcare team if he was unable to be independent. All care was to be clearly documented in the medical file and ACCT document. Any concerns were to be raised with healthcare at the earliest opportunity.

34. The following day, he saw Doctor B again. He told the doctor that he was unhappy with his Advance Directive. He said that additions had been made without being initialled and he no longer wanted any intervention from healthcare including blood pressure (BP) checks. The doctor advised that he should stop taking Bisoprolol (medication for high blood pressure) if he was not willing to have BP checks. He was told that the medication could be restarted if he agreed to BP checks. He should let staff know if he developed dyspepsia (indigestion) so that consideration could be given to stopping the other medication he was taking. The doctor agreed to have the Advance Directive retyped in readiness for a psychiatric review the next week.

35. Also in November, PAS wrote to the Governor at Gartree in response to another letter (date unknown) from the man regarding his food refusals and his right to remain in a segregation unit. PAS explained that he had a 'living

will' which stated his wish to refuse medical treatment. PAS added that the man was comfortable in the segregation unit and asked that he be allowed to remain there.

36. On 2 December a mental health nurse attended the man's ACCT review. She noted in the medical record that he had agreed to recommence medical observations from the following day including BP, urinalysis and weight. She also recorded that he appeared alert and was coherent in the review.

37. At some point later that day, although his solicitor was not due to see him until 4 December, the man signed an Advance Directive. It is signed and dated 2 December 2008 by him and witnessed by a Senior Officer. It said:

> 1 "I confirm that I do not consent to force feeding or artificial provision of nutrition or any other form of medical treatment designed to keep me alive in the event of a deterioration in my condition and/or loss of consciousness and that I do not wish to receive any treatment in connection with the effects of my refusal to eat on my body.
>
> 2 I consent to medical treatment for any ailment or condition which is not related to my food refusal.
>
> 3 I consent to the administration of pain relief providing that this pain relief is not designed to prolong my life.
>
> 4 I confirm that I wish this advance decision to apply even if my life is at risk. Any revocation of the directive will only be effective if it is in writing, signed by myself and witnessed.
>
> 5 I have signed previous advance directives, including one on 9 December 1999 which I signed in the presence of my solicitor and the then Senior Medical Officer at HMP Belmarsh. I have considered and understand the implications of refusing such medical treatment as set out in this advance directive.
>
> 6 I have taken the decision to make this advance directive because I have been held illegally for more than twenty years, having been denied a barrister at trial, which both the Home Office and judiciary have conspired to cover up ever since. I have proof of this but all solicitors are afraid to face up to the consequences of challenging such powerful people. I was advised of this by the solicitor of a friend on an "off the record basis", I now wish to end my life by declining all food and drink only low quality orange squash, as a way of recording my contempt for Home Office Judiciary."

38. The Head of Health Care and the Acting Head of Residence at the time, and a Principal Officer (Principal Officer A, the segregation Principal Officer and part of the safer custody team) had a review with the man's solicitor on 4 December. The man's Advance Directive was discussed and his solicitor confirmed that it was a legal document, the instructions of which would be recognised in a court of law. The Head of Health Care was concerned that healthcare staff were still bound by their code of conduct to preserve and maintain life. She was advised that, if the man's wishes were not adhered to,

staff could face prosecution. The Head of Health Care felt that some of the Advance Directive was open for interpretation and asked that it be clarified. The following day, Doctor A and a member of the nursing team asked the man to clarify point two of the Directive Doctor A had written in the medical record. The man was quite clear that:

1. "He would not want any intervention that would prolong his life in the event of a heart attack or stroke but would want analgesia (painkillers) if he was in pain or distress.
2. However, he did request that he WOULD (sic) want treatment if he developed any infection such as a chest infection."

39. Throughout December, as had been the case throughout all the man's time at Gartree, a cross section of staff had discussions with him each day. Frequent offers of help or support were made and attempts made to persuade him to stop his food refusal. He refused assistance on each occasion, with the exception of receiving flasks of water from staff. Staff noted that he was frail and weak, although on several occasions, he was also described as alert and coherent. He was helped with his personal hygiene as and when he needed and requested it. He was also seen regularly by the duty doctors. Additional specialist equipment was provided when necessary. For instance in December, the man was provided with an extra mattress for his bed.

40. On 18 December, he asked a member of staff to check the amount of money in his prison account. He wanted it to be given to his nominated next of kin for his funeral expenses. He was concerned when he was told that it would take approximately two weeks for the money to be given to his next of kin. He replied that he would be dead by then and she (the next of kin) would need the money. The member of staff asked him again whether he wanted some food, to which he is recorded as saying, "no this is it this time, I reckon it will all be over in a week". The member of staff wrote that they had a light humoured discussion about the man's stubbornness. He also added that the man was frail but lucid and in good spirits.

41. A few days later, on 23 December, a Governor visited the man to let him know that she had spoken to segregation staff about what to do if he became unresponsive or his situation seriously deteriorated. The Governor wrote in the ACCT book that the man could be transferred to healthcare or outside hospital if he wished to be medically treated. He declined. The Governor explained that this meant he might possibly die in the segregation unit but the man replied that that was what he wanted.

42. He signed a 'do not resuscitate' document the next day. This states:

> "I, currently residing in the segregation wing at HMP Gartree, and I state that I do not want to be resuscitated or receive any first aid should I become unconscious. I also instruct the healthcare staff to sign a disclaimer on my behalf to state to paramedics, that I do not wish to be transferred to hospital."

It was signed by the man and witnessed by the Head of Healthcare, a member of the IMB and an officer from the segregation unit.

43. Also dated 24 December is an ‘Emergency Intervention Plan’. It states that the man did not want to be transferred to hospital in the event of his condition deteriorating. Should he become unconscious or “slow to respond” the segregation staff were advised to contact healthcare, the duty governor and the orderly officer. No staff were to attempt to administer first aid or cardio pulmonary resuscitation (CPR). Healthcare would contact the paramedics and share the content of the Advance Directive and other relevant paperwork. Provision was also made should the man change his mind at any time and choose to receive medical treatment.

44. In January 2009, the logs and interactions with the man were similar to the previous month. On 3 January, a senior officer (SO) from the segregation unit saw one of the man’s friends, Prisoner A on a wing. He spoke to him about the man’s deterioration. The SO asked Prisoner A to visit the man to see if he could find out if there was anybody they could contact to convince him to end his food refusal. Prisoner A visited him on 3 and 4 January. He kept a log of his visits where he noted his shock at the deterioration in the man’s appearance. The man told Prisoner A about the hallucinations he was having, but was sufficiently alert to know that they were hallucinations. He told Prisoner A that the segregation staff were looking after him which he found “funny” as he had spent many years fighting them (referring to staff in other prisons).

45. However, on 6 January, the man declined to speak to the officers in the segregation unit or Nurse A. Nurse A was told by officers that this might have been linked to a conversation that the man had with a governor the previous day but there is no further information about it and nothing untoward written in the ACCT log from the previous day.

46. Prisoner A makes a brief reference saying it was a governor who the man had met previously at HMP Belmarsh, but the governor is not named and the issue, if there was one, is not recorded anywhere. The man continued to decline conversation with the staff until 10 January, although he would communicate by nodding his head. There is no apparent reason for his behaviour or why it ended. The only entries of note in the ACCT refer to his children. He was given a message from his daughter that she sent her love. He then seemed in good spirits. Until then, the man had not had any outside visitors by his own choice. He told Prisoner A that he did not want to have emotional visits that might “weaken his resolve” to continue his protest.

47. He had another visit from Prisoner A on 11 January. Afterwards Prisoner A told staff that the man would like to see his daughter. However, he felt that it would be too upsetting for her. One of the prison governors spoke to him and reassured him that, should he change his mind, a visit could be arranged. Up until this point, the man had wanted to keep his situation away from his family because he did not want to cause them distress. Three days later, Prisoner A

visited again. This time he was surprised to see his friend sitting at his desk looking more "bright eyed".

48. On 18 January, the man was transferred into a larger cell within the segregation unit as a hospital bed was being provided for him. The bed also had a pressure relieving overlay mattress. This had apparently been discussed with him and other staff at an ACCT review two days earlier, but there is no note of the review in his prison record. The man appeared pleased and moved cells without much assistance, although he was frail.

49. A week later, on 26 January, he had a visit from some family members. He had reportedly been looking forward to it for several days and asked for assistance to shower and shave beforehand. The log notes that the visit took place in the chapel and appeared to go well.

50. A Governor spoke with the man the following day. They talked about his visit, refusing food and the affects on his friends and family. He said that he could see that his food refusal hurt his family and friends but it did not change his mind. They spoke at length about his continued determination to refuse food and to engage in the parole process.

51. Principle Officer A had a conversation with the man on 28 January. The Principle Officer told him that his nephew had telephoned and wanted the man to know that his daughters would like to visit again. The man said he would write to them. Principle Officer A described the man as in high spirits and keen to talk. Two days later however, he was reportedly stressed about the visits which had subsequently been arranged. It appears that he felt it was too much but he did not want to hurt anybody's feelings. He told the officer that he wished he had not started with visits. This said, it is clear from his conversations with Prisoner A and the staff that he was very happy when he received correspondence or spoke to his family on the telephone.

52. The IMB also had regular contact with the man and would see him on their regular rounds of the segregation unit. A member of staff from the IMB saw the man on 29 January. She too noted that he enjoyed the visit from his family. She also highlighted that an electric heater and some brighter coloured blankets, which had been put in the man's cell, made a "surprising" difference. She spoke to the segregation unit staff. They were aware it was a matter of time before the man would succeed in his protest and staff would witness him die. She asked how the staff were coping with looking after somebody who overtly wanted to end his life. She was told that there were counselling sessions available. However, I too note that this must have been a difficult task for staff.

53. During February and March, the records show similar events relating to the man's daily activity, care and treatment. He was becoming increasingly frailer. An entry in his medical record by the duty doctor on 19 March shows that he had felt low in mood for a few days and was unable to concentrate as well as before. He reported "a rushing train of thoughts" which included reference to self harm. This had scared him and he had pressed his cell bell

to ask for a 'Listener'. (A Listener is another prisoner who has been trained by the Samaritans to be a contact for any prisoner feeling vulnerable or at risk. The scheme is confidential.) The man spoke with the Listener for an hour and a half which he reported was helpful. The doctor went on to note that the man was frail and slightly anxious but was able to converse and made good eye contact. The doctor told him to seek immediate attention if he had any similar thoughts.

54. Doctor A, who was on duty the following day 20 March, saw the man. The doctor noted that he looked very weak and tired compared to the previous week. The man also spoke to the doctor about his lack of concentration, feeling very tired and "muddled in the head". The man said he had no suicidal thoughts but did not feel in control. He added that he did not fear death, but did not like losing control. He said he could not concentrate enough to read a whole letter or write a reply which upset him. Doctor A offered the option of reintroducing some nutrition to improve his energy levels but the man declined. The doctor did not feel there was any risk that he would harm himself but, in view of his recent low mood, felt that he should be monitored every 30 minutes (at the time it was approximately every hour) until the following week.

55. On 23 March, the man signed a document agreeing to move into the healthcare centre at HMP Gartree where he could be made more comfortable. However, he also signed to say that he did not agree to any further treatment at the time. The document was witnessed by an officer and the Head of Healthcare.

56. The forensic psychiatrist saw him again on 26 March. The man confirmed that he did not want to change any of the terms in his Advance Directive. They also discussed ways in which to assist him, including contact with his family. He told the psychiatrist that he had contact with his family but did not want them to visit him in prison.

57. The clinical care plan dated 26 March showed that the man was now living in the healthcare unit. He was to be seen by the duty doctor every weekday morning and be monitored by healthcare staff at regular intervals through the day and night. His blood pressure and pulse were to be monitored daily for a week. Further medical observations were to be carried out as his condition indicated thereafter. The man's personal needs were to be met by the healthcare team if he was unable to do so himself (for example intimate personal care, pressure area care). The care plan was reviewed on 30 March.

58. A brief 'End of Life Plan' summary was written on 8 April by Nurse A and the Head of Healthcare. They recorded that an on-call rota system would be in place to support lone staff during evening duties and night shifts from 13 April. It noted that, if the man's condition deteriorated significantly, two members of staff would be required to safely provide nursing care such as turning him regularly and continence care. The new staffing levels reflected this need. An open door policy for nursing care was authorised if the man's condition

deteriorated and his death was imminent. In the event of a significant deterioration of the man's health, the Emergency Intervention Plan was to be followed.

59. The clinical care plan was reviewed and updated again on 15 April. It stipulated that the man would continue to be seen by the duty doctor every weekday morning and monitored regularly by healthcare staff. Physical observations were to be recorded as appropriate, medication administered as prescribed and reviewed regularly by the doctor. His personal needs would also continue to be met if he was unable to do so himself. The plan was reviewed again on 30 April and the arrangements remained the same.

60. From April onwards there are regular entries about the man suffering from shortness of breath for which he was given oxygen. Some days he would accept assistance with personal care when he felt too tired, other days he declined. The same applied to cleaning his cell. In May, he became increasing weak and frail. He needed to use oxygen and an inhaler more and was becoming vague and confused on occasion. Personal hygiene and cleaning his cell was done for the man as he was less able. He was also becoming less able to communicate without becoming breathless.

61. He was given personal care on 2 May. He had his face and hands washed and clothing changed. He declined a shave or for his cell to be cleaned. The nurse was unable to check his pressure areas, but wrote that the man told him he had no discomfort or pain in the areas and just felt cold and tired. Staff offered a visit from Prisoner A but he said he was too tired. He asked to be left alone and spent the afternoon watching snooker on the television. He continued to take fluids but declined meals.

62. The following day followed a similar pattern and that night the man was said to have been settled. However, on the morning of 4 May, the nurse on duty wrote in the medical record that the man sounded “a bit vague”. He was saying that he had been kidnapped and wanted to know why. The nurse reassured him that he was in his cell and had not been kidnapped. After about half an hour he returned to sleep.

63. When the man woke later, he still appeared slightly confused. He also said that he was feeling “very dry”. The nurse on duty made him a cup of coffee and gave him a litre of fruit drink as well as two pints of hot water. He then had his hands and face washed and his bed tidied.

64. The medical records show the man to be more orientated on 5 May. He had been incontinent during the night and so his bedding and cell were cleaned, but he declined a change of clothes. His personal items were put next to him so that he could reach them more easily. The man was incontinent of faeces the following morning, and staff cleaned up as much as he would allow. He was reportedly very tired after being washed and having his bed changed. Staff felt he would be better having a bath but left him to rest. Later he was given a wash in his bed again and this time accepted clean clothing.

65. That afternoon, the man did not respond much to staff and his breathing was laboured, and staff had been afraid that he was about to die. Doctor A saw him that evening and described him as having "rallied well". Doctor A saw the man again on 7 May. It was reported that he was feeling a little better than the previous day. The doctor spoke to him about changing his mind and accepting food, saying that nobody would think ill of him if he changed his mind. The man said that he was determined, although he did thank the doctor for the thought.

66. Later that day the medical records show that he was very weak and confused and did not communicate much. He was offered some flasks of hot water and some fruit juice but he declined. He indicated that he did not want to drink and had sufficient at hand if he did want one. That evening he complained of shortness of breath and was given oxygen. He also had visit from Prisoner A.

67. The man was incontinent in his bed during the morning of 8 May. His bedding was changed and washed. He took his medication and received some personal care. That evening he was made comfortable in the bed. He was reportedly cold so his quilt was pulled back over him, and his electric heater switched on. The man was drinking coffee and seemed more alert although speaking appeared to be an effort due to a dry throat. During that night, as previously the man was moved to increase his comfort and prevent pressure sores. He was offered fluids but declined.

68. Early in the morning on 9 May, a nurse noted that the man's breathing had changed and was more laboured. In line with the Emergency Intervention Plan, the paramedics were called. They were told of his Advance Directive and so no action was taken. Later, his personal hygiene was attended to by nurses and his breathing was thought to have improved. There was no change in his condition through the rest of the day.

69. At approximately 5.30am the next morning, 10 May, an entry in his medical records shows that the man's condition remained unchanged. He was semi-conscious with laboured breathing. At 10.30am he was given personal care and his cell cleaned and tidied. His condition remained the same.

70. Nurse A wrote an entry in the man's medical record at 1.53pm. She noted that he was able to move his limbs independently but his breathing remained laboured. Shortly afterwards at 2.10pm a Nurse came to alert Nurse A that she had been to check the man and found him unresponsive. The man's pulse, breathing and pupils were checked but there were no signs of life. The paramedics declined to attend in the circumstances. The police did attend, as they do for all deaths in custody.

Events following the man's death

71. The Duty Governor and Orderly Officer were informed and the man's cell was secured as is the policy in a death in custody. The prison carried out the appropriate death in custody contingency plans.

72. The Head of Health Care contacted the man's named next of kin. Prior to his death, the prison and the man's next of kin had made arrangements for how the news would be broken. It was decided that, because of the next of kin's awareness of the man's condition, that an initial telephone call would be appropriate.

73. HMP Gartree paid for the man's funeral and the Deputy Governor and Family Liaison Officer attended.

74. I have already mentioned how difficult it must have been for all the staff to care and treat the man whilst they knew he was dying. The Governor arranged for counselling services for staff who had dealt with the man. Staff also had the services of the prison Care and Welfare Team made available to them. These services were also available to staff during the period of the man's food refusal.

75. Prisoner A was monitored by wing staff and his personal officer. He was also offered the services of the Chaplaincy team and the Listeners (Samaritan trained prisoners who are a point of contact for any prisoner who feels vulnerable).

ISSUES CONSIDERED

Clinical Review

76. Given the man's health and situation, the review of his clinical care was central to this investigation. The Clinical Reviewer carried out the review and interviewed the Head of Healthcare at Gartree. The reviewer was satisfied with the quality of the documentation available that he felt no need to interview other healthcare staff. In his report he summarised the man's past medical history which included:

    - "Drug misuse
    - Gunshot wound to right shoulder causing osteoarthritis, persistent pain and limitation of movement
    - Partial amputation of left index finger
    - Pulmonary tuberculosis of right lung – residual scarring and effusion (fluid)
    - Lower Urinary Tract Obstruction symptoms
    - Hypertension
    - Atrial Fibrillation (fast and irregular heart beat)."

    The Clinical Reviewer concluded that the notes and medication suggested that these problems were appropriately managed. He felt that further exploration of the man's past medical history revealed no issues relevant to the cause of his death.

77. As well as his medical history, the Clinical Reviewer took into account his food refusal and protest history. He considered a psychiatric report from 1981 (previous sentence) that showed recurring themes throughout the man's custody. These are as follows:

    - "… no evidence of psychosis, depression or any mental health disorder.
    - Food refusal as an avenue of protest at the humiliation he felt at being detained within the penal system.
    - Lack of regret for any of his convictions.
    - Reluctance to accept responsibility for his actions.
    - Reluctance to accept prison as an appropriate punishment for his conviction.
    - Normal intelligence."

78. The Clinical Reviewer also noted the man's other forms of protest behaviour such as dirty protests, work refusal and periods of non communication. The Clinical Reviewer has not given detailed summaries of these events as they would not change the outcome of his report. However, in his opinion, the cause of the man's death in custody is best understood in the context of his inclination towards protesting.

Overall clinical care

79. One of the issues considered by the reviewer was whether or not the man received medical care which was comparable to that which he might expect to receive in the community. The Clinical Reviewer was of the view that the man's health problems were appropriately managed in the months leading up to his death and that his medications were appropriately reviewed.

80. He concluded that the man's past medical history and medication revealed no evidence of issues relevant to his cause of death. From the evidence that he had, the Clinical Reviewer believes that the care provided to the man was at least as good, if not better, than that which he could have expected in the community.

81. The clinical reviewer is also asked to highlight any learning opportunities. He felt that there were no particular learning opportunities with regards to the man's care and treatment and went as far as to comment that this case could be an exemplar for other prisons.

Information Sharing

82. So often in investigations I am critical about information sharing, particularly medical information. I am therefore pleased to be able to comment here on the good information sharing between healthcare and the segregation unit staff. This is all the more important when looking after someone with complex needs who is living in the segregation unit. Although the officers did not necessarily know all of the man's medical history, nor would they need to know, they had instructions on emergency intervention and knew that he needed particular monitoring.

Record keeping

83. The Clinical Reviewer relied primarily on the documentation provided by Gartree to conduct his review. He felt the quality of the documentation was such that he could get most of his information without the need to formally interview many staff. In fact, he has described the man's clinical records to be of a consistently high standard providing an "excellent" narrative of the thoughts and actions of staff at Gartree. It is pleasing to report positively on clinical records as they are also commonly criticised in this office's investigations.

Early Release on Medical Grounds

84. One question that the man's next of kin raised was why he was not released on compassionate grounds as they were aware that other prisoners in different prisons had been released.

85. The Prison Service has a policy for the release of prisoners, this is Prison Service Order (PSO) 6000. A full copy can be found on the prison service website www.hmprisonservice.gov.uk. Chapter 12 of the PSO describes the

conditions for early release on medical grounds. This can be considered where a prisoner is suffering from a terminal illness and death is likely to occur within a short period. This is usually judged to be within three months although there are no set time limits. Additionally, the Secretary of State needs to be satisfied that the risk of re-offending is past. Conditions which are self-induced, such as a food refusal, would not normally qualify a prisoner for compassionate release on medical grounds.

86. Formal consideration was not given to early release for the man as he would not have met the criteria. Firstly, he was not suffering a terminal illness. Secondly, his condition was self-induced and, had he chosen to resume eating, he would not have died in the way that he did, nor would his condition have been terminal. Lastly, because he never accepted the legality of his imprisonment, he had not engaged in the parole process or in any work to show a reduction in his risk of re-offending.

87. I hope that this explanation provides some clarity for the man's next of kin on this issue.

CONCLUSION

88. Although not all the contact and intervention has been included in this report, there is much evidence that the staff at Gartree, both healthcare and discipline, treated the man with compassion and dignity. Most notable is that, despite staff members' personal feelings and beliefs about his food refusal, the man's wishes were respected and adhered to. In the journal entries that he shared with my colleagues, Prisoner A noted the good treatment and decency of segregation staff in supporting his friend.

89. One of the most important questions is whether a death in custody could have been avoided. The Clinical Reviewer notes that, based on the evidence, there was no doubt that the man had the mental capacity to persevere with his food refusal and that he understood the consequences. There is also plenty of evidence that all steps to treat and care for him within the boundaries of his Advance Directive were taken. There are many documents showing that his condition was regularly reviewed and staff would attempt to persuade him to change his mind. There is evidence of good information sharing and record keeping. His mental health was reviewed on several occasions. He was placed on self harm monitoring and there are regular entries in his segregation wing history sheet.

90. The Clinical Reviewer has added, and I concur, that it would be speculative to consider why the man persevered with this final protest. There is no evidence to suggest that the provision of care the man received at Gartree had any influence on his determination to end his life. The opposite would be true. I am satisfied that the man was treated with dignity and compassion and the staff who worked with him should be commended. I make no recommendations in my report. I do however, draw the Clinical Reviewer comments about using this as an exemplar for other prisons to the attention of the Director of Offender Management, who may wish to share it with the prisons in her area and the wider prison estate.