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 in June 2010, at hospital, while in the custody of HMP Gartree

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 report of an investigation into the circumstances of the death of a man at hospital in June 2010, while a prisoner at HMP Gartree. He was 56 years old and had been diagnosed with diabetes, chronic liver disease and hepatitis after a long history of severe alcohol abuse. His condition deteriorated during his sentence and his death was expected. An inquest was held on 2 November 2010 and a verdict of death from natural causes was recorded. I would like to offer my sincere condolences to his wife and daughter and to the staff at Gartree who were involved in his care and were affected by his death.

A colleague conducted the investigation on my behalf. A clinical reviewer undertook a review of the man's medical care, on behalf of the local Primary Care Trust. His contribution to my investigation is invaluable and I am grateful for his report. I would also like to thank the Governor of Gartree and his staff for their cooperation. I am particularly grateful to the healthcare and discipline staff who spoke to the investigator on her visit.

My investigation has highlighted excellent practice in respect of multi-agency working between HMP Gartree, Morton Hall and the social services department of the local authority. Visiting arrangements between the man, his wife and daughter were complex not least because his wife was a serving prisoner and their young daughter was in foster care.

The clinical reviewer has judged that the care given to the man was equal to and possibly exceeded that which he would have expected in the community. He made no recommendations as he could suggest nothing that would have improved the high quality of care that the man received from healthcare staff at HMP Gartree.

Overall, I commend the prison and the healthcare department at Gartree for the care and consideration given to the man and the efforts made on his behalf. I am particularly impressed with the excellent standard of communication and cooperation between Gartree and Morton Hall in ensuring that the man's wife was granted release on temporary licence quickly in order to visit him in prison and hospital. This is in keeping with the highest standards of the National Offender Management Service.

I apologise for the delay in issuing this report, and any additional distress this may have caused.

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.

Thea Walton
Acting Deputy Prisons and Probation Ombudsman **July 2011**

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SUMMARY

The man was convicted of conspiracy to murder on 19 July 2001, at Crown Court. He had served lengthy prison sentences in the past and was sentenced to life imprisonment for his part in this offence. He had a longstanding history of severe alcohol misuse while living in the community and was found guilty of distilling illegal alcohol in prison during his life sentence.

He had an extensive clinical history and was diagnosed with cirrhosis of the liver in November 2004 and hepatitis C a month later. A move from the high security prison, HMP Whitemoor, to a lower category prison was approved. However, this was difficult to achieve as other prisons were reluctant to accept him because of the complexity of his condition and his high medical needs. HMP Gartree eventually accepted him and he transferred in August 2007.

Throughout his sentence and until his death, he went to hospital as an inpatient on numerous occasions, with varying medical conditions linked with cirrhosis and hepatitis C. His ailments included poor mobility, confusion, a decreased appetite, memory loss, confusion and sickness, numerous urinary infections, abdominal pain, jaundice due to the liver disease, gastritis, constipation and fluid in his stomach.

In February 2008, the man was diagnosed with insulin dependent diabetes and healthcare staff appropriately referred him to specialist diabetic clinics for management and monitoring. A consultant hepatologist at the hospital regularly reviewed his cirrhosis and hepatitis C conditions. He was not an easy patient to nurse and frequently failed to follow medical advice by refusing his food and medication and discharging himself from hospital.

The head of security and the head of healthcare held a meeting in December 2009, to discuss his release on compassionate grounds. They agreed that he was not eligible because his life expectancy could not be estimated to within the advised three month limit required. Despite this, the prison made two applications but both were refused as the National Probation Service considered him to be high risk and accordingly, did not support the application.

He married his partner while in prison. Family liaison and communication between HMP Morton Hall, Gartree and the social services department of the local authority throughout his illness was excellent and his wife and daughter regularly visited him. Gartree liaised with Morton Hall so that his wife could be released on temporary licence and his wife and daughter were with him when he died.

The clinical reviewer found nine areas of good practice and made no clinical recommendations. I concur with his view that he was given a high standard of care at Gartree and I am pleased to say that I found no failings in his management and therefore make no recommendations. I commend the prison for the excellent clinical care and family liaison arrangements he received.

THE INVESTIGATION PROCESS

1. The man died in June 2010 at hospital. My office was notified of his death the same day. Terms of reference and notices were issued to staff and prisoners at Gartree telling them that an investigation would be taking place, and inviting those who wished to make themselves known to the investigator. No one came forward. The investigator requested copies of his core, clinical and probation records as well as other records relevant to his time in custody and his death.

2. My investigator also contacted HM Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. The Coroner's Officer told the investigator that the man died of multiple organ failure and cirrhosis of the liver. The inquest was held on 2 November 2011. A finding of death by natural causes was recorded.

3. The investigator visited Gartree in June 2009. She met the Head of Residence, who also acted as the prison's liaison officer, the Head of the Offender Management Unit and the Head of Healthcare, who knew the man well and had previously cared for him during his imprisonment at HMP Whitemoor.

4. A review of the man's clinical care was commissioned from the local Primary Care Trust (PCT) and undertaken by a clinical reviewer. The clinical reviewer focussed on the clinical care he received at Gartree.

5. My senior family liaison officer contacted the man's wife as his next of kin, to advise her about my investigation and give her the opportunity to raise any questions or concerns to be considered as part of this. She did not raise any concerns and has praised the prison for their care of her husband.

HMP GARTREE

6. HMP Gartree is the largest of three dedicated prisons for life sentenced prisoners in England and Wales. The prison comprises six residential units holding around 689 adult males. Each prisoner is accommodated in a single cell.

7. Health services are provided by the local Primary Care Trust. Prison doctors are contracted from a local practice and provide eight surgery sessions a week. There is a registered nurse on duty in the prison at all times. The healthcare inpatient unit was closed for extensive refurbishment during June 2010. This coincided with the terminal stage of the man's illness. However, nursing care was delivered through wing-based nursing staff.

8. An inspection by HM Chief Inspector of Prisons in May 2010 found that Gartree had progressed considerably since the previous inspection. The prison was judged to be well ordered and calm, with healthcare provision described as "good and was expected to improve further with the imminent opening of a new healthcare centre". The inspection found that the life sentenced population provided stability to the prison, although there needed to be more work, educational or recreational activity for prisoners.

9. The Independent Monitoring Board[1] (IMB) Annual Report for 2008/2009 described the prison as operating close to its operational capacity of 689 during the reporting period. The IMB acknowledged that recruitment of nursing staff was difficult and that the healthcare team were understaffed. However, despite this, healthcare was described as "very able".

10. The Prison and Probation Ombudsman was tasked with investigating deaths in prison custody in 2004. Since then, there have been nine deaths prior to the man's attributed to natural causes at Gartree. In some of the investigations that followed the deaths, recommendations about healthcare provision were made.

[1] The Independent Monitoring Board comprises volunteers from the community. They monitor daily life in prison to ensure that decency is maintained, deal with prisoners' complaints and submit an annual report to the Secretary of State for Justice.

KEY EVENTS

11. The man, together with his partner and co-defendant, was convicted of conspiracy to murder on 19 July 2001, at Crown Court. A sentence of life imprisonment was imposed on both. He had previous convictions for serious offences for which he had served lengthy prison sentences. Following an appeal against his tariff (the minimum amount of years a prisoner must serve before being considered for parole), he was expected to serve a sentence of ten years and 55 days before he could be considered eligible for release on parole licence.

12. Throughout his sentence he was assessed as a high risk prisoner, based on a number of factors, including an escape from prison during a previous sentence in 1998 and a longstanding and severe problem with alcohol before his latest period in custody. He was also found guilty and disciplined for distilling illegal alcohol in prison. During his time at HMP Norwich in 2001, he failed a mandatory drug test and remained on closed visits for three months.

13. The clinical record shows that he was a heavy smoker. Further significant medical events are recorded from early February 2002, when he suffered from helicobacter pylori[2]. In November 2004, he was diagnosed with cirrhosis of the liver followed by hepatitis C in December of the same year. A year later, he suffered liver failure followed by a left sided cerebral hemisphere cerebrovascular accident (a stroke) in March 2006. An incident of self-harm is recorded on 1 January 2007 and a drug overdose noted on 21 July 2007.

14. On 29 August 2001, a "Record of Contact with a Life Sentenced Prisoner" shows that he was told he was due to be transferred to HMP Whitemoor prison. Although he accepted the transfer, records show he was unhappy as his preference was a transfer to HMP Wormwood Scrubs.

15. Throughout his sentence, he managed to maintain contact with his partner through inter prison telephone calls while she was serving her sentence at HMP Bullwood Hall. Their daughter was brought to the prison on family visit days so that he was able to continue contact with her throughout his sentence. He married his partner in Whitemoor on 22 November 2002, while they were both in custody.

16. He did not always comply with the prison regime to a satisfactory standard to qualify for an enhanced level under the incentive and earned privileges scheme but remained on standard level on occasion.[3] He was subject to restricted visits and in

[2] Helicobacter pylori is a bacterium that infects the mucus lining of the human stomach. Many peptic ulcers and some types of gastritis are caused by this.

[3] The Incentives and Earned Privileges scheme was introduced to encourage and reward good behaviour in prisons. Governors have devolved responsibility to draw up their own schemes however the scheme must operate on at least three tiers: Basic, Standard and Enhanced. Prisoners move between levels according to their behaviour and performance. The key earnable privileges/incentives are: extra and improved visits, eligibility to earn higher rates of pay, access to in-cell television, opportunity to wear own clothes, more private cash to spend and time out of cell for association. In addition to the key earnable privileges, prisons may make other privileges and incentives available to suitable prisoners according to local circumstances.

February 2004, he lost his job as a trusted prisoner. As a result, family visits facilitated by social services bringing his daughter to see him were stopped. He failed a number of mandatory drugs tests, the results of which he disputed, claiming that the medication he was taking (chlorphenamine[4]) affected his urine sample and created a positive result. He went through the adjudication process and was found guilty.

17. In January 2006, the man was re-categorised from a category A prisoner (the highest level of risk in the prison estate) to a lower risk category B. This entitled him to move to a prison outside the high security estate in order to progress in his sentence. The transfer was delayed and his solicitors wrote to the Governor on 30 April, asking for the transfer to Gartree to take place as soon as possible. The prison replied on 8 May, confirming that he had been granted a transfer out of high security conditions, but prisons were reluctant to accept him because of his medical condition. The prison admitted that the situation was "not ideal" and they were making ongoing efforts to find a suitable prison place for him.

18. He transferred to Gartree in late August 2007. On 6 September, he became unwell and a nurse manager examined him. She found him disorientated, unstable on his feet, hot to the touch, and noted that he had not been eating or drinking very much. She admitted him to healthcare for observation and to await the doctor the following day.

19. Later the same day, she spoke to the doctor, who advised that the man should be sent to hospital for further assessment. An ambulance was called because of his poor mobility. He remained in hospital and returned to the prison on 11 September. Healthcare staff did not know what tests or treatment he had been given because no discharge information was provided by the hospital.

20. On 26 October, a practice manager made a note in the clinical record that he resided in the healthcare centre because of population pressures in the prison and for respite care with his chronic and long term health problems. His appetite remained poor.

21. His assessment by healthcare staff on 6 September and the subsequent admissions to the healthcare centre and hospital were the first of a large number of admissions until his death in June 2010. During the remainder of 2007, he was admitted to healthcare and hospital for treatment on a number of occasions. This was because of memory loss, confusion and sickness, numerous urinary infections needing intravenous antibiotic treatment, abdominal pain, jaundice due to chronic liver disease, gastritis, constipation and fluid in his stomach. However, despite his illnesses, there were also days when he told staff that he felt well.

22. He was admitted to hospital again in January 2008. A discharge letter from the hospital said that although he had been relatively well since his last admission in

[4] Chlorphenamine is an antihistamine medicine for allergies.

November 2007, he was complaining of feeling drowsy. A Consultant Hepatologist diagnosed this as being in keeping with "some low grade encephalophy"[5]. He described him as clearly having quite advanced liver disease, but felt unable to treat his hepatitis C condition as this would counteract the treatment for the liver disease. He considered the only option would be for a liver transplant.

23. On 2 February 2008, Nurse A became concerned about the man's condition. He was complaining of stomach pain, and an unusual frequency in passing urine. Staff contacted the out of hours doctor service and he was taken to hospital. The clinical record shows that he returned to the prison with a diagnosis of insulin dependent diabetes. Plans were made for him to be referred to the optician to check for diabetic eye disease. He was advised to change his diet and understood the need for doing so.

24. It is evident from a clinical record entry for 6 February that he could manage to monitor his insulin but needed supervision during the procedure. He had also been told "in no uncertain terms" that he must heed dietary advice and not add sugar to his food or eat sweets. He did not always listen to medical advice because he considered that his diet was already restricted because of his liver problems.

25. Healthcare staff gave the prison kitchen dietary advice relating to his diabetic and liver conditions. Staff in the kitchen were aware of his poor appetite and provided suitable food to ensure that he was eating a diet appropriate to his medical conditions, particularly his diabetes. However, despite effective collaboration between the kitchen and healthcare, he did not always eat the food given to him because he did not like it and chose poor alternatives. He was reminded that other alternatives were available, including the facility to make his own food on the wing. The kitchen manager visited him on 30 September in response to the difficulties. He said he was unhappy with the food he was being served and until the matter was resolved, he refused to take his medication.

26. A reminder to healthcare staff from the practice manager was placed in the healthcare record in March, warning staff that protective clothing was necessary when dealing with blood matters from the man. This was because he had hepatitis C and also suffered from oesophageal (food pipe) bleeding because of his liver condition.

27. Healthcare staff continued to monitor and treat his various chronic conditions and adjust his insulin if he was unable to eat. In October, he admitted to Prison Doctor A that he was being pressured by other prisoners to obtain medication on their behalf. In January 2009, Prison Doctor B made an entry in the clinical record to advise that there had been problems with the man's insulin syringes being used by other prisoners in healthcare and therefore it was necessary for him to change to using an insulin pen instead. However, as his eyesight was poor, using the pen was not advised and staff intended to seek advice from the specialist diabetic nurse.

[5] Encephalopathy is brain malfunction due to liver disease.

28. In addition to frequent hospital admissions, he attended review appointments to monitor his liver condition at hospital under the Consultant Hepatologist's care. He attended the joint hepatitis clinic at the same time.

29. In January, 2009, the man's health deteriorated and he experienced ascites[6], confusion and loss of balance due to liver disease. There is evidence from the clinical record that staff from HMP Morton Hall, where his wife was imprisoned, called the healthcare centre to ask about his condition on her behalf. His wife wanted to know whether she could visit him in hospital and healthcare staff said they would contact Morton Hall with the information. A senior officer at Morton Hall would ask permission of the head of security at Gartree for the wife to visit him in hospital if he was admitted.

30. He was discharged from hospital on 17 February, with a letter saying that the excess fluid in his stomach had been drained. In April, he was noted to have a pronounced tremor to his mouth and right arm. However, he was able to manage day to day living with the help of fellow prisoners. Care plans were in place and a review took place on 11 April. The outcome was that he would have daily blood pressure and weight checks. His blood glucose level was to be taken twice daily before meals or as necessary. Any improvements or deterioration were to be recorded on the healthcare computer system (SystmOne). He continued to complain of sickness and stomach pain.

31. His sickness meant that he was unable to absorb his medication. Therefore it was agreed that he would take his anti-sickness tablet first, followed by the rest of medication. This appeared to be an effective method of dealing with the problem.

32. A note in the clinical record made on 28 April, by a prison mental health nurse, said that the man was finding everyday activities increasingly difficult. He was unable to drink because of the uncontrollable tremors in his arms and hands and became concerned when he was unable to shave. Staff found solutions such as providing a feeding cup with a spout and an electric razor for his use, with the promise of assistance from staff if he needed it. He was noted to be exhausted from lack of sleep because the tremors were constant. His health continued to decline and staff and prisoners helped with everyday tasks.

33. A report from the Consultant Hepatologist dated 12 May, said that the man's tremors were not attributable to Parkinson's Disease, although the symptoms were similar. He therefore did not respond to medication for that disease. His medication was adjusted accordingly and Neomycin (an antibiotic) was prescribed, although he was told that this was not to be taken long term as it caused hearing problems.

34. On 3 June, Nurse Manager B, spoke with the man about his general condition. HMP Norwich had a specialist unit for older life sentenced prisoners and he said he

[6] Ascites is the accumulation of fluid in the stomach.

would be happy for a referral to be made because it would move him closer to his family. He had falls in his cell in the healthcare centre and needed help to get up. He needed assistance with personal care and healthcare staff gave this when necessary. Healthcare staff made a referral to the physiotherapist, who assessed him and advised that he needed a walking stick and this would be arranged for him. He had been prescribed antidepressants and believed they were lifting his mood.

35. The clinical record for the remainder of 2009 records the efforts of healthcare staff to manage his fluctuating appetite, nausea, falls, abdominal pain, bloating and monitor his blood glucose levels. He was admitted to hospital on a number of occasions for excess fluid to be drained from his stomach, difficulties with blood clotting and encephalopathy[7]. However, in between periods when he was unwell, there were days when he felt well enough to walk up and down the healthcare unit and associate with staff and other prisoners. Prison healthcare professionals were sensitive to his discomfort and when it was clear that the hospital did not have an available bed for a planned admission, the prison arranged for a hospital admission via the hospital bed bureau.[8] In September, staff referred him to the Leicestershire Nutrition and Dietetic Service for help with his food intake and management of his liver and diabetic condition.

36. Entries in the clinical record for November 2009, describe the man as frail and weak with shorter periods between hospital admissions to drain fluid from his stomach. On 11 November, he moved cell in healthcare to be nearer to the nurses' station. He was seen to be comfortable in his new cell and his pain was better controlled since starting on phantanyl patches.[9] However, it is evident from the clinical record that he was spending the majority of his day in bed as he did not sleep well and tired easily. In December, he was noted to be suffering from breathing difficulties and asked for oxygen which helped ease his breathing.

37. The clinical record shows that on 14 December, prison managers considered release on compassionate grounds. A meeting was held with the head of healthcare and the head of security. They agreed that he was not eligible for compassionate release because his life expectancy could not be estimated. His treatment would continue, he would be seen regularly by the doctor and his condition was to be monitored on a daily basis as before.

38. On 23 December, the healthcare department and discipline staff made plans for him to see his wife and daughter. The visit was initially kept from him until the arrangements were confirmed and in place. He was seen to be relatively well on Christmas Day. On 29 December, he went to hospital for fluid removal. Prison escort staff told their healthcare colleagues that nine litres of fluid had been drained and he had been fitted with a drainage bag. An entry the following day implies that

[7] Encephalopathy is brain malfunction due to liver disease.
[8] This is a centralised unit for finding a hospital bed within a number of hospitals in a given area.
[9] Phantanyl patches are patches placed on the skin, usually the upper arm, that release pain relieving medication.

the hospital had told him of the seriousness of his condition. In early January 2010, he was given a wheeled walking frame to help his poor mobility.

39. Prison Family Liaison Officer A and a practice manager met with the man to discuss the family liaison officer's visit to his wife. The purpose of the visit was to prepare her for the seriousness of his condition and the unlikelihood of his recovery. He said he was happy for the family liaison officer to share information with his wife about his condition and treatment.

40. On 13 January, the Head of Healthcare, Head of the Offender Management Unit and prison Family Liaison Officer B, discussed with the man his final wishes in view of his poor prognosis. They had also arranged to visit his wife at Morton Hall regarding future visits and ongoing support for her. His daughter was due to visit with her foster parents in February and the Head of Healthcare agreed to contact the Social Services Department of the local authority to ask if his wife could visit at the same time.

41. The family liaison log shows that a meeting was held on 8 February to discuss the management of his condition. A sentence plan review was completed which would prompt a review of his categorisation which was currently at level B.[10] Prison staff considered that in view of his condition he could be re-categorised to a category C risk status and also because the healthcare department at Gartree was closing for refurbishment. The concern was that he would not receive such good support in a category C prison and it would be difficult to manage his complex health needs on the wing in the face of closure of the healthcare centre. A transfer to HMP Moorland, which had an inpatient unit, was considered and noted as an action point for further exploration.

42. The man's condition continued to deteriorate with increasing periods of confusion. Further hospital admissions to drain fluid took place and his medication was reviewed as necessary. On 1 April, he was found unresponsive in his cell and an emergency ambulance was called. More excess fluid was drained and he was given antibiotics intravenously for an infection. He was reviewed by a consultant who advised a salt free diet. A family visit to the hospital was arranged.

43. A discharge letter from the hospital, dated 22 April, said that he had been admitted with increasing confusion and a recurrent swollen stomach. He had a cranial computed tomography (CT) scan of his head and the results were normal. (A CT scan uses X-rays and a computer to create detailed images of the inside of your

[10] Prisoners are risk assessed when they come into prison and given a category based on their offence and the risk that they pose to the public should they escape. There are four categories: A, B, C and D, with category A prisoners being the most dangerous. Category B are prisoners for whom the highest security conditions are not necessary but for whom escape must be made very difficult. Category C are prisoners who cannot be trusted in open prison conditions but who would not have the ability or resources to make a determined escape.

body. It can monitor many different health conditions and give views of structures inside the body including internal organs, blood vessels, bones and tumours.)

44. During his time as an inpatient, hospital staff drained fluid from his stomach on two occasions. Medical professionals also discussed his suitability for a liver transplant. It was agreed to refer him to the liver transplant unit at hospital two weeks later for assessment. The Head of Healthcare confirmed to the investigator that this was under discussion.

45. On 2 May, he was admitted to hospital again and his health was noted to be rapidly deteriorating. The prison contacted his wife at Morton Hall to tell her. The clinical record showed that the restraints were removed as he was unconscious and unresponsive. However, on 4 May, he appeared to have recovered to some extent and wanted to discharge himself from hospital because he was not allowed to smoke. The Head of Healthcare told the investigator that on occasions such as this when he had wanted to discharge himself, she had driven over to the hospital and spoken firmly to him about his decision. He changed his mind on this occasion.

46. Prison healthcare staff visited the hospital the following day. They explained that the prison did not have the facilities to deal with his complex needs. This was because the healthcare unit was due to be closed for refurbishment and he would be accommodated in the main prison. They suggested that the withdrawal of treatment would be detrimental to his health.

47. The Head of Healthcare spoke with the investigator. She said that closure of the healthcare inpatient facility for refurbishment meant that he had to be managed on a residential wing. She said that they managed without inpatient healthcare by introducing the primary care community model into the prison. There were eight sessions per week from a local GP practice and 17 nurses with a range of skills. There was a registered nurse on duty in the prison at all times. However, she said that healthcare and wing staff were concerned that he could die on the wing.

48. The Head of the Offender Management Unit said that around eight weeks before the man's death, a seriously ill prisoners meeting was held to discuss his management. Representatives from healthcare, family liaison, the Head of Residence, Head of Security and a member of the chaplaincy attended. Compassionate release was discussed and was subsequently applied for. In an informal interview with the investigator, he said that the National Probation Service were unable to support the man's application for release as he was still considered high risk. He added that probation's view was that he should be in hospital but were not prepared to discuss it further. However, the investigation revealed that he had brewed illegal alcohol in the prison in the past, including during a stay in healthcare. The Head of Healthcare told the investigator that alcohol was a risk factor as he had told her that even if he could not get to an off-licence, he would send someone to go for him.

49. The man returned to the prison from hospital unexpectedly on 19 May and was given a cell on G wing. Neither the wing, nor healthcare staff had prior warning of his return. A mental health nurse and Nurse A went to the wing, where they found him in a distressed state. He told them that he was refusing all his medication because he did not want to be on G wing and would rather die than stay there. The suicide prevention and management of self-harm procedures were put in place an Assessment, Care in Custody and Teamwork (ACCT) plan[11] was opened with observations by staff to take place every 15 minutes, reflecting the level of concern.

50. The Head of Healthcare told the investigator that he refused some aspects of his treatment during the last weeks of his life. She said she knew him when he was at Whitemoor Prison and described him as stubborn but knowing what he wanted. She considered his treatment refusal was his last effort at controlling a situation. In her view, while he refused his treatment, the outcome would be the same.

51. On 20 May, Prison Doctor B spoke with the man. Despite refusing his medication as a protest at being accommodated on G wing, he described him as "looking like his normal self" and "coherent and alert". He advised him against refusing medicine as it would put him at risk of death, but he replied that he did not care.

52. An entry in the clinical record shows that later the same day, healthcare staff visited him three times during the day. At around 12.00pm, the practice manager and an operational manager spoke with him, who repeated to them that he was unhappy on G wing. They were aware that he was refusing his medication and so attempted to negotiate a solution to the problem. They suggested a move to another cell on G wing that would be able to accommodate a hospital bed as this would be more comfortable for him. However, he did not accept this because he believed that if he did so it would delay his move off the wing.

53. Healthcare staff visited again in the afternoon. He remained adamant that he would not take his medication and he agreed to sign a treatment disclaimer form. However, he had given more thought to having a hospital bed and had decided that he would like to have one despite the fact he would have to move cells.

54. At around 8.00pm, Nurse B visited with Nurse Manager B. Although eating and drinking, he still refused his medication. An ACCT review followed and he was to be observed by staff once every two hours. He was noted to be happier with a reduced level of observations and with the care he was given on the wing. He declined the offer of a copy of his nursing care plan. He also refused to sign the ACCT

[11]The ACCT system is used to monitor and support prisoners assessed as at risk of suicide or self harm. Once placed on ACCT, the prisoner will be subject to regular case reviews that will direct observations/conversations to be carried out at intervals determined by their perceived level of risk. The observations continue during the day and the night.

documentation, but signed a treatment disclaimer form which would enable information to be provided to wing staff and operational managers with regard to his medical and nursing care. The form also confirmed that he refused to take his prescribed medication or to be physically examined and understood that his refusal was against medical advice.

55. In late May, the man said he wanted to move to B wing where he could be with other prisoners who would collect his food from the prison servery and carry out other necessary tasks for him. Healthcare staff were unhappy with this. They considered it was not possible to allow him on B wing as he needed to use the stairs. The matter was left that it would be referred to the Head of Residence as wing transfers were not within healthcare's role or responsibility. The family liaison log shows that his wife contacted the prison on 28 May to raise her concerns about her husband's accommodation on B wing. The prison said that they were unable to move him but would arrange for a prisoner whom him knew well to come from B wing and support him. An evening visit was arranged for him and his wife, agreed with Morton Hall.

56. His health noticeably deteriorated. On 29 May, he refused to go to hospital or accept treatment because he could not smoke and thought he was being unfairly treated. He agreed to go to hospital later that day as he was experiencing severe pain in his stomach. He was admitted but refused to take any medication, including his insulin. He underwent an endoscopy[12] and no further treatment was planned until the results were known.

57. The Head of Healthcare visited the hospital on 7 June. She spoke with staff and then visited the man. He appeared to be frail and had difficulty eating, drinking and walking and was assessed as not well enough to return to the prison. The senior registrar told her that life expectancy was at the most around two months and possibly only weeks because he had stage three cirrhosis which was a "definite diagnosis of a terminal condition". He said the consultant would confirm this in writing to the prison, which could help with moving him to the End of Life Unit at Norwich Prison, or elsewhere on compassionate release.

58. The clinical notes show that the Head of Healthcare discussed the man's end of life care with the Head of Operational Management Unit, who would look into this. The entry said that the deputy governor and Head of Security reviewed the security arrangements regarding the use of restraints and it was agreed that they would not be in place when he was lying in bed.

59. On 8 June, the man demanded to return to Gartree. Nurse Manager C and a healthcare officer went to the ward. While waiting for the discharge letter to be produced, he began coughing blood and continued to refuse food and medication. He was adamant he was discharging himself back to the prison, despite complaining of chest and stomach pain. He collapsed while they were lifting him from his bed to

[12] An Endoscopy is where the inside of the body is examined internally with an endoscope, a long thin flexible tube with a camera.

the wheelchair and was placed back in bed. He eventually agreed to accept treatment. The prison told his wife at Morton Hall.

60. The family liaison log shows that two days later on 10 June, prison staff telephoned Morton Hall and left a message for the man's wife with an officer. The message was that a doctor at the hospital had asked if his wife could go to the hospital urgently. The officer agreed to pass the message onto her and added that she was unwell at the time.

61. In his statement, Officer A, a prison escort officer, said that at around 7.30am on 11 June he went to hospital to carry out bedwatch escort duties. (If a prisoner is admitted to outside hospital, depending on the risk assessment carried out by the prison, they will generally be escorted by two officers who will stay beside their bed at all times. Two or three daily shifts of officers will stay with the prisoner until treatment is completed.) The officer said that the man died at 1.25pm that day with his wife and daughter by his side.

62. The Head of Healthcare said that after the man's death, a memorial service was held at the prison. His wife was invited to visit the prison to see the cell he occupied in his final days at Gartree and to speak with those who knew him. The prison paid for the cost of the funeral and healthcare and prison staff attended.

ISSUES

Clinical care

56. A clinical reviewer carried out a review of the man's clinical care on behalf of the local Primary Care Trust. He reviewed the clinical management of the diabetes and liver condition. He found that hospital admissions were arranged in a timely manner and the man attended regular appointments with the Consultant Hepatologist. He described the decision to move him from one hospital to another for end of life care as "an appropriate and considered decision". He concluded that he could make no recommendations that would improve upon the high quality of care given to the man by healthcare staff at Gartree and in both hospitals and that this exceeded that which he could have expected in the community.

57. The clinical reviewer also commented on the issue of compassionate release and whether this could have been considered. It is evident from the documentation that it was considered but the investigator was told that the National Probation Service, when considering all the relevant risk factors, was unable to support the decision. When the inpatient healthcare unit at Gartree was due to close, healthcare and prison staff with responsibility for the man's care considered whether a move to a category C prison would be appropriate but decided not to pursue this.

58. Within the clinical review, the reviewer highlights nine areas of good practice, including regular monitoring for diabetes with referral to a dietician, appropriate medical investigations, medication reviews and clearly documented care plans. He also found good practice regarding interdisciplinary working between healthcare staff in the community and at the prison, with effective communication as a strong feature of the man's care.

59. I agree that the liaison and subsequent arrangements between Gartree, Morton Hall (where the man's wife was serving her sentence) and Social Services to ensure successful family visits was impressive, demonstrated compassion and is an example of excellence. This is an aspect of his care of which both discipline and healthcare staff at Gartree and Morton Hall can rightly be proud.

CONCLUSION

60. The man entered the prison system in 2001 with hepatitis C and cirrhosis of the liver, a chronic and life threatening condition. He developed insulin dependent diabetes later in his sentence, but chose not to heed medical advice regarding his diet and refused treatment on a number of occasions. Overall, the investigation has judged that, while he was not an easy man to nurse, his complex medical conditions were well managed by prison and healthcare staff at HMP Gartree.

61. The success of his care management was partly due to the good relationship forged by healthcare and prison staff with the local hospitals. Effective communication between Gartree and the hospitals ensured that there were planned admissions and regular reviews. Gartree, Morton Hall and social services also put in place the necessary complex arrangements for his wife and daughter to visit.

62. I am pleased to say I concur with the clinical reviewer's view that the care he received at Gartree was comparable to, and possibly exceeded, that which he would have received in the community.