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A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

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**Investigation into the death of a man at HMP Gartree  
on 1 November 2014**

## ***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 of a man, who died of a heart attack on 1 November 2014 at HMP Gartree. He was 66 years old. I offer my condolences to his family and friends.

A clinical review was commissioned to investigate the man's clinical care. The prison cooperated fully with the investigation.

The man was serving a life sentence and had been in prison since May 2011 and at Gartree since July 2012. He had several medical conditions, including heart disease, poor circulation and an aortic aneurysm, but did not always comply with his treatment. On 27 October 2014, he complained of chest pains, but refused to go to hospital. The next day, when a prison doctor examined him and detected abnormalities in his heart, he agreed to go to hospital as an emergency. At hospital, doctors diagnosed a heart attack. Against all advice, the man discharged himself from hospital and went back to the prison that afternoon.

On the morning of 1 November, the man reported feeling unwell. A nurse arrived to see him within a few minutes. At first, he was responsive, but his condition declined rapidly. He became unconscious and staff attempted to resuscitate him. An ambulance arrived quickly and prison staff and paramedics continued emergency treatment, without success. At 9.49am, paramedics pronounced the man dead.

I am satisfied that there is nothing staff at the prison could have done to prevent the man's death. Had he not discharged himself from hospital on 28 October, the outcome could well have been different. The man was not an easy patient and often refused necessary treatment against medical advice, but the clinical reviewer identified some areas for improvement, which the prison will need to address. In particular, I am concerned that the prison cancelled an important hospital appointment because of a lack of escort staff and that there was no process to routinely review prisoners discharged from hospital.

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**

**May 2015**

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## SUMMARY

1. The man was serving a life sentence and had been at Gartree since 27 July 2012. He had a number of health conditions, including an aortic aneurysm, heart disease and epilepsy. Prison healthcare staff reviewed him frequently, but did not use formal care plans for all his conditions. Specialists monitored the aortic aneurysm until he was discharged from treatment in February 2012. The man often did not take his medication as prescribed, and sometimes refused to attend healthcare appointments or allow healthcare staff to examine him.
2. On 10 July 2013, the man told a prison doctor that he had been experiencing chest pain for some time. The doctor referred him urgently to a rapid access chest pain clinic, but he missed an appointment on 24 July, as there were not enough prison staff to take him. Healthcare staff did not refer him again until 5 September. The man attended the clinic on 25 September, but insisted on returning to the prison before the assessment was complete. Healthcare staff continued to monitor him, but he still often refused to engage with treatment.
3. On Monday 27 October 2014, the man reported having chest pain, but rejected a nurse's advice that he should be examined in hospital. Instead, he agreed to see the prison doctor the next day. The doctor conducted an electrocardiogram test, which detected abnormal heart rhythms. The man then agreed to go to hospital as an emergency. Hospital staff diagnosed that he had suffered a heart attack, but he declined any treatment and discharged himself, against medical advice. Healthcare staff were not informed when he came back from hospital and did not monitor or review him.
4. At 7.40am on Saturday 1 November, the man asked to see a member of healthcare staff urgently. When nurses and other prison staff went to his cell he was initially conscious and responsive, but his condition deteriorated quickly. At 7.50am, the prison called an ambulance. Shortly afterwards, his heart stopped and staff began cardiopulmonary resuscitation and used a defibrillator to restore his heart rhythm. The man began breathing again and was stable for a short time. The ambulance arrived at 8.10am. By then, his heart had stopped again and the paramedics continued emergency treatment. At 9.49am, paramedics pronounced the man dead.
5. While the man was often uncooperative with healthcare staff about his treatment, the investigation found that staff at Gartree missed some opportunities to coordinate his care. There was a failure to monitor him effectively after he discharged himself from hospital a few days before his death. We are also concerned that he missed an important hospital appointment because of a shortage of escort staff and that there was a delay rearranging it. We make two recommendations.

## THE INVESTIGATION PROCESS

6. The investigator issued notices to staff and prisoners at HMP Gartree, informing them of the investigation and inviting anyone with relevant information to contact her. No one responded.
7. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison records. She spoke to three prisoners on 27 November and interviewed six members of staff at Gartree on 8 December.
8. NHS England commissioned a doctor to review the man's clinical care at the prison.
9. We informed HM Coroner for Leicester City and South District of the investigation, who provided a copy of the post-mortem. We have sent the Coroner a copy of this investigation report.
10. One of the Ombudsman's family liaison officers contacted the man's son, his nominated next of kin, to explain the investigation. He had no specific questions for the investigation to consider.
11. The man's next of kin was informed the draft report was available, but did not wish to receive a copy or make any comment. The prison considered our draft report and recommendations and has accepted these. The prison has also submitted an action plan detailing what they have done to address the issues we raised and this is included at the end of the report.

## **HMP GARTREE**

12. HMP Gartree is a category B Prison, near Market Harborough in Leicestershire, which holds up to 708 men sentenced to life imprisonment and other indeterminate sentences. Leicestershire Partnership Trust is responsible for delivering primary physical and mental health services in the prison and Northamptonshire Healthcare NHS Foundation Trust runs secondary mental health in-reach services.

## **HM Inspectorate of Prisons**

13. The most recent inspection of HMP Gartree was in March 2014. Inspectors were positive about the standard of health services. They noted there was a stable healthcare workforce who were qualified to deliver a range of appropriate services. Prisoners' access to healthcare services was very good and waiting times for all clinics were short. Nurses held triage clinics daily with open access for prisoners with urgent needs. Prisoners were able to see a GP routinely within three days. There was sufficient emergency resuscitation equipment, including automated external defibrillators, which were appropriately positioned around the prison and checked weekly. The Inspectorate was concerned that too many hospital appointments were cancelled because of a shortage of escort staff.

## **Independent Monitoring Board**

14. Each prison in England and Wales 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 recently published report for the year to November 2013, the IMB commented that 34% of hospital visits were cancelled caused equally by prisoners refusing to go, by the hospital cancelling, or by the lack of officers to escort prisoners.

## **Previous deaths at HMP Gartree**

15. The man's death is the fourth from natural causes since January 2013. We have previously made recommendations about improving the management of heart disease.

## KEY EVENTS

16. On 19 May 2011, the man was remanded to HMP Holme House, charged with murder. At an initial health assessment, a nurse noted that he had a history of epilepsy, arthritis, gout and heart disease and had several prescribed medications. He had been diagnosed with an aortic aneurysm (a swelling of the main blood vessel from the left side of the heart down to the abdomen), which hospital specialists monitored. On 21 October, the man transferred to HMP Durham.
17. On 21 December, the man received a life sentence with a minimum period to serve of 14 years before he could be considered for release. Over the next few months, he continued to attend appointments with a vascular surgeon to review his aortic aneurysm. Prison healthcare staff reviewed his medical conditions and warned him several times about the importance of taking his medication.
18. On 27 July 2012, the man transferred to HMP Gartree. When he arrived, a nurse noted that he had been on medical hold before his transfer, but Gartree had not received any handover or advance warning about his medical conditions. Healthcare staff noted from the SystmOne electronic medical record that he suffered from reduced blood flow to his leg which caused pain and that he was receiving specialist treatment for an aortic aneurysm.
19. On 2 August, a prison GP, referred the man to a vascular surgeon closer to Gartree, to oversee his aneurysm. He advised the man to give up smoking, but he did not want to stop. Healthcare staff reviewed him and his medications frequently, but noted that he was often not compliant with his treatment and medication, particularly medication prescribed for high cholesterol.
20. On 26 February 2013, a specialist nurse for aortic aneurysms, reviewed the man and referred him to his hospital vascular specialist team, because of worsening blood flow to his leg. On 8 April, his hospital consultant told him that he had the option of an angioplasty (a procedure to widen narrowed arteries), although without lifestyle changes (such as giving up smoking) it might not be beneficial.
21. On 10 July, the man told a prison GP that he had been experiencing irregular, left-sided chest pain for several months. The doctor noted his chest was clear and that his blood pressure and pulse were within normal range. As she knew that he was at high risk of vascular and cardiac disease, she referred him to a rapid access chest pain clinic and prescribed GTN spray (glyceryl trinitrate – to relieve muscle pain in the heart). She noted he was shortly due a have a scan for his vascular problems.
22. On 24 July, the prison cancelled the appointment for the rapid access chest pain clinic because there were no officers to escort the man. Healthcare staff did not consider his need for a further referral until 30 August and did not refer him again until 5 September, when he told a healthcare support worker, that

his chest was sore. A nurse conducted an ECG and noted there had been no acute changes.

23. The man attended the rapid access chest clinic on 25 September. Before hospital staff could complete his assessment, he became aggressive and abusive and demanded to return to the prison. The hospital subsequently sent a discharge letter to the prison healthcare department. This indicated that an ECG test at the clinic was normal, but they had not assessed any other symptoms. They advised the prison to refer him to the hospital cardiologist if there were any future concerns about his heart.
24. The man continued not to comply with treatment in hospital or in prison and sometimes refused medication. However, prison healthcare staff and hospital consultants continued to monitor him. Throughout 2014, he reported poor leg circulation. A vascular surgeon offered him surgery if he stopped smoking (as there were no lasting benefits to patients who continued to smoke), but he refused to give up.
25. On Monday 27 October 2014, a nurse saw the man in his cell after he reported pains in his chest and left arm. She found that his oxygen level was below normal range, his blood pressure was high and his heart rate and blood sugars were within normal range. The man admitted that he had not taken his medication for some time. Because of his history of heart disease, the nurse tried to persuade him to go to hospital as an emergency to have an ECG, but he refused to go. He said he would see the prison GP in the morning and she advised him to contact healthcare staff if the pain continued or worsened.
26. A doctor reviewed the man on the morning of Tuesday 28 October. He said that the pain had lasted several hours but had settled eventually. His blood pressure, pulse and oxygen level were all in the normal range. The doctor did an ECG test, which suggested that the man had ischaemia (poor oxygen supply to the heart) and needed an urgent blood test to determine whether he had had a heart attack. He agreed to go to hospital as an emergency.
27. The man went to hospital in an ambulance, escorted by two officers. At the hospital, he had blood tests, an ECG and a chest X-ray. The escort officers recorded that the longer they were in the hospital, the more agitated he became and they warned him for shouting and swearing in the waiting room.
28. The man asked to go back to the prison, but a hospital doctor told him that he had had a heart attack and should stay at the in hospital. He refused to stay and signed a disclaimer form to say he was leaving hospital against medical advice. The hospital did not send any discharge information to indicate whether any further investigations or specific care would be necessary. Healthcare staff were unaware that the man had returned from hospital and did not review him when he got back to the prison, or over the next few days.

## **Saturday 1 November**

29. At 7.40am on the morning of 1 November, the man pressed his cell bell. An officer went to the cell and looked through the observation panel. The man was sitting on his bed and told the officer that he needed to see a member of healthcare staff urgently. The officer said that the man looked pale. The officer went to the wing office and phoned the healthcare centre. No one answered, so he phoned staff in the communications room to ask them to radio for healthcare assistance.
30. The officer told the investigator that he did not consider it was an emergency. He had telephoned the healthcare centre as the man was conscious and thought he was smoking a cigarette at the time. Had he known about the man's recent heart attack, he would have been more concerned and might have radioed an emergency medical code to summon help.
31. The officer then phoned a custodial manager and asked him to come to the wing to open the man's cell. The custodial manager said in a statement that he had arrived at the man's cell at 7.43am. He was lying on the floor at the time, but he was conscious. As he opened the cell door, a nurse arrived with an officer. They helped the man to get up and sit on the bed.
32. A nurse described the man as responsive, but clammy and very unwell. His clinical observations were initially satisfactory, but he quickly deteriorated - his pulse rate increased and his oxygen levels decreased. The nurse asked for an ambulance to be called. Ambulance records show that the call requesting one was received at 7.52am. The nurse also asked for oxygen and a defibrillator (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest to reestablish a normal heart rhythm.)
33. The duty governor that day arrived at the cell. From the window, she saw another nurse arriving for duty and called her to help. The duty governor brought oxygen to the cell and asked a nurse to get the defibrillator. Nurses maintained the man's airway.
34. At 7.50am, the man became unresponsive. His oxygen levels fell suddenly and he stopped breathing. A nurse began chest compressions while the man was still on the bed. Another nurse then arrived with the defibrillator. They moved the man to the floor and a nurse attached the defibrillator, which advised and gave a shock at 8.10am. The man began breathing again. At that point, the paramedics arrived and took over the emergency treatment. They moved the man to the cell floor. He remained stable for a short time, but then had another cardiac arrest, so they resumed cardiopulmonary resuscitation. Prison staff and a nurse continued to assist the paramedics and another paramedic arrived at 9.35am. While the paramedics were there, they gave the man nine doses of adrenaline and used a mechanical CPR machine. The attempts to resuscitate him were unsuccessful and, at 9.49am, the paramedics pronounced him dead.

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

35. During the resuscitation attempts, officers checked and reassured the prisoners in nearby cells because they were able to hear and see some of what was happening to the man. After the paramedics pronounced him dead, staff unlocked the prisoners and took them away from the wing to speak to them as a group about what had happened to offer them support. Notices were put up in the prison informing staff and prisoners of the man's death and how to get support.
36. Managers held a hot debrief on the day for all staff involved in the incident, to discuss what had happened and offer further support.

### **Liaison with the man's family**

37. The man's son, his next of kin, lived a long way from Gartree. The prison therefore asked HMP Durham to send a family liaison officer to his home to break the news of the man's death to him and his sister. An officer from Gartree then contacted the family to offer condolences and support. In line with national guidelines, the prison contributed towards the cost of the funeral.

### **Post-mortem**

38. A post-mortem examination showed evidence of heart disease, a recent heart attack (ten to 14 days before the man died) and another event within 12 hours of his death, which is likely to have caused his sudden death.
39. A non-cancerous tumour was found in the man's brain, and evidence of poor kidney function, chronic obstructive pulmonary disease and an inflamed liver. None of these contributed to his death and there was no evidence of drug abuse.
40. The post-mortem report concluded that the man died of myocardial infarction and coronary artery arteriosclerosis. (A heart attack, caused by narrowed arteries.)

## ISSUES

### Clinical care

41. The clinical reviewer considered the man's death could not have been prevented and that, although some aspects of his medical care were equivalent to that he could have expected in the community and there were some examples of good care, there were also some missed opportunities to manage his cardiac risk more effectively. This included a lack of communication between staff, no clear monitoring after he attended the rapid access chest pain clinic, or follow up after he discharged himself from hospital on 28 October. The clinical reviewer acknowledged that the man's own decisions and non-compliance with his medical care contributed to this, but he concluded that, on balance, the man's care was not equivalent to that expected in the community. He considered that Gartree needed to improve some of its systems and record keeping and has made recommendations in his review, which the Head of Healthcare will need to address.

### Cancelled hospital appointment

42. After reporting persistent chest pain in July 2013, a prison doctor referred the man to a rapid access chest pain clinic. The prison cancelled an appointment on 24 July as no officers were available to escort him. The clinical reviewer stated that this was an important appointment which the man should not have missed, and there should have been sufficient notice to make the necessary arrangements. We agree that prisoners should not miss such urgent appointments. We note that at the most recent inspection of Gartree in March 2014, HM Inspectorate of Prisons was also concerned that the prison cancelled too many hospital appointments because of problems with escorts.
43. The cancellation was not recorded in the man's record until 30 August, over a month later. Another referral was sent on 5 September and he had an appointment on 25 September. It is concerning that for a *rapid access* chest pain appointment, there was no evidence that healthcare staff considered rescheduling the appointment until a month after it was meant to have happened. The man was not taken to the appointment until two months after the first had been booked. Although he then did not cooperate with that appointment, this should have been rearranged sooner. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that hospital appointments are not cancelled unless there are overriding, fully justified and documented security reasons and there is no detriment to the prisoner's health. When appointments are cancelled, they should be rescheduled urgently.**

44. On 28 October, hospital doctors diagnosed that the man had had a heart attack, but he discharged himself the same day, against medical advice. Healthcare staff did not review him when he returned from hospital or contact the hospital to obtain discharge information. It appears that they were

unaware that he had returned. There is no process at Gartree for healthcare staff to review prisoners routinely when they are discharged from hospital. Reception staff do not appear to have informed healthcare staff that the man had returned, although PSO 3050 (Continuity of Healthcare) requires prisons to have protocols to screen prisoners who have left the prison and pass back through reception for any potential healthcare or suicide and self-harm issues. The clinical reviewer noted that this was a missed opportunity to review the man's care and share medical information. It also meant that healthcare staff did not monitor him after he discharged himself from hospital. Although he might not have accepted any further treatment or monitoring, it should have been offered. We make the following recommendation:

**The Head of Healthcare should ensure prisoners are reviewed when they return to prison after they have been discharged from hospital and monitored for ongoing health issues as necessary.**

## **RECOMMENDATIONS**

1. The Governor and Head of Healthcare should ensure that hospital appointments are not cancelled unless there are overriding, fully justified and documented security reasons and there is no detriment to the prisoner's health. When appointments are cancelled, they should be rescheduled urgently.
2. The Head of Healthcare should ensure prisoners are reviewed when they return to prison after they have been discharged from hospital and monitored for ongoing health issues as necessary.

**ACTION PLAN: The man – HMP Gartree**

| <b>No</b> | <b>Recommendation</b>   | <b>Accepted/Not accepted</b> | <b>Response</b>  | <b>Target date for completion and Function Responsible</b>            |
|-----------|---|------------------------------|--|---|
| 1         | The Governor and Head of Healthcare should ensure that hospital appointments are not cancelled unless there are overriding, fully justified and documented security reasons and there is no detriment to the prisoner's health. When appointments are cancelled, they should be rescheduled urgently. | Accepted                     | <p>HMP Gartree will review actions taken following the HMIP report and recommendations and ensure a clear pathway remains in place to allow monitoring of reasons for cancellations.</p> <p>Healthcare now have daily contact with the detail team to ensure escorts are facilitated and a decision log for each cancelled appointment will document circumstances, justification, impact on the individual and plans for future treatment.</p> <p>Cancelled appointments are raised at a quarterly discussion through the contract and performance meeting with commissioners and the prison partnership board continues to take place.</p> | <p>30 April 2015</p> <p>Head of Operations and Head of Healthcare</p> |
| 2         | The Head of Healthcare and Governor should ensure prisoners are reviewed when they return to prison after they have been discharged from hospital and monitored for ongoing health issues as necessary.   | Accepted                     | <p>A protocol will be put into place to ensure that prison staff inform healthcare when a prisoner returns from hospital so that healthcare can assess the prisoner as soon as possible.</p> <p>Healthcare will then review the prisoner and put into place ongoing support required.</p>  | <p>30 April 2015</p> <p>Head of Operations/Head of Healthcare</p>     |