

**Investigation into the circumstances surrounding the  
death of a man  
in March 2010, in hospital,  
whilst in the custody of HMP Garth**

**Report by the Prisons and Probation Ombudsman  
for England and Wales**

**June 2011**

This is the report of an investigation into the circumstances of the death of a man.

He died in hospital in March 2010 whilst in the custody of HMP Garth. My Senior Family Liaison Officer spoke to his niece to explain the purpose of my investigation. I offer my condolences to his family, and I apologise for any added distress caused by the delay issuing my report.

The investigation was undertaken by one of my senior investigators. Both he and I would like to thank the Governor of Garth and his staff for their participation in this investigation.

He was transferred to Garth in January 2010. He was an elderly man, who had been in prison for a number of years. Although he had no major health issues, he had problems with his back and had suffered from high blood pressure for some time. After his arrival at Garth, he complained on several occasions of pain and occasional loss of vision in his left eye, and was taken to hospital a number of times. In the early hours of 5 March, his health deteriorated, and later that morning he was taken to hospital. Doctors said that he appeared to have suffered a stroke. Hospital staff did what they could to make him comfortable, and he died early in the morning the next day.

The local Primary Care Trust (PCT) commissioned a clinical reviewer to review the man's clinical care, and I greatly appreciate his assistance. The clinical reviewer finds that he received good medical care at Garth. He makes three recommendations to the Head of Healthcare at HMP Kingston about his care during his time there, and I draw her attention to the clinical review. My investigator has discussed the recommendations with her, and I have included her responses in this report.

I do not think that it was dignified that the escort chain was only removed ten minutes before he died and so I make one recommendation relating to security assessments on prisoners who are in outside hospital. I am pleased to see that the National Offender Management Service has accepted this recommendation.

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**  
**Acting Prisons and Probation Ombudsman**

**June 2011**

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## SUMMARY

1. The man was sentenced to life imprisonment in 1983. He had therefore spent a number of years in the prison system, and was 65 years old when he died.
2. He did not have any major health problems in the course of his sentence, apart from an occasion where his hepatitis made him unwell in early 2000. He complained of chest pain later that year, and was prescribed medication to treat high blood pressure. He also suffered some pain in his back, which was found to be caused by sciatica.
3. In July 2009, whilst in HMP Kingston, he complained of headaches and was prescribed medication for high blood pressure. In September he hurt his head whilst rearranging the furniture in his cell, and sustained a cut which needed stitching. Over the next few months he continued to be monitored by healthcare staff, but was described as a difficult patient to deal with. He was argumentative and occasionally aggressive towards staff, and would not always comply with his medication or treatment.
4. In January 2010, he was transferred to HMP Garth. The day after he arrived, he was given an initial health screening where staff assessed that his blood pressure was very high and referred him directly to hospital. Although he was not admitted on that occasion, he continued to be monitored by healthcare staff on the days after his return to prison. He remained a difficult patient to deal with, refusing to engage fully with staff and not complying with the suggested dosage for his medication.
5. He continued to suffer from high blood pressure, and on 22 January complained of loss of vision in his left eye. He was taken to hospital for tests, and found to have a blocked vein in his eye (a retinal occlusion). He was prescribed aspirin, but continued to complain of headaches. Following further loss of vision and other problems, he moved several times between hospital, the prison's healthcare centre, and an ordinary prison wing through mid to late February.
6. On 1 March, he refused to take his blood pressure medication, saying that it made his pain worse. He took his medication the following morning, but later that day refused all medication before asking for some painkillers. He refused his blood pressure medication in the afternoon of 3 March but took his medication at night.
7. The following day he refused to have his eye drops. He took his medication that night, but was later sick. During the early hours of 5 March he became unwell and later that morning the doctor came to see him. He arranged for him to be taken to hospital.
8. A security assessment was carried out, and in view of his previous behaviour it was agreed that he should be restrained with an escort

chain whilst he was in hospital. The chain was removed whilst he was undergoing medical assessment, but replaced when the assessment was complete.

9. Later that afternoon healthcare staff were told that he may have had a stroke. By this stage he was extremely unwell. His blood pressure was very high, and he had had a massive bleed to his brain. Nursing staff provided an oxygen mask to assist his breathing, but he was not expected to live much longer. In the early hours he was given some medication to ease his pain, but nursing staff said that he would not recover from the bleed on his brain. At approximately 2.18am escorting staff removed the handcuffs and his death was confirmed ten minutes later at 2.28am.
10. Through his years in custody, he had lost contact with any friends or family outside prison. Although prison staff had considered contacting his family when it was suspected that he had had a stroke, they had not managed to trace anyone before he died. Having asked for assistance from the police, his family were eventually traced and notified.
11. I do not think that it was dignified for a man at the end of his life to be restrained by an escort chain and so I make one recommendation relating to security assessments on prisoners in outside hospital. In addition the clinical reviewer makes three recommendations to the Head of Healthcare at HMP Kingston, which have been drawn to her attention and the responses to which are included in this report.

## THE INVESTIGATION PROCESS

12. HMP Garth provided the Ombudsman's investigator with the man's prison record. He also obtained his medical records. He spoke to staff who knew him at Garth, as well as to the Head of Healthcare at HMP Kingston.
13. Notices were issued to staff and prisoners informing them of the investigation and inviting anyone with relevant information to contact my investigator. No further information was received.
14. The local Primary Care Trust (PCT) conducted a clinical review of the man's care and treatment. This was undertaken by the clinical reviewer. My investigator discussed the report with him, and they worked together through the investigation. Unfortunately, a delay receiving the review contributed to the overall delay in publishing this report.
15. My investigator maintained ongoing contact with his liaison officer in Garth throughout the investigation. He also wrote to the Head of Healthcare at HMP Kingston and spoke with her on the telephone. He provided ongoing feedback to his liaison officer at Garth during the investigation.
16. My Senior Family Liaison Officer contacted the man's niece to explain our investigation and offer the opportunity to contribute. The family asked if the report could indicate his offence and sentence, and give details of how and where he died. I hope that my report addresses the family's questions.
17. My investigator wrote to HM Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. Throughout the course of the investigation, my investigator remained in contact with the Coroner's office. Upon completion, this report will be sent to the Coroner to assist his enquiries into the man's death.

## **HMP GARTH**

18. HMP Garth is a category B training prison, which opened in 1988. It holds category B prisoners (not the highest security, but for whom escape must be made very difficult) who are serving sentences of four years or more, including life sentence prisoners.
19. Healthcare is provided by the local Primary Care Trust (PCT). The team includes general and mental health nurses, and the prison has 24-hour care. Although it has since closed, at the time of the man's death there was an eight bed in-patient unit.

## **Previous deaths at Garth**

20. Since my office took over responsibility for investigating deaths in prison custody in 2004, the man is the eighth prisoner to have died whilst in the custody of Garth. In 2007 I made a recommendation relating to the importance of updating next of kin records, which I draw to the Governor's attention in this report. I do not repeat my recommendation here as I think it unlikely that he would have been able to provide contact information.

## **Her Majesty's Inspectorate of Prisons**

21. The last report published on Garth by HM Chief Inspector of Prisons followed an unannounced inspection from 30 March – 3 April 2009. The report does not raise any issues which are relevant to this investigation.

## **Independent Monitoring Board (IMB)**

22. Each prison in England and Wales has an Independent Monitoring Board, made up of members of the community, responsible for monitoring day-to-day life in the prison and to ensure that proper standards of care and decency are maintained. The last report published by the IMB for Garth does not contain any issues that are relevant to this investigation.

## **Security arrangements when under escort**

23. On each occasion when a prisoner is escorted outside of the prison to hospital a risk assessment is completed which considers the risk to the public, potential for escape and likelihood of outside assistance. The assessment informs the decision about the number of escorting officers and the type of restraint to be used. The alternatives are single security handcuffs, which were used for the man, or a two metre long escort chain with cuff at either end to attach the prisoner to one of the escort officers. The assessment also determines the circumstances and the authority required for the restraints to be removed. The risk assessment should be reviewed by prison managers each day that a prisoner is in hospital and amended where necessary.

## KEY EVENTS

24. The man was born in South Wales in October 1944. He was 65 years old when he died.
25. He said that he had had difficulties from a young age, being taken into care at the age of eight. After leaving school, he had lived a rather nomadic lifestyle, living for some time in the Midlands. He sometimes worked as a labourer on building sites.
26. In December 1983, he was convicted at Crown Court of having committed murder in July of that year. He was sentenced to life imprisonment.
27. He spent many years in the prison system in a number of prisons. He was often described as a difficult prisoner, not engaging with staff, going on hunger strike and/or threatening to cause damage to property if he did not get what he wanted. Records show that on occasions he also refused to take the medication he had been prescribed as a form of protest. He was initially in contact with his family, but through the years contact faded.
28. His medical notes show few major problems throughout his sentence. After becoming ill he was diagnosed with hepatitis B in early 2000. On 15 December 2000, he complained of chest pain, and he was prescribed drugs to treat hypertension (high blood pressure) and cardiovascular (heart) disease. Records show that he continued to be prescribed this medication until 2003, but do not show why it was stopped. There are no notes of any further incidents of chest pain, or any further medical investigation. There are also references on the medical files to him having had laser surgery on his eye to correct cataracts, but again there is no clear indication as to when this was.
29. In 2008, he complained of pain in his back, saying that he had suffered from this for some years. This was found to be due to sciatica (pain in the back or, more commonly, leg, caused by compression on the sciatic nerve in the lower back) and was treated, using medication, by prison medical staff.
30. On 6 November 2008, he was transferred to HMP Kingston. In July 2009, he was again prescribed medication for high blood pressure after complaining of headaches. There are concerns noted in the medical records over whether he took his medication as directed. He was prescribed further medication for his blood pressure on 18 September.
31. A note on his medical file shows that on 20 September he suffered an injury to his head. This was caused by a stereo speaker falling from a shelf while he was rearranging his cell. The injury required five sutures (which are similar to stitches and used to close a wound), but appeared to be only superficial.

32. On 12 October, he became angry with healthcare staff who were treating him. He made threats against them and refused to take his medication. He was referred to the prison doctor, and attended his appointment on 21 October. Once there, however, he refused to take his medication or have his blood pressure monitored.
33. He saw the locum prison doctor on 21 October. He again refused to comply with his medication or to have his blood pressure monitored.
34. The next time he was seen by healthcare staff was on 11 November. He approached the staff and said that he had been suffering with flu-type symptoms for three weeks. However, he was again confrontational and argued over the treatment offered, although he did accept paracetamol.
35. Complaining of headaches, he saw healthcare staff three days later on 14 November, and was given more paracetamol. On 18 November, he again told staff that he was suffering constant headaches. He asked for paracetamol and ibuprofen, but said that he did not want to deal further with healthcare staff.
36. He had a review of his medication with a prison doctor on 16 December. The doctor noted that he had refused to take his blood pressure medication, and told him that this might be a cause of his persistent headaches. He allowed the doctor to take his blood pressure, which was noted to be high. He was, though, still argumentative. The doctor advised him to consider his situation, and to make a further appointment if he wanted. It does not appear that he did so.
37. He transferred out of HMP Kingston in January 2010. After a stopover at HMP Woodhill, he arrived at Garth on 6 January.
38. During his induction assessment at Garth, he said that he had no family or friends, and was not in contact with anybody outside the prison. He was given a reception health screening on 7 January, and was referred for a mental health assessment. As part of his initial health screening, he was noted to have high blood pressure. Staff were sufficiently concerned to refer him to hospital, and he was taken there that afternoon. He was assessed but was not admitted, and he returned to prison that day for ongoing observation by healthcare staff.
39. He saw Nurse A in healthcare on 10 January. He was unhappy with the medication which had been prescribed, and said that he had previously been taking double the dosage. The nurse explained that it was important that he followed the doctor's advice, but he said that he was prepared to be taken to the segregation unit if his demands were not met. His demands included a soft bed, draught-free windows, better heating and better painkilling medicine. The nurse said that he would raise the issue of medication with the prison doctor. (The segregation unit is an area of the prison where prisoners are separated from the

general prison population. This can be for their own protection, or to maintain the good order of the prison.)

40. Having been referred for a mental health assessment at his reception screening, he was assessed by Nurse B, a mental health nurse, on 19 January. He told her that he was still in prison after such a long time because he refused to engage with offending behaviour work. He said that he had not considered progressing, and was quite happy to remain in prison. She found no evidence of mental illness, low mood, or any other cause for concern. No follow-up from the mental health team was considered necessary.
41. On 22 January, he complained of a sudden loss of vision in his left eye. He was seen in the healthcare centre, and his blood pressure was noted to be high. He was taken to the ophthalmology department at hospital for treatment, returning the same day. He was referred for further eye tests, and on 23 January it was noted that one of the veins in his eye was blocked (known as a retinal occlusion). He was prescribed aspirin (which can be used to thin the blood).
42. When attending the healthcare centre for treatments on 16 February, he complained of severe headaches. His blood pressure was still high. At 11.01pm Nurse C was called to see him, as he was still suffering headaches. He seemed anxious and asked for co-codamol (for the treatment of pain). She advised him to rest in the dark and contact healthcare again if the pain worsened.
43. The following morning he complained of pain and loss of vision in his left eye, and had been sick. He was again referred to hospital and, following assessment in the ophthalmology department he was admitted overnight. He returned to prison the following day, 18 February, with a follow up outpatient appointment planned. However, after suffering a bleed behind his eye, he had to return to hospital, before coming back to prison and staying in the healthcare centre for observation.
44. Although discharged from healthcare on 19 February, he had problems administering his eye drop medicine, and had to return. Following discussion with healthcare staff, he returned to an ordinary prison wing, C wing, on 20 February. However, on 24 February, he reported severe pain in his left eye. He said that he still had no vision in that eye. He was taken back to hospital as an emergency. After treatment he returned to prison later that day, with a prescription for dihydrocodeine (a strong painkiller). He was once again taken to the healthcare centre for observation. He did not sleep well due to the pain, and in addition to dihydrocodeine, he was given paracetamol and ibuprofen (both prescribed to relieve pain).
45. Over the following days, he continued to complain of pain and loss of vision. On 1 March, he refused to take the medication prescribed for high blood pressure. He said that taking it made his pain worse. He

took his medication the following morning, but later that day refused all of his medication. He said that he wanted to go back to the prison wing. That afternoon he requested, and was given, some painkillers. The following day, 3 March, he refused his blood pressure medication in the afternoon, saying that it made his pain worse, but took his medication at night.

46. On 4 March, he refused to have his eye drops, but accepted an increased dosage of dihydrocodeine. He took his medication that night, but was later sick. During the early hours of 5 March he asked the night staff for some hot water, and he appeared to be confused and unsteady on his feet. He fell, and two members of staff went into his cell and helped him into his bed. He was again sick, and staff provided clean bedding and clothing.
47. When his cell was unlocked at 8.00am, he tried to get out of bed but was unable to do so. He did not respond to attempts by staff to engage with him, and appeared to be disorientated and unable to speak. He had also suffered some incontinence. The staff washed him and provided more clean clothing. After helping him into a chair, they called the doctor. He was not well enough to have breakfast or to take his medication. The doctor came to see him, and after assessing him telephoned the Medical Assessment Unit (MAU) at the hospital for advice. In the light of this advice, he was taken to the hospital at 11.00am.
48. A security assessment was carried out, and in view of his previous aggressive behaviour it was agreed that he should be subject to a security escort chain (medical advice was that he could not wear handcuffs). It was removed whilst he was undergoing medical assessment, but replaced when the assessment was complete.
49. Later that afternoon healthcare staff contacted the MAU and were told that he might have had a stroke. In the light of this, at approximately 4.00pm, prison staff began to consider how to contact his next of kin. The records showed this to be his brother, but he was listed as being of no fixed abode. He was believed to live in the Brighton area, so the local probation service was contacted for any assistance they might be able to provide.
50. When a prisoner is in hospital outside of the prison, they are generally accompanied by one or more prison officers who are known as the bedwatch staff. The bedwatch log shows that a consultant assessed him at 6.05pm, who said that there was not much that could be done for him at this time. He was referred for a chest x-ray. Once this was completed he was given a change of clothing. Prison healthcare staff again contacted the MAU at 7.21pm and were told that he was extremely unwell. His blood pressure was very high, and he had a massive bleed to his brain. At 7.40pm nursing staff provided an oxygen mask to assist his breathing. At 8.00pm his bedding was changed while his clinical observations were taken.

51. The bedwatch staff changed shifts at 9.00pm. The officers coming on duty found that he was in a very poor state of health, and although relatively comfortable, was not expected to live much longer. By 11.00pm he was having trouble breathing, and was under close observation from nursing staff. At 12.25am on 6 March the ward doctor visited and asked the bedwatch staff about his family.
52. At 1.30am he was given some medication to ease his pain, but nursing staff said that at this point they knew that he would not recover from the bleed on his brain. At approximately 2.18am, the bedwatch staff took the decision to remove the security restraints from him. At 2.28am it was confirmed that he had died.
53. He had not been in contact with his family for some years, and the details held for his next of kin were out of date. The prison staff were unable to trace any of his family, and so they contacted the local police to ask for assistance. Eventually, the police found contact details for his nephew, and news of his death, as well as the prison's contact details, were passed to the family by the police a few days later.
54. The prison arranged and paid for his funeral and his family were invited to attend.

### **Debrief**

55. It is usual following the death of a prisoner for the prison to hold a debriefing session with staff involved in his or her care. These ensure that staff have an opportunity to discuss any issues arising, and for support to be made available. A debrief was held with the prison officers who had been on bedwatch duty with him when he died. No issues were raised.

### **Support for staff and prisoners**

56. Notices were posted in the prison informing both staff and prisoners of his death. They were advised where to seek help if they felt they needed to.

### **Post Mortem**

57. A post mortem was carried out by a consultant pathologist on 6 July 2010. He concluded that the man's death was due to:
  - 1a Spontaneous acute intracerebral haemorrhage
  - 1b Bilateral idiopathic adrenal cortical hyperplasia and hypertension
58. In layman's terms, he died of internal bleeding in his brain having suffered a stroke.

## ISSUES

### Clinical care

59. The clinical reviewer notes that the man's medical history through most of his sentence was unremarkable. He became unwell through his hepatitis in 2000, but this seems to have been the only occasion. He had ongoing issues with sciatica and with high blood pressure, but no significant health issues.
60. The clinical reviewer addresses the man's care whilst in Kingston, prior to his transfer to Garth. Although his comments do not appear to be relevant to the circumstances of his death, he moved to Garth less than three months before he died, and so I refer to them in my report. He notes that there appeared to be some changes in his character after he sustained a head injury in September 2009. He notes that he complained to healthcare staff at Kingston of headaches, after having received a recent head injury. Although he had a known history of high blood pressure, and occasionally refused his medication, further investigations were not undertaken at this stage. He recommends that the Head of Healthcare at Kingston reviews the staff training needs in relation to Clinical Decision Making and Assessment skills.
61. He also notes that when the man saw the locum prison doctor on 16 December, his blood pressure was very close to the level that the National Institute for Health and Clinical Excellence (NICE) cites as potentially dangerous, but again there does not seem to have been any follow-up. He recommends that the Head of Healthcare at Kingston ensures staff are aware of the NICE guidance, both generally, and specifically relating to hypertension.
62. The investigator discussed the clinical reviewer's recommendations with the Head of Healthcare at Kingston. She notes that he had complained of headaches prior to the incident when he hurt his head. She also pointed out that he saw a doctor on a number of occasions about his blood pressure and his medication. He refused to comply with his medication on more than one occasion, and also refused to attend healthcare for assessments. She said that healthcare staff are aware of the NICE guidelines, but cannot treat patients against their will. Having raised these issues with her, I do not make any recommendations but I draw the clinical reviewer's report in its entirety to her attention.
63. The man's clinical records do not indicate whether, before he was transferred to Garth, he was medically assessed as fit for transfer. This should be a routine practice for every prisoner transferring to another prison. The clinical reviewer recommends that the Head of Healthcare at Kingston reviews protocols for ensuring that prisoners are medically reviewed prior to transfer. Again, the investigator raised this question with the Head of Healthcare. She explained that all prisoners transferred out of Kingston are assessed to establish that they are fit for transfer,

and gave examples of instances where transfers have been blocked by healthcare because someone was considered not fit. Fitness for transfer is documented on a form which is attached to the front of the sealed pack containing the medical record, which travels with the prisoner. As the form is on the outside of the sealed medical record, once the receiving prison has opened the pack the form may well be discarded with the packaging. I accept this possibility, and she was adamant that he would have been assessed before transfer. I once again draw her attention to the clinical reviewer's comments, and invite her to consider whether Kingston should have some way of recording prisoners being marked fit for transfer. Kingston now has electronic medical records, so this is something that should be fairly easily achieved.

64. The clinical reviewer notes that, once he arrived at Garth, the care the man received was at least as good as he could have expected in the community. On arrival, his condition was noted and acted upon. He was monitored regularly, and was engaged with and consulted with regards to his care. Records were well maintained, and care and interventions were timely and responsive.
65. I have considered whether, bearing in mind how he presented when his cell was unlocked on 5 March, an ambulance should have been summoned earlier. He had been unwell for a while, and his symptoms had not appeared suddenly. He had suffered some incontinence, and staff showed care for his dignity by cleaning and dressing him while the doctor was on his way to see him. As soon as the doctor saw him, an ambulance was called. In the circumstances I think that the actions by staff were reasonable and that the ambulance was called at the appropriate time.
66. I have been told that he was a difficult patient for healthcare staff to treat. He complained of health problems, yet was argumentative and often would not comply with medication. Notwithstanding the clinical reviewer's comments and the Head of Healthcare's replies, I do not think that there was more that could have been done for him whilst he was at Kingston. Once he had arrived at Garth, I agree with the clinical reviewer that his care was timely and responsive. He was taken to hospital whenever it was judged necessary, and was monitored whilst in prison. Refusal to comply with treatment can raise the question of whether the person was competent to make that decision. He was given a mental health assessment on 19 January, and no evidence of mental illness was found. Although it does not seem that his mental capacity was specifically assessed, I have seen no evidence that he was incapable of deciding whether or not to accept medical treatment.

## Use of restraints

67. The man was moved to hospital in the late morning of 5 March. He was security assessed before leaving the prison, and in view of his previous difficult behaviour it was agreed that he should be subject to physical restraints by way of an escort chain (a pair of handcuffs with a long chain attaching the prisoner to a prison officer) and two escorts. Once he arrived in hospital, his health deteriorated rapidly. Staff from the prison healthcare remained in contact with the hospital and were kept updated on his condition.
68. By 9.00pm on 5 March, he was not expected to live much longer. He was not, however, reassessed as to whether his security should be changed. In the event, his security restraints were removed just ten minutes before he died.
69. The investigator has discussed this with the governor who was duty governor on 5 March. The Governor said that, whilst he was made aware that he was becoming increasingly ill, he was not made aware of the seriousness of his condition. At the point when the prison began to try to contact the family, the duty governor also discussed the security arrangements with the deputy governor. At this stage, they judged that the security escort chain was still necessary. Although I am pleased to see that this was considered, I believe that further security assessments should have taken place in the hours that followed.
70. It was helpful that prison healthcare staff continued to seek regular updates on his condition. However he deteriorated rapidly and it appears that the duty governor was not made aware of how quickly this was happening, either by the healthcare or the bedwatch staff. Therefore the security arrangements were not reassessed. When the officers on bedwatch realised that he was close to the end of his life, they took the decision to remove his security restraints. Prisons have a responsibility to protect the public by preventing prisoners from escaping. By this stage it was clear that he was very poorly and did not present a risk to the public. The bedwatch staff acted promptly and made their decision without waiting for management approval. I think that it was a reasonable and humane decision, and I am pleased that it was supported by the duty governor when discussed at the debrief.
71. Garth is aware that there was a breakdown in communication through the night about security assessments. It is most regrettable that he was not reassessed and allowed more dignified time in his final hours. The investigator was told that, from now on the duty governor will reassess security whenever it is requested, or when the prisoner's circumstances change. Although it will be of little comfort to his family, I am pleased to see that this is being acted upon and I recommend that the effectiveness of this system is kept under review.

**The Governor should ensure that effective systems are in place to facilitate regular communication between bedwatch staff and the prison and that security is regularly reassessed when a patient is in outside hospital.**

### **Informing the family**

72. Over his years in prison, the man had gradually lost contact with his family. When he went into hospital for the last time, staff began to make efforts to establish who to contact. Sadly, he died before they were able to do so. The prison was unable to locate any family, and had to seek assistance from the police. The family were not therefore informed of his death until some days after he had died.
73. The situation concerning his next of kin is obviously not ideal, and it would have been better if the prison had been able to make earlier contact with his family. However he had been out of touch with his family for a number of years, the last visit from his family being in 1993. Although his brother was listed as his next of kin, he was recorded as of no fixed abode.
74. In a previous report of a death at HMP Garth in 2007, I made a recommendation about maintaining data for prisoners' next of kin. It is not clear whether the prison had made any attempt to update the next of kin record for him. However I think it likely that, even had the prison sought to update their records, he would have been unable to provide details of any next of kin. I do not think it unreasonable, therefore, that the prison was unable to contact anyone at the time when he died. Consequently, I do not make a recommendation, but remind the Governor of my previous recommendation and ask her to consider whether there are reasonable systems in place to ensure that prisoners' family details are updated periodically.

## CONCLUSION

75. He was an elderly man who had spent a number of years in the prison system. He had had some problems with high blood pressure, and had complained of headaches. Towards the end of 2009, whilst in Kingston, he injured his head and, in the subsequent months, complained to staff about headaches. He was, however, a difficult patient for healthcare staff to engage with, and would sometimes not comply with medicine prescribed to him.
76. At the beginning of 2010, he was transferred to Garth. At his reception health screening the day afterwards, his health problems were identified to the extent that he was taken straightaway to hospital over concerns about his blood pressure.
77. Over the next few weeks, he continued to complain of headaches and loss of vision. Like the clinical reviewer, I believe that he was treated appropriately and referred to hospital on several occasions. He was largely located in the healthcare centre when back in prison.
78. In early March, his health took a turn for the worse. He was still not complying with his medication and treatment, but I judge that staff did their best to look after him. During the night of 5 and 6 March, he became quite unwell, and was confused and disorientated. In the morning the prison doctor sent him to hospital.
79. His security was assessed. An escort chain was put in place and he was accompanied by two prison officers. The restraints were removed while he received medical treatment, and replaced afterwards.
80. That afternoon it was became known that he might have suffered a stroke. Prison staff began to try to contact his family, but because of the number of years that he had been out of contact, found this a difficult task.
81. His condition continued to deteriorate. He had suffered a large bleed to the brain, and was not expected to live much longer. He began to have trouble breathing, and an oxygen mask was provided. Painkillers were administered at 1.30am and at 2.18am the bedwatch officers decided to remove the escort chain. His death was confirmed ten minutes later.
82. It appears that he received good medical care whilst in Garth. Any problems were identified and addressed, even though he was not always the easiest patient to deal with. The only issue identified relates to security assessments when prisoners are in hospital. The prison has already identified this, and my single recommendation seeks to ensure that the changes put in place prove to be effective.

## **RECOMMENDATION**

The Governor should ensure that effective systems are in place to facilitate regular communication between bedwatch staff and the prison and that security is regularly reassessed when a patient is in outside hospital

The National Offender Management Service has accepted this recommendation. The Head of Security will revise current systems to ensure that once bedwatch staff have been advised that a patient is in the last stages of his life the cuffing arrangements are reviewed. It is intended that this should be in place by 31 May 2011.