Investigation into the circumstances surrounding the death of a man at HMP Gartree in October 2006

Report by the Prisons and Probation Ombudsman for England and Wales

December 2007

This is the report of an investigation into the death of a man. He was a life sentenced prisoner and died of apparently natural causes at HMP Gartree in October 2006. He was 39 years of age.

The man was located in the supervision and assessment unit (SAU) in Gartree on 21 October 2006, after a punishment of 14 days cellular confinement had been imposed. He was found lying dead in his bed five days later. The post mortem has been unable to establish a cause of death.

My colleagues and I offer sincere condolences to his family and friends for their sad loss.

This investigation has been undertaken by two of my colleagues. I would like to thank the Governor of HMP Gartree and her staff for their participation in the investigation.

An appointed GP undertook a review of the man's clinical care on behalf of Leicestershire County & Rutland PCT. The clinical reviewer found that the man's medical records were in poor chronological order, and this made it difficult to follow the course of clinical events, particularly relating to the prescription of anti-depressant drugs. My report includes one recommendation relating to that matter and I draw one other issue to the Governor's attention.

The man had been remanded into custody at HMP Winchester on 25 March 2003. He subsequently transferred between several different prisons until his last move, on 23 August 2006, when he arrived at Gartree for the second time. During his time in custody, the man engaged with a variety of services and treatments to tackle his drug addiction. These had varying degrees of success.

I much regret the delay in issuing this report. This was caused in part by a wait of almost eight months before I received the clinical review which could not be written until the post mortem result was received.

Stephen Shaw CBE
Prisons and Probation Ombudsman **December 2007**

CONTENTS

Summary

The Investigation Process

HMP Gartree

Key Events

Events on 26 October

Issues
Family concerns
Clinical review

Recommendation

SUMMARY

The man was remanded in custody at HMP Winchester on 25 March 2003 on a charge of murder. He was transferred to HMP Bullingdon on 30 December, still on remand. He returned to Winchester on 23 March 2004 following his conviction and sentence. He was given a life sentence with a 17 year tariff, later reduced to 14 years. During his time in custody, he was transferred between several different prisons. On 3 May 2005, he moved from Winchester to HMP Parkhurst. On 22 November, he was located overnight in HMP Wandsworth and arrived at HMP Gartree on 23 November. The man was then located at HMP Grendon on 23 August 2006. His final move was back to Gartree on 28 September 2006.

During his time in custody, the man undertook various treatments to help with his drug addiction. These included engaging with the CARATs (Counselling, Assessment, Referral, Advice, Throughcare) programme and undertaking mandatory drug tests. (The CARATs programme provides non-clinical treatment to the majority of prisoners who have substance misuse problems. CARATs teams assess prisoners and provide on-going support and referral to outside agencies.)

The man was located in the supervision and assessment unit (SAU) in Gartree on 21 October 2006 after he failed a mandatory drugs test. On that date he pleaded guilty to the internal disciplinary charge against him. The punishment imposed by the adjudicator was 14 days cellular confinement.

At around 8.30am, the man's cell was entered by prison officers and he was found dead, lying face down on his bed. The post mortem examination has been unable to establish a cause of death which remains unascertained.

THE INVESTIGATION PROCESS

1. My investigators studied all relevant prison records relating to the man who died. These included his main prison record, medical record and statements made by prison staff.

2. A GP was asked to carry out a review of the man's clinical care on behalf of Leicestershire County & Rutland Primary Care Trust (PCT). I am grateful for this review being undertaken.

3. My investigators contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation, and to request a copy of the Post Mortem report. Upon completion, this report will be sent to the Coroner to assist in his enquiries into the man's death.

4. One of my Family Liaison Officers contacted the man's family. His father replied by e-mail indicating that he was concerned that the Coroner had been unable to establish a cause of death. He believed his son might have had flu shortly before his death, and asked if he had received medication or treatment for any illness the week before he died. The parents would like to know whether their son received any medical help at this time. They also asked if any medication was given for his symptoms and whether flu or some other illness could have caused his death. These concerns are fully discussed in a later section of my report.

5. My investigators discussed aspects of the man's treatment with both staff at Gartree and the clinical reviewer. (Notices were issued to staff and prisoners telling them of the investigation and offering them the opportunity of contributing.) During the course of the investigation seven members of staff were interviewed. My investigators spoke with the police in relation to their investigation. They also met with three prisoners and a prison chaplain.

HMP GARTREE

6. HMP Gartree opened in 1966 as a category C prison but a year later was converted to a high security dispersal prison. It was regraded in 1990 to a main centre for category B life sentenced prisoners. Gartree currently holds adult, male, life sentenced prisoners, mainly in the first stage of their sentences, who spend three to five years there. Gartree aims to help life sentenced prisoners come to terms with their sentence and tackle their offending behaviour.

7. The most recent inspection report by HM Chief Inspector of Prisons says:

> “The segregation unit, known as the supervision and assessment unit (SAU), was clean and well ordered, with an average daily occupancy of around nine prisoners. Authorisations for segregation were satisfactory but reviews were ineffective in managing long-staying prisoners back to normal location. There was little to occupy prisoners. We were concerned about insufficient oversight of the unit and in one case four meals had been withheld from a prisoner without managers noticing.”
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> “There was an apparent low incidence of illegal drug use, with the rate of mandatory drug test positive results at 3.4%. However, there was some evidence of unauthorised possession of opiate-based medication. Arrangements for the management of medications were poor and we were told this led to some bartering and bullying for prescription drugs. We were told that finds of alcohol were increasing, although the security information records did not support this. Even if the incidence of drinking had been low, it was related to serious violence. Substance users’ clinical needs had usually been met before they arrived at Gartree. There were appropriate protocols and good liaison between healthcare and the drug strategy team.”

8. There have been seven other deaths at Gartree since April 2004, six from natural causes and one apparently self inflicted death. There are common issues between the death of this man and two of the natural cause deaths, to which I shall refer later in this report.

KEY EVENTS

9. The man was transferred from the Magistrates' Court to HMP Winchester, on remand, on 25 March 2003. He was charged with murder. During the first reception healthscreen, he said he was not taking any prescribed medication but admitted to having a heroin and cocaine habit which was costing him around £50 a day. He did not give any indication that he had any intention of harming himself. On 27 March, he had an induction interview at which he said that he used heroin and wanted help overcoming his addiction. He was put on an opiate and benzodiazepine detoxification plan and was referred to the CARATs team on 28 March. He was clearly not content with this initial detoxification programme as he subsequently took out medical negligence proceedings against Winchester regarding the standard of care he received at that time.

10. On 15 April, the man reported that he was having trouble sleeping. This was considered to be due to his detoxification. On 7 May, he said he was low in mood and he was prescribed Seroxat (Paroxetine) 20mg (an anti-depressant) and Promethazine (a sedative to help him sleep).

11. On 6 July, the man had a disciplinary adjudication for assaulting an officer. He pleaded not guilty but was found guilty during a hearing on 9 October. He faced another adjudication on 2 November for using abusive language towards a nurse. He pleaded guilty at a hearing on 4 November and was given a punishment of seven days cellular confinement.

12. On 30 December, the man was transferred to HMP Bullingdon. He saw a Roman Catholic chaplain on 31 December as he was concerned that he should not have been transferred owing to his pending case in Winchester. He wanted to be closer to his legal representatives. On 4 January 2004, the man made a public expense telephone call to his brother. (According to PSO (Prison Service Order) 4400, Chapter 4, prisoners can use official telephones if there are urgent legal or compassionate circumstances such as imminent court proceedings or a domestic crisis. Operational managers have discretion to authorise these calls and did so for the man.)

13. On 23 February 2004, the man was interviewed by a lifer officer as a potential life sentence prisoner. On 25 February, he asked to be moved into a single cell as he said he felt under pressure due to his impending case. He was moved to a single cell and was told by the officer to let him know if he started to feel depressed. On 26 February, he received his first behaviour warning for not attending education six days earlier.

14. On 8 March, the man was transferred back to HMP Winchester. He appeared at Crown Court on 15 March, and on 23 March when he was sentenced to life imprisonment. He was given a 17 year tariff which was subsequently reduced to 14 years. On 11 April, he went missing from his cell and was later found in another cell. He had made up his bed to make it look like he was in his own cell. A Security Information Report (SIR) was submitted by staff and his name was placed on an escape list (E list).

15. On 13 April, 4 August and 22 November 2004, the man attended workshop skills training. He was taken off the escape list on 24 June. On 3 October, he sprained his left ankle during gym in the sports hall. On 29 November, he tested positive for opiates. He was subject to mandatory drug testing. On 10 December, he tested positive for benzodiazepine medication and was given his first warning for misuse of drugs. On 4 January 2005, he tested negative for benzodiazepine medication. The man started a P-ASRO course (Prison - Addressing Substance Related Offending) on 4 January 2005. On 7 and 20 January, the man tested positive for opiates/benzodiazepines. He received his first warning on the P-ASRO course. Subsequently he tested negative for drugs on 27 January and 8 February.

16. The man appears to have been unsettled. On 12 February, he had a fight with a cleaner and on 26 February he became verbally aggressive to an officer when asked to go behind his door. It was noted in his core record that, when he was approached by other staff, he became threatening and more aggressive. On 3 March 2005, he tested positive for opiates and received his second warning on the P-ASRO course.

17. On 8 March, the man had a review as part of the P-ASRO course with two officers. It was noted that he had a long talk about how he was feeling. He said he was still unsure of his future but wanted to stay on mandatory drug testing for the time being. On 22 March, he had an inter-prison phone call to HMP Eastwood Park with his partner who was located there.

18. On 29 March, the man failed another mandatory drugs test. He was placed on the frequent testing programme. On 30 March, he had a negative drugs test. He was transferred to HMP Parkhurst on 3 May. He was located on F wing where his induction was completed. It was noted that he did not have any problems. On 12 May, his main prison record indicated that he was worried about his partner. An officer rang her and reported to him that she was alright. On 22 July, the man told an officer that he was in debt on the wing. The man was asked if he wanted to be considered a vulnerable prisoner under prison Rule 45, which he accepted. He was relocated in the segregation unit the same day for his own protection. He stayed in the segregation unit until 22 November.

19. On both 13 August and 27 August 2005, it was noted in his main prison record that he was quiet and had no problems. On 20 August, he applied to transfer to HMP Swaleside or HMP Bristol. He was transferred to HMP Wandsworth on 22 November where he remained overnight and was then transferred to HMP Gartree on 23 November. On 28 November, he saw an occupational therapist from the Mental Health In-reach team. The therapist arranged for the man to attend an anxiety management course of six weekly group meetings.
20. The man was located in the SAU for two days from 11 April 2006 following an adjudication for charges of offending against good order and discipline. A note in his medical record said that he was seen in the SAU on that date by the acting Senior Healthcare Officer. On 8 May an F2052SH form was

opened as the man was low in mood. (F2052SH was the system used by HM Prison Service at the time to monitor and support a person at risk of suicide or self harm. It has since been replaced by ACCT (Assessment, Care in Custody and Teamwork).) The man saw a member of the mental health in-reach team (MHIRT), on 9 May. The man denied any thoughts of suicide or self-harm and the F2052SH was closed. He

21. was seen by a psychiatrist, on 16 May. The psychiatrist concluded there was no need for further MHIRT input for the man.

22. On 22 May, the man started the Enhanced Thinking Skills (ETS) course. The man was located in the SAU again on 30 May for seven days, a punishment for being in possession of fermenting liquid. He returned to the SAU on 28 July for 21 days, again as punishment for being in possession of fermenting liquid. On 16 August, he had a fight with another prisoner on G Wing, where he was located. He was taken to A&E for treatment and later returned to the SAU. The man had an assessment to establish whether he was suitable for location in HMP Grendon. (Grendon is a therapeutic community and all prisoners make a voluntary compact to remain drug free while they are in therapy. For this reason Grendon's drug strategy is pro-active and aimed at both prisoners and visitors in an attempt to stop the smuggling in and use of drugs. Prisoners should not take any opiate-based medication when at Grendon.)

23. The man completed the ETS course at Gartree on 22 August 2006. He was transferred to Grendon on 23 August. All prisoners are given an assessment on their initial reception to Grendon. Identification of the prisoner's needs is based on his sentence plan and security measures, including mandatory drug testing. Support and advice is provided through CARATs (Counselling, Assessment, Referral, Advice, Throughcare), which is available on induction. This is augmented by a voluntary testing programme, which is based on prisoner needs determined by individual and frequent assessment. The man had an initial reception healthscreen on 23 August, followed by a full reception healthscreen on 27 August. On 24 August, the man had a CARATs assessment, when he was screened for drug and alcohol problems by a CARATs worker.

24. On 12 September, the man was seen by a Community Psychiatric Nurse (CPN), who referred him for a mental health assessment. Another CPN assessed him on 18 September and planned to see him for further assessment in two weeks. He was transferred from Grendon before then.

25. On 26 September the man took his whole day's dose of prescribed medication, Diazepam (anti-anxiety drug). He demanded replacement tablets and threatened to 'put a chair leg round somebody's head'. The man returned to Gartree on 28 September. He was given medication from Grendon in his possession (seven days supply of Citalopram, an anti-depressant, and three days supply of Diazepam. The man saw the prison's doctor on 29 September. The man told the doctor that his time at Grendon had made him anxious. The doctor prescribed Diazepam 5mg (in possession) to be taken three times a day for one week and decided that the man was to continue taking his anti-

depressant (Citalopram 20mg) daily. The prison doctor saw him again on 2 October when he complained of ongoing anxiety. The man had already taken his weekly supply of Diazepam within three days. A note in his medical record said that he took all his Diazepam on 2 October. The doctor continued to prescribe Diazepam for him but at a reduced dosage.

26. On 6 October 2006, the man complained about the availability of drugs on B wing and told an officer he wanted to move wings. He saw a Psychological Assistant, who noted:

> "Saw him briefly on the wing following his return from Grendon. Said he had learnt a lot about himself in the 4 weeks he had spent in Grendon and was motivated to return to complete the therapy. Was aware that he needed to complete the CALM course and knew that he would have to wait to start the course as there was a waiting list. Had been frustrated in Grendon and had been having panic attacks and 'blowing up' during wing meetings. Said he felt calmer since he had returned to Gartree. In the meantime he was motivated to help himself through education and going to the gym. He talked to staff about the possibility of being located in the Gartree therapeutic community."

The Gartree therapeutic community (GTC) is a unit comprising a number of small therapy groups which come together for whole community meetings. The man said he would think about it. He told the assistant psychologist that he was feeling much better, and his panic attacks had stopped, but he wanted to get off B wing as he said there were a lot of drugs there. She completed a security information report (SIR) and the authorising governor wrote that her information should be added to the current intelligence.

27. The man failed a mandatory drug test on 10 October. On the same day, he saw the GP and asked her for more Diazepam. The GP prescribed a week's supply of Diazepam 2mg. On 12 October, he saw the GP again. He told her that he had taken all his Diazepam and complained the dosage was too low. The doctor prescribed a further one day's supply (that is, three tablets) of Diazepam 5mg. On 12 October, the therapist from the Occupational Therapy in-reach team, completed a mental health assessment for the man. He said that the man presented as extremely agitated and animated. The man told him he had struggled with interpersonal relationships at Grendon. Since returning to Gartree, he continued to be agitated. The occupational therapist noted in the medical record that the man was still taking Diazepam and was also taking Cipramol (Citalopram) which had recently been increased from 20mg to 40mg. The prescription chart confirms the dosage of Citalopram was increased from 20mg to 40mg on 13 October and the man was prescribed two days' medication. The prison's doctor made a note in the medical record dated 13 October that the man was very anxious. He was told about relaxation techniques that might help him, and his Citalopram was increased from 20g to 40mg. (Although the earlier entry from the occupational therapist indicated this had happened on 12 October.) The man had applied to study Art and English and to go to the gym.

28. On 21 October, the man had an adjudication relating to his failed mandatory drug test on 10 October. The punishment imposed by the adjudicator was 14 days cellular confinement and the man was located in the supervision and assessment unit (SAU). (When asked by my principal investigator, the prison could not find the history sheet (F2052A) for him between 28 September and 21 October 2006.)

29. National policy guidance on segregation decrees that a segregation safety algorithm must be completed for all prisoners in the segregation unit and before cellular confinement can be given. Prison Service Order (PSO) 1700 refers to segregation and says:

> "Segregation under Prison Rule 55(e) (YOI Rule 60(f)) – cellular confinement. An adjudicator may impose a punishment of cellular confinement following a finding of guilt at an adjudication as long as a doctor or registered nurse has indicated that there are no relevant health factors that would advise against this. The maximum period of cellular confinement that can be imposed is 21 days for adult prisoners and 10 days for young offenders. Governors must ensure that only a minimum loss of facilities results. The adjudicator would, however, normally be expected to impose a punishment which does not include segregation."

30. A staff nurse and the duty governor authorised the man's segregation on 21 October. On 22 October, the man was seen by the wing nurse. She noted that the man did not mention any problems. The man saw a chaplain, on the same day. He told the chaplain that he wanted to stop taking drugs and needed help. The chaplain told my investigators that he saw him in the SAU on 22 October 2006. In his opinion, the man was his usual self: slightly sad but cheerful at the same time. He recalled that the man sat on his bed, seemed relaxed and did not show any signs of agitation. The chaplain told him that he wished he could do without drugs and said he felt weak because he could not manage without them. The chaplain felt that being in the SAU was a positive thing for him to keep away from drugs. He said that the man did seem to be definite about wanting to give up drugs and described him as being 'happy go lucky' and full of remorse for his crime which he said was linked to drugs. He described the man as having 'a wistful air' about him, almost as if he was sad that life was not better for him. The chaplain said that the man never complained about staff or other prisoners.

31. The chaplain said he was unaware that the man suffered from panic attacks and did not discuss with him what treatment, if any, he was undergoing for drugs. He said his body language was relaxed and at ease and there was no indication that he had any physical ailments.

32. The man saw a member of the Independent Monitoring Board (IMB) on 23 October 2006 and told them that he had no problems. (Every prison has an IMB made up of volunteers, who are appointed by the Home Secretary. The

board members are independent of the Prison Service and monitor day to day life in prisons.)

33. On 23 October, the man also saw a member of the psychology team, in response to his application of 29 September for an urgent appointment. She told my investigators that the man talked about his anxiety and drug use and she said that she encouraged him to speak to a member of the CARATs team. She also discussed relaxation techniques and strategies with him. She told him that she would look into the possibility of getting him a cassette player so he could listen to relaxation tapes. She also recommended that he refer himself to CARATs to get help for his substance misuse. She passed on his referral to the CALM team to make sure he had been added to their waiting list. Finally, she left him with some strategies to help reduce any violent or aggressive thoughts. The man agreed to take up exercise to help deal with feelings of aggression.

34. The man also saw a chaplain on 23 October. He told the chaplain that he was alright. On the same day, he saw the GP again. The doctor did not note any issues or concerns in the man's medical record or main prison record.

35. On 24 October, a chaplain spoke the man about support from the CARATs team. She noted that the man was going to be seen by a CARATs worker the following week. On the same day, he was seen by another chaplain. He noted in the core record that the man did not raise any issues. The man was also seen by the acting Senior Healthcare Officer, during her SAU rounds. She did not record any concerns about him either.

36. On 25 October, the man was seen by yet another chaplain who noted that the man did not report any problems. The man was seen again by the GP on her rounds in the SAU. She did not note any concerns in his medical record or his main prison record.

37. The Senior Officer (SO) told my investigators that he spoke to the man that evening. He said the man was jovial and recalled that they shared a joke.
38. A prison officer told my investigators that he was the prison officer on night duty in the SAU on 25 October. Part of his duty was to check prisoners in cellular confinement every hour, and these included the man. The officer explained that the requirement is to perform a visual check every hour to ensure the prisoner is alright.

39. The prison officer confirmed he checked the man at 10.00pm and noted in his hourly monitoring sheet that he was okay. (Monitoring sheets are used for prisoners on cellular confinement to record hourly observations.) He checked him again at 11.00pm and again noted he was okay. The officer recalled that the man was awake some time between 11.30pm and midnight when he asked him to turn the light off in his cell. He said the man appeared normal and the officer had no concerns about him.

EVENTS ON 26 OCTOBER

40. The prison officer continued his hourly checks on the man. He recorded that at 12:01am he was ok, at 1.00am he was asleep, 2.00am asleep, 3.00am asleep, 4.00am asleep, 5.00am asleep and 6.00am asleep. The last check he completed was at 7.00am and again he recorded that the man was asleep. The SAU does not have an electronic pegging system, as some prisons do, to record when an officer visits each cell. The officer could not recall whether the man was lying on his back or front when he saw him, or whether he was under his bed covers. The officer thought he could remember seeing him lying on his front. He handed over to day staff in the morning between 7:30am and 8:00am at the end of his night shift. It appears that the morning roll call was completed by the wing SO at around 7.30am.

41. The wing officer told my investigators he was taking applications from prisoners. He reached the man's cell at around 8.30am. This was later than usual due to a planned move of four prisoners from C wing to the SAU. The officer explained that officers visit each prisoner in the SAU every morning. One officer takes and empties the prisoner's flask, the other asks what the prisoner's needs are for the day (for example, exercise, shower or phone call). A third officer carries the application book and records any other specific individual needs. The SO and the landing officer were on duty with the wing officer.

42. The SO went into the man's cell first and immediately felt a coldness. The man was lying on his front with his face buried in the pillow. He had the blankets over him. The SO touched him on the side of his face and then put his finger down the back of his neck. The man was ice cold. The SO shouted out, 'Medical emergency.' The landing officer then called for medical assistance over the radio. The wing officer had already gone to the multi-faith room to get medical assistance as there were several members of healthcare staff there waiting to assist with the planned removal of prisoners from C wing to the SAU. The principal officer (PO) and the wing SO arrived at the cell immediately on hearing the call and the SO was standing by the cell door. The SO and the wing SO turned the man over onto his back.

43. The duty nurse, the staff nurse, the wing nurse and the acting senior healthcare officer were in the multi-faith room when they were alerted by the emergency call and the wing officer. The staff nurse contacted the healthcare centre to ask the doctor to attend. The acting head of healthcare commenced Cardiopulmonary Resuscitation (CPR), and continued with chest compressions until the doctor arrived. The wing nurse had gone to the SAU office to collect the medical emergency bag and was getting equipment out of the bag when the prison doctor arrived at around 8.35. The doctor continued to administer CPR with the acting healthcare officer. At 8.37am, he instructed that CPR should cease and he pronounced the man dead.

44. Police found the following medication in the man's cell, all of which had been prescribed for him:

- One tablet of a packet of seven Citalopram 40mg
- Empty box of Paracetamol 500mg tablets
- Nine tablets of a packet of 16 Ibuprofen 200mg tablets
- 31 of a packet of 90 Glucosanine Sulphate 750mg tablets
- Full packet of 28 Glucosanine Sulphate 1500mg tablets.

ISSUES

Family concerns

45. As they live in France, the man's parents were notified of their son's death by the police. They were already aware as they had been told by another family member or friend of the family who knew about the police efforts to trace them. The parents and his brother have thanked the prison for their support following the man's death. The man's property was returned to his brother and the prison paid the funeral costs. The prison's family liaison officer also kept the brother up to date with the post mortem findings. The man's family are concerned that the Coroner has been unable to establish a cause of death. They believe their son might have had flu shortly before his death and asked if he had received medication or treatment for any illness the week before he died. The man's father said in the few weeks leading up to his death his son had been keeping fit and was training in the gym. He had reported that he was eating well and had started to include fruit into his diet. The father said he received a letter from his son about a week before his death saying that he had not been feeling very well and thought he might have had flu. The letter said that he was feeling a bit better and in brackets he had written, "I think", indicating to his family that he still did not feel one hundred per cent. The parents would like to know whether their son received any medical help at this time. They asked whether any medication was given for his symptoms and whether flu or some other illness could have caused his death. My investigators have established that the man was seen by a nurse on 21 October before going to the SAU and no physical ailments were noted. He was seen by a nurse and chaplain on 22 October and again no problems or concerns were noted about his physical health.

46. On 23 October, the man was seen by a member of the psychology team, another chaplain and the doctor, and no concerns were raised about his physical health. On 24 October, he was seen by a member of the psychology team, another chaplain and the doctor, and no concerns were raised. On 24 October, the man was seen by a member of the CARATs team, another chaplain and the acting senior healthcare officer. Again, no concerns were raised about him having any physical ailments. Finally he was seen by a chaplain and the doctor on 25 October and there is no note of any concerns raised. Three prisoners interviewed also stated that the man appeared in good health. I give a detailed account of what they said at paragraphs below.

Clinical review

47. On 31 October 2006, my investigator asked Leicestershire County & Rutland Primary Care Trust to conduct a clinical review of the man's treatment in custody.

48. The clinical reviewer examined the man's GP records as well as his prison medical record and CARATs file. He notes that the GP records were difficult to decipher and do not appear to be continuous until 1 September 1996. The man's GP records are in the EMIS computer record format from 2000. His history of depression is first noted in September 1996 when he was prescribed an anti-depressant, Seroxat (Paroxetine), 20mg daily. It is not clear how long he had been prescribed this medication before then and he does not appear to have taken it again after that. In January 1998, there is further reference to the man's depression, this time on his return from a trip to Venezuela. He was prescribed Prothiaden 75mg (an older anti-depressant). It was noted on 8 October that he was depressed again. He was prescribed Seroxat (Paroxetine) 30mg which he appears to have taken until at least May 1999. An entry dated 4 November records a past history of depression, drinking to excess and paranoia.

49. The first note in the computerised format in January 2000 says that the man was taking Seroxat (Paroxetine) at that time but the medication was not subsequently prescribed. All other entries appear to relate to his drug addiction and the prescription of methadone and other drugs in conjunction with the Acorn Community Drug & Alcohol Service in Guildford.

50. The clinical reviewer observes that the man's prison medical records were in a chaotic state which made it impossible to trace an exact chronology relating to the prescription of anti-depressants. It is clear that the man was prescribed various anti-depressants by different doctors. However, the clinical reviewer says it is impossible to say exactly what medication the man was taking and for what length of time to be able to assess how he was complying and responding to the treatment. He notes that the man may not have complied well with his treatment so none of his medication really had a chance to work properly and his symptoms continued. If this was the case a clear record of medication would have helped to identify it. The clinical reviewer also notes that the man participated in the CARATs programme at various prisons to help him deal with his drug addiction. He concludes that both the man himself and various health professionals appear to have spent a lot of time and effort addressing his drug addiction. At times, the man appeared to make progress. However, the clinical reviewer questions the value of the CARATs programme in this case as the man did relapse several times. Nevertheless, having identified these issues relating to the management of the man's drug addiction and depression, the clinical reviewer concludes, "these are ultimately only of academic interest as neither appears to have directly contributed to his death. Spending further time on the analysis of these issues would not therefore contribute anything useful to this report."

51. The cause of the man's death has not been established. The post mortem report states:

> "The man was found lying face down in his bed apparently in a sleeping position. Time of death cannot be determined. Congestion of tissues of body and numerous pethechial and purpuric heamorraghes over the front of his body and face. Likely to be a result of how he was lying at the time of his death. Cannot rule out an asphyxial element to his death though his bed was not disturbed and his body position would appear to rule out suffocation. Toxicology analysis shows no evidence of drugs abuse in his body at the time of death. Citalopram, an anti-depressant drug, was found in his body with a blood concentration above the quoted therapeutic range. However, this level is below those where death has been associated with both Citalopram alone or when in combination with other drugs. The blood level result in this case may also reflect post-mortem redistribution and not indicate an overdose of Citalopram. The levels of paracetamol and ibuprofen identified are insignificant. In view of the above I have not been able to identify a cause of death which must remain unascertained.
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> "The man had ingested Citalopram, paracetamol and ibuprofen prior to his death. The Citalopram levels, although raised, may not necessarily be indicative of an overdose."

52. The clinical reviewer concludes:

> "Without an established cause of death it is not really possible to identify learning points in the usual way and make recommendations to avoid such an incident occurring again. However, my investigation has highlighted a problem that I have encountered elsewhere in the Prison Service, which relates to the medical records. It was extremely difficult to follow the course of clinical events from inspection of his clinical records. It was particularly difficult to identify the specific chronology relating to the prescribing of anti-depressant drugs. If it was difficult for me then it would probably also have been difficult for clinicians who were trying to provide him with ongoing care. This could be potentially dangerous for the patient as well as being an area of medico-legal risk for the prescriber. The situation may have been compounded by his frequent moves but this should not matter."

53. Concerns over record keeping were raised in two of my previous investigations of deaths from apparent natural causes at Gartree. The final reports following these investigations were issued in October 2006 and July 2007 respectively. In one of those cases I recommended that, "Accurate, informative, contemporaneous and legible records are essential to support communication between staff and improve patient care. Training and regular audits of the standard of record keeping should be implemented … In cases where treatment is more complex, a communication sheet, separate from record or care sheet would be valuable to aid sharing of relevant information quickly." In the other case I recommended that, "the prison should identify

funding for note summarising of all current inmates' medical records. The first phase being for those with chronic diseases." I also said that, "a priority should be to review medical record keeping and put measures in place to ensure records are ordered logically, contain only clinical information and that all entries are signed and names printed alongside. Particular attention being paid to identifying prisoners with chronic medical conditions diagnosed prior to transfer to Gartree."

Recommendation:

The Healthcare Manager should remind staff of the need to complete medical notes appropriately and in accordance with the guidelines of the professional bodies for doctors and nurses with regard for the expected standards of records and record keeping.

54. Although not identified as an issue in the clinical review, the man's medical records show that the GP prescribed a week's supply of Diazepam for him on 10 October. She saw the man again on 12 October when he told her he had taken all his Diazepam and he demanded more. The GP prescribed a further day's supply of Diazepam, despite the man's history of taking all his Diazepam medication at once. Unfortunately, the GP has retired so my investigators were unable to speak to her about her prescribing practices.

55. My investigators spoke to three prisoners. Prisoner A was in Grendon at the same time as the man and was on the same group therapy course. He said that the morning the man went back to Gartree he was angry and chased another prisoner down the corridor. He was clearly struggling with the therapy sessions. He said that the man was given some medication before he left Gartree and he was 'popping the pills.' He said that he told him to slow down and not take any more. His opinion was that the man should have been taken off his medication gradually and that he was literally rattling. He said that the man was always 'hyper' but did not show any sign of physical illness and went to the gym a lot.

56. Prisoner B knew the man when he first arrived at Gartree. He said that the man was struggling to come to terms with his sentence and not being with his children. He said that he was hyperactive and had mood swings. He recalled that the man was involved in a couple of fights at that time. He saw him when he returned to Gartree from Grendon. He said that the man was still the same, still hyperactive and quite paranoid that other prisoners were plotting against him. He said that the man took heroin three or four times a month and drank illegal alcohol (hooch) once a week or so. He said the man never mentioned feeling unwell. He did speak about wanting to kill himself but prisoner B told him to think about the pain it would cause his family.

57. Prisoner C knew the man when he was in Gartree on both occasions. He said that the man was normally jovial, sometimes depressed but appeared to be coping with his sentence. He said the man's behaviour was sometimes erratic and trivial things could upset him. He saw him the day before he died. The man seemed fine and was glad to be back in Gartree from Grendon. He

said the man seemed in good health although another prisoner told him that the man had a heart condition. The man never mentioned that to prisoner B himself.

58. I am concerned that there was no history sheet (F2052A) available to my investigators for the time between 28 September 2006 (when the man arrived back at Gartree) and 21 October 2006 (when he was located in the SAU). I draw this to the Governor's attention.

RECOMMENDATION

> **The Healthcare Manager should remind staff of the need to complete medical notes appropriately and in accordance with the guidelines of the professional bodies for doctors and nurses with regard for the expected standards of records and record keeping.**

Prison Service comments:

The Prison Service has accepted the recommendation. They note that the HMCIP report mentioned is now over two years old and comment that the vast majority of the recommendations made in that report have been addressed.