PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man while in the custody of HMP Gartree in December 2013

Our Vision

'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution
to safer, fairer custody and offender supervision'

This is the investigation report into the death from liver failure of a man in December 2013, while a prisoner at HMP Gartree. He was 61 years old. I offer my condolences to those who knew him.

A clinical review of the care the man received at Gartree was undertaken. The prison cooperated fully with the investigation.

The man was sentenced to life imprisonment in May 2005 and had been at Gartree since May 2007. When he arrived at Gartree, it was noted that he had a long-standing liver condition. Other than this, he was a relatively healthy and uncomplaining man, who did not come to the attention of healthcare staff until April 2013, when staff noticed a significant deterioration in his health.

The man was then admitted to hospital on a number of occasions with symptoms associated with liver disease. His health continued to deteriorate and he was admitted to hospital on 12 October. In November, a hospital consultant told him that his life expectancy was just a matter of weeks. He moved to a hospital palliative care suite for end of life care on 28 November and in December.

The clinical reviewer found that the man should have had annual blood tests to monitor the progress of his condition; but that once the deterioration in his health was identified he received a very high standard of care at Gartree. I agree, but I am concerned that the use of restraints when he was taken to hospital was not justified by a fully considered risk assessment which took into account his poor health and mobility. This is a matter I have raised with the Gartree before.

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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **June 2014**

CONTENTS

SUMMARY

1. The man was remanded into custody in September 2004 at HMP Gloucester. He moved to HMP Exeter in November that year and was sentenced to life imprisonment in May 2005. He transferred to HMP Gartree in May 2007. He had been diagnosed with a liver condition in 2003, before his prison sentence. Despite this, he was a relatively healthy man and did not come to the attention of healthcare staff until April 2013.

2. On 4 April, officers were concerned about the man and nurses examined him. They noted that he had a distended stomach, swollen scrotum and ankles and that he became breathless on exertion. A GP saw him on 5 April and sent him to hospital where he was diagnosed with acute ascites (abnormal accumulation of fluids) a secondary condition of liver disease. He was discharged back to prison on 9 April.

3. Between April and August, healthcare staff frequently reviewed the man and he attended a number of hospital appointments for his liver condition.

4. The man was admitted to hospital in August and twice in September as his condition deteriorated. On each occasion he was treated and returned to Gartree.

5. On 12 October, the man was admitted to hospital and tests confirmed he had end stage liver failure. He remained in hospital and, on 7 November, he was told his condition was terminal and his life expectancy would be a maximum of three weeks. He moved to a hospital palliative care suite on 28 November, where he died in December.

6. The clinical reviewer is satisfied that, once the deterioration in the man's condition was identified, he received a very high standard of healthcare. However, before he became obviously ill, his chronic condition was not monitored and he did not have annual blood tests, which he would have received in the community.

7. Although the man was assessed as a low risk of escape, restraints were used when he was in hospital and we are not satisfied that the risk assessment fully took into account his state of health and mobility. We make two recommendations.

THE INVESTIGATION PROCESS

8. The investigator issued notices to staff and prisoners at Gartree informing them of the investigation and inviting anyone who had relevant information to contact her. No one responded.

9. NHS England commissioned a clinical reviewer to assess the man's clinical care at the prison.

10. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison records. She and the clinical reviewer interviewed five members of staff at Gartree on 11 February. She gave the Governor initial written feedback.

11. We informed HM Coroner for Leicester City and South District of the investigation, who provided the cause of death. We have sent the Coroner a copy of this investigation report.

12. The man did not have any listed next of kin and, despite enquiries, no relatives have been found.

13. The investigation has assessed the main issues involved in the man's care, including his diagnosis and treatment, whether appropriate palliative care was provided, efforts to locate his relatives, his location, whether compassionate release was considered; and security arrangements for escorts.

HMP GARTREE

14. HMP Gartree, near Market Harborough in Leicestershire, holds up to 707 men sentenced to life and other indeterminate sentences. Leicestershire Partnership Trust are responsible for delivering primary physical and mental health services in the prison and Northamptonshire Healthcare NHS Foundation Trust run secondary mental health in-reach services.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Gartree was in May 2010. Inspectors found good GP cover, with seven sessions a week and prisoners were able to get routine appointments within seven days. New arrivals had a brief health assessment with a more comprehensive assessment the next day. Chronic disease management was good with support from GPs and visiting health professionals. Inspectors noted that an inpatient facility had recently closed and a wing-based nursing system was working well.

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its most recent published annual report for the year to November 2012, the IMB reported that patients were now managed on the wing unless needing hospitalisation. The IMB noted that too many hospital appointments were cancelled, with only 72% fulfilled.

Previous deaths at HMP Gartree

17. The man is the third prisoner to die from natural causes at Gartree since 2011. We have raised the issue of inappropriate use of restraints before.

ISSUES

The diagnosis of the man's terminal illness and informing him of his condition

18. The man was sentenced to life imprisonment in 2005, and transferred to HMP Gartree on 15 May 2007. He was diagnosed with primary biliary cirrhosis (an autoimmune liver condition) in 2003. Despite this diagnosis he did not have any monitoring checks. He did not have any reported symptoms until prison staff noticed he appeared unwell in April 2013.

19. Nurses assessed the man on 4 April and noted he had a distended abdomen and his ankles and scrotum were swollen. A prison GP examined him on 5 April. The doctor was concerned at his condition and sent him to hospital the same day. In hospital, he was diagnosed with acute ascites (abnormal accumulation of fluids), a symptom of liver disease. His abdomen was drained of fluid and a drain inserted to enable further fluid drainage (this was removed on 17 April). He was prescribed diuretics (to prevent water retention) and discharged back to prison on 9 April.

20. From April to August, healthcare staff saw the man frequently to review his condition. He attended a number of hospital appointments in relation to his liver condition.

21. On 29 August, a prison GP noted the man had difficulty standing, jaundice, hypertension and abnormal blood tests. He arranged for him to be admitted to hospital the same day. He was treated and discharged from hospital on 30 August, with a follow up appointment for the Hepatology Clinic (liver specialist).

22. On 6 September, the man was taken to hospital as an emergency when he became very unwell and was semi-conscious. A CT scan of his head showed no specific abnormalities. He was treated in hospital and he returned to the prison on 16 September. On 27 September, he was admitted to the hospital again after his condition deteriorated further. When he was discharged on 29 September, records show that he was very weak and required a wheelchair.

23. On Saturday 12 October, a nurse saw the man and noted that he appeared confused, felt cool to touch and had low blood pressure. He was admitted to hospital and, on 1 November, he was diagnosed with terminal end stage liver failure.

24. On 7 November, a hospital consultant informed the man that his life expectancy would be a maximum of three weeks. He initially appeared upset by this news and the prison's clinical manager visited him and helped him understand his prognosis. She noted that he appeared to come to terms with this.

25. The man had informed prison staff at Gloucester about his diagnosis of primary biliary cirrhosis (PBC) when he arrived in September 2004 and the prison obtained his community medical records. These contained a letter of

January 2004, from his consultant, which confirmed the diagnosis of PBC and asked to see him in a year's time. The records do not show if this appointment took place. When he got to Gartree, he also told healthcare staff about his condition. His records, including the letter from the consultant, were available, yet there was no further follow up of his condition until he became ill in April 2013.

26. The clinical reviewer says that primary biliary cirrhosis is a condition that causes low grade inflammation of the liver, which over time progresses to liver damage and cirrhosis. It is not a common condition and the rate of deterioration after diagnosis is variable, with good health often maintained for many years. The clinical reviewer says that patients in the community with this condition would usually have an annual blood test to check liver function. He notes that there was no monitoring of the man's medical condition and no annual blood tests recorded in his prison health records. While the condition is ultimately fatal, the clinical reviewer concludes that such tests might have indicated his deterioration and enabled clinicians to act on his symptoms earlier and make him more comfortable. We make the following recommendation:

The Head of Healthcare should ensure that patients with chronic conditions are appropriately managed in line with practice in the community.

The man's medical treatment

27. After his terminal diagnosis, the man remained in hospital until his death. Hospital care and treatment is outside the remit of the Ombudsman. Healthcare staff from the prison kept in frequent contact with the hospital and received regular updates on his condition.

28. On 28 November, the man transferred to a hospital palliative care suite and died peacefully on 4 December.

29. We agree with the clinical reviewer that the care given to the man from April 2013 during his illness and deterioration was very attentive. He was reviewed regularly by nursing staff and doctors, and care was taken to obtain information while he was in hospital.

The man's location

30. The man lived on the second landing of his wing which required him to climb two flights of stairs. He began to find the stairs difficult as his condition deteriorated, but told staff he did not want to move and enjoyed the exercise.

31. After he returned from hospital on 29 September the man agreed to move to a ground floor cell which had grab rails and could accommodate a wheelchair. Initially he managed well, but his mobility declined. His meals were then delivered to his cell and a 'buddy' lived in the next door cell. (A buddy is a specially selected prisoner to assist with day to day living.) His health

deteriorated and he was admitted to hospital on 12 October, where he remained for over six weeks.

32. A doctor from the hospital contacted healthcare staff on 13 November to discuss the man's end of life care. He said the man would require extensive medical and nursing care, which Gartree was unable to provide. He was assessed by the palliative care team at the hospital and, on 28 November, he moved to the palliative care suite at a hospital for end of life care.

33. We are satisfied that staff at HMP Gartree did their best to ensure the man was able to remain in his preferred place of care for as long as possible, where he was well supported by staff and prisoners. Once he became seriously ill, he was admitted to hospital and was appropriately moved to hospice care at the end stage of his illness.

Restraints, security and escorts

34. The Prison Service has a duty to protect the public when escorting prisoners to hospital, and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes into account factors such as the prisoner's health and mobility. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process. It also deemed that restraining by handcuffs of a prisoner receiving chemotherapy (and by implication, other life saving treatment) was degrading and that such restraint would be likely also to be regarded as inhumane unless justified by other relevant considerations.

35. When the man was taken to hospital on 5 April, he was accompanied by two officers and restrained using double cuffs. The restraints were removed for treatment and reapplied shortly afterwards. At 10.05pm that night, the duty manager gave permission for the double cuffs to be replaced with an escort chain.

36. The man was taken to hospital on 29 August. At the time, he was finding it difficult to stand and was hypertensive and jaundiced. He was again accompanied by two officers and restrained using double cuffs. The risk assessment was reviewed later that day and the double cuffs were replaced with an escort chain when he was moved into a wheelchair. Single cuffs were used for his return journey to prison on 30 August.

37. The man was taken to hospital again on 6 September, and was semi-conscious. He was restrained using an escort chain. The escort chain was removed when he became unconscious and was taken to intensive care. The

escort record shows that at 7.50pm, the escort chain was reapplied when he regained consciousness.

38. On 27 September, the man was again taken to hospital; he was very ill and unable to respond to staff. This time he was accompanied by two officers but not restrained.

39. On 12 October, the man was taken to hospital as an emergency. He was accompanied by two officers and restrained using double cuffs. The risk assessment noted that single cuffs could be used during treatment but double cuffs should be used at all other times. Later that day, the cuffs were replaced by an escort chain. On 1 November, hospital staff raised concerns about the use of restraints, as his wrist was swollen and the cuff was rubbing. The clinical manager informed the Head of Security of his poor prognosis, lack of mobility and the issues about the use of cuffs. Despite this, restraints were not removed until 7 November, after which they were not reapplied.

40. On each occasion the man was taken to hospital, he was assessed as a low risk of escape. The healthcare section of the risk assessment indicated there was no objection to the use of restraints, which is not the test required by the court judgement. Assessments contained little detail about his medical condition and nothing about how it impacted on his risk of escape. He was restrained on each occasion apart from 27 September.

41. Double cuffing entails the prisoner having his hands cuffed in front of him and then having one wrist attached to a prison officer by an additional set of handcuffs. This is usually required for moving category A or category B prisoners in good health. The man was a category B prisoner, but was seriously ill with limited mobility and consistently assessed as low risk of escape. There is no evidence to support the decision to double cuff him and we can see no reason how it would be justified. The risk assessment form used at Gartree does not include a prompt for a prisoner's medical condition and mobility to be considered. We spoke to the Head of Security at the prison, who told us that all category B prisoners would automatically be double cuffed. Such a default position is not acceptable and contrary to the court judgement which requires health and mobility to be taken into account.

42. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances which must be fully considered, taken into account and balanced against the security risks. We are not satisfied that the decisions taken were justified by fully considered risk assessments that took into account the man's medical condition. This is a matter we have raised with Gartree before. We make the following recommendation:

The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

Liaison with the man's family

43. The man did not have any next of kin recorded. His only known relative, an elderly aunt had died some time ago. Enquiries were made but no other relatives were found.

44. A memorial service was held in the prison chapel on 5 December. The prison organised and paid for the funeral.

Compassionate release

45. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months.

46. On 7 November, while in hospital, the man was told his life expectancy was a matter of weeks. A senior manager told us that he was asked if he wished a compassionate release application to be made, but he declined. He had no relatives and nowhere to go. In the circumstances we are satisfied that compassionate release was appropriately considered.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that patients with chronic conditions are appropriately managed in line with practice in the community.

2. The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

ACTION PLAN:

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and **function responsible**
1	The Head of Healthcare should ensure that patients with chronic conditions are appropriately managed in line with practice in the community.	Accepted	The Head of Healthcare will review all prisoners with chronic conditions to ensure they are being appropriately managed in line with practice in the community	August 2014 Health Service Manager
2.	The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.	Accepted	In January 2014, further guidance was issued by NOMS to all Governors and Directors about the use of restraints. All on-call mangers at HMP Gartree that complete risk assessments will be given training in line with national guidance on the legal position when prisoners are escorted to hospital. A much more in depth risk assessment document has now been introduced at HMP Gartree which takes into account the physical health and mobility of each prisoner and records the risk they present at the time of assessment. Risk assessments for prisoners with chronic conditions will be reviewed by the Safer Custody team and learning will be shared with on-call managers.	May 2014 Head of Residence and Safety