

**Circumstances surrounding the death of a man at a local
hospital, whilst in the custody of HMP Garth,
in December 2007**

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

October 2008

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.

This is the report of an investigation into the death of a prisoner at HMP Garth who died from natural causes on 2 December 2007. He was 68 years old.

I would like to add my personal condolences to those already expressed to the man's family on behalf of this office by one of the Ombudsman's Family Liaison Officers.

The Ombudsman's investigator and I would like to thank the Governor of HMP Garth and her staff, especially the Residential Manager, for their assistance. A clinical reviewer was asked by Central Lancashire Primary Care Trust to undertake a review of the man's clinical care and I also much appreciate her help.

The man was taken by ambulance to a local hospital on 20 November and it was there that he died during the evening of 2 December. I have noted the issues highlighted by the clinical reviewer and I endorse most of the recommendations made in her clinical review. I also noted that the clinical reviewer considered that the man's care in some instances was not comparable to what he would have received in the wider community. In particular there was an unacceptable delay of 15 months before the referral for specialist treatment received attention. The Primary Care Trust and the prison will develop an action plan to address the matters raised.

Jane Webb
Deputy Prisons and Probation Ombudsman

October 2008

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SUMMARY

The man was 68 years old when he died at a local hospital. The man died from natural causes as a consequence of chronic liver failure.

The man had been received into prison custody as a remand prisoner on 8 October 1969. He was later sentenced to life imprisonment on 30 July 1970. The man arrived at HMP Garth on 16 December 1996 after being held in a number of prisons. During his initial health screen at Garth it was noted that the man had been diagnosed with diabetes and angina.

Ten years later, in May 2006, the man attended a local hospital as he had been diagnosed with possible oesophageal varices (varicose veins in his throat). The consultant who saw him recommended that the man be reviewed by a colleague. A consultant physician and gastroenterologist eventually saw the man on 13 August 2007. He noted that the man's liver and spleen were both enlarged and he had fluid around his liver. Blood tests also showed problems with the man's liver function and a low platelet count which was consistent with liver disease.

The man was admitted to outside hospital from 4 to 18 October 2007. On his return to Garth he was placed in the healthcare centre. The man was again admitted to hospital on 1 November and five days later he had an operation on the varicose veins in his throat. He discharged himself from hospital on 11 November and returned to the healthcare centre at Garth.

The man returned once more to outside hospital on 20 November. He was admitted to the Medical Assessment Unit and was later moved onto a ward. Whilst he was in hospital the man developed MRSA (methicillin resistant staphylococcus aureus). This is an infection which is resistant to commonly used antibiotics. The man's medication was changed to deal with this new infection. During the evening of 2 December 2007, the man's condition started to deteriorate rapidly and he died at 11:32pm.

When the man was first an in-patient in outside hospital, a bedwatch was carried out by two prison officers. The initial security risk assessment, on 4 October 2007, identified that an escort chain was to be used. However, the risk assessment was later revised, on 20 November, after the man was again admitted to hospital. The second risk assessment was that no restraints were to be used. The risk assessment was revised again on 21 November and the bedwatch was reduced to a single officer. The man's family were allowed to visit him whilst he was in hospital.

The clinical review carried out concludes that the man's clinical care was not in some instances comparable to that available in the community. I have endorsed five of the recommendations made in the clinical review. I have written to the Governor about two of the reviewer's other recommendations. I have also made a recommendation that a review takes place of Garth's death in custody and care team policies are reviewed.

THE INVESTIGATION PROCESS

1. One of the Ombudsman's investigators opened this investigation on 3 December 2007. He issued notices announcing the investigation to both staff and prisoners. The notices included an invitation to those who wished to contribute to the investigation to make themselves known. In the event, nobody came forward. The investigator also studied all relevant prison records relating to the man. These included his main prison record, bedwatch logs, medical records and statements made by staff.
2. The investigator visited Garth on 18 December and 26 February 2008. He discussed aspects of the man's treatment with staff at the prison. He met the Governor, the Residential Manager and the man's personal officer. The man's personal officer was able to provide background information about the man and his activities whilst in custody. My investigator also interviewed the Head of Healthcare for Garth, a prison officer and a Principal Officer. The prison officer and the Principal Officer had been allocated bedwatch duties on the day the man died.
3. The Central Lancashire Primary Care Trust commissioned a Consultant Clinical Psychologist/Reviewer to carry out a review of the man's clinical care. I am grateful to the clinical reviewer.
4. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of the 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.
5. One of the Ombudsman's Family Liaison Officers contacted the man's family. This gave them the opportunity to discuss the purpose of the investigation and to raise any concerns or questions they would like explored or addressed. The man's family raised a number of concerns about the treatment he received while in custody:
 - The family felt very strongly that the man would not have died had he received earlier treatment and diagnosis. They felt that he had not received appropriate treatment in light of his condition.
 - The family were also concerned about the difficulties the man encountered when making appointments to see his consultant.

The clinical reviewer and my investigator have explored these points and I hope that my report fully addresses their concerns. The family were very complimentary about the support they received from Garth towards the end of the man's life and after he died. The family also told my family liaison officer that, when they visited the man in the healthcare wing at Garth, he told them that he enjoyed being there.

HMP GARTH

6. HMP Garth, near Preston, is an adult male category B training prison which holds over 800 male adult prisoners. It is a purpose built establishment that sits alongside HMP Wymott on the site of a former Royal Ordnance factory.
7. Accommodation at Garth consists of seven residential units, A to G, most with dual purposes. F wing is used as a first night centre and induction wing. The re-integration unit on D wing is used to house some vulnerable prisoners. The healthcare centre consists of a primary care service and 24 hour in-patient care with eight beds. Nurse led clinics, including a heart disease management clinic, are in operation. Prisoners are called to attend for regular check ups with in-house nursing staff or visiting specialists.
8. The most recent report of a full announced inspection by Her Majesty's Chief Inspector of Prisons (HMCIP) was published in 2004. Inspectors found Garth to be a safe, respectful and improving prison with solid relations between prison staff and prisoners. The report congratulated Garth for securing an environment that placed emphasis on purposeful activity, including work, education and training, for some of the most challenging long term prisoners.
9. HMCIP found that healthcare services had improved since the last inspection in 2001, and that a good working relationship had developed between the local Primary Care Trust and Garth's healthcare centre. Healthcare staff were found to be highly qualified and annually trained in resuscitation. HMCIP reported that training was carried out in-house by two members of staff who were Resuscitation Council (UK) trained advanced life support officers. The pre-inspection prisoner survey results indicated that prisoners felt healthcare provision was good or very good, especially nurse-led healthcare. This placed Garth above the average when compared to similar establishments.
10. An unannounced short follow-up inspection was carried out between 5 and 7 July 2007. The inspection found that Garth remained an essentially safe, respectful and active prison, which had improved its resettlement function. Relationships between staff and prisoners were generally positive and supported by a functioning personal officer scheme. The inspection also found that health services had continued to improve and commended managers and staff on the continued progress at Garth.
11. The Independent Monitoring Board (IMB) in its latest report for Garth (2004 – 2005) says that overall the prison continues to be well managed. It highlighted the absence of property storage facilities for prisoners and the additional work this created for staff.
12. Since 2004, when I became responsible for investigating all deaths in custody, I have investigated four deaths as a result of natural causes at Garth. There was no link between the circumstances surrounding this investigation and the previous deaths at Garth.

KEY EVENTS

13. The man arrived at Garth on 16 December 1996 after being previously held in a number of other prisons in England. On first reception in Garth the man had two established medical conditions. He had experienced angina attacks since 1994 and he also had diabetes. A range of medication was prescribed for the man and he was allowed to keep these in his possession for self administration.
14. On 30 June 2005, the man was taken to a local hospital as he appeared to be confused and suffering from a weakness on the left side of his face. He was admitted to the Medical Assessment Unit where he was diagnosed with a listeria infection. The man was discharged from hospital on 18 July.
15. The man attended an appointment, on 27 October, with a Consultant in Diabetes and Endocrinology. The consultant noted that the man's diabetes was poorly controlled. He recommended the commencement of insulin treatment and made a referral to a haematologist.
16. In a report dated 1 December, a Consultant Physician in General and Geriatric Medicine noted the man had the following pre-existing conditions:
 - diabetes
 - portal hypertension
 - hyperthyroidism
 - ischaemic heart disease
 - angina
 - arthritis of shoulders and elbows
 - symptoms of Parkinson's Disease
 - iron deficiency anaemia
 - raised cholesterol level
 - listeria septicaemia.
17. On 10 February 2006, the man attended an out-patients appointment at the local hospital as he had been suffering from abdominal pain. The cause of the pain was diagnosed as a possible umbilical hernia and right inguinal hernia (a hernia is protrusion of an organ through the wall of the area which normally contains it). A Consultant Surgeon Day who saw the man recommended that upper and lower gastro-intestinal endoscopies were carried out. (An endoscopy is a test that looks inside the body. The endoscope is a long flexible tube that can be swallowed. It has a camera and light inside it.) The consultant surgeon said that if the result of the endoscopies was normal then the man's hernias could be repaired.
18. The man attended a local hospital, on 11 May, for an endoscopy investigation for possible oesophageal varices (varicose veins in his throat). The result of the endoscopy was a diagnosis of portal hypertension (raised blood pressure in the vein which links the stomach and intestines to the liver) and the consultant who saw the man recommended that he was reviewed by a medical colleague

with regard to an apparent 'hepatic problem' (a problem relating to the man's liver). It was also noted that an ultrasound had shown a small amount of ascites (an accumulation of fluid) around the man's liver.

19. In a letter dated 19 December, the consultant surgeon again recommended that the man's apparent liver problem be reviewed. The consultant surgeon commented on the delay in referring the man to the appropriate specialist.
20. On 7 March 2007, the man attended an appointment with a Consultant in Diabetes and Endocrinology. The Consultant in Diabetes and Endocrinology made a referral to an optometrist and changed the man's insulin regime.
21. Two days later, the man attended a local hospital for a hernia operation. Staff at the hospital informed the prison officers escorting the man that the surgeon who was due to conduct the operation was unwell. The officers were told that another surgeon would conduct the operation but he would not arrive until later in the day. The officers contacted the security department at Garth and were advised to return to the prison and not wait for the surgeon. The healthcare department at Garth were unfortunately not involved in this decision. An appointment was later made for the man to see the consultant surgeon again.
22. In a letter dated 20 June, the consultant surgeon summarised his consultation with the man on 15 June. The consultant surgeon noted that, although the man's hernia was quite large, the concerns about his liver were more significant. The consultant surgeon arranged for blood and liver tests. He also made an appointment for the man to see the consultant in physician and gastroenterologist.
23. In a letter dated 15 August, the Consultant Physician and Gastroenterologist summarised his consultation with the man which had taken place two days earlier. The Consultant Physician and Gastroenterologist wrote that the ultrasound scan had shown evidence of hepatosplenomegaly (enlargement of the liver and spleen) and ascities. Blood tests had also shown problems with the man's liver function and a low platelet count which was consistent with cirrhosis (liver disease). This consultation took place 15 months after the initial concern about the man's liver problems was raised.
24. On 4 October, the man was suffering from abdominal pain and was taken to a local hospital. Fluid was removed from around his liver and he was discharged from hospital around noon on 18 October. On his return to Garth the man was located in the healthcare centre.
25. In his signed statement to an independent researcher, dated 23 October, the man said:

"I am happy with the treatment I have received for my various illnesses and have nothing but praise for the way I have been treated here at Garth hospital."

26. On 1 November, as the man had increased abdominal swelling, he was admitted to hospital. Five days later, on 6 November, the man had an operation on the varicose veins in his throat to stem the bleeding. The man discharged himself from hospital on 11 November and returned to the healthcare centre at Garth. The self-discharge form identified the following risks if he did not receive treatment:
- vomiting blood
 - encephalopathy (a degenerative disease of the brain)
 - further abdominal swelling
 - renal failure
 - death.
27. During the evening on 19 November, the man was found by staff on the floor of his cell. He told staff that he might have fainted. Two nurses helped the man to sit up and measurements of his vital signs were taken. The man was observed by nursing staff throughout the night and he was taken to hospital the following morning. Two officers accompanied him in the ambulance. When the man arrived at the hospital he was taken to the Medical Assessment Unit. After an x-ray and an electrocardiogram (ECG), the man was moved to a side room. The man had a Computer Topography (CT) scan the following day. He was moved to a general ward 26 November.
28. Blood was taken from the man for tests and another x-ray took place on 29 November. The blood tests showed that he had MRSA (methicillin resistant staphylococcus aureus). This is an infection which is resistant to commonly used antibiotics. The man's medication was changed to deal with the new infection.
29. Whenever the man was an in-patient at the hospital, a bedwatch was carried out by prison officers. The initial security risk assessment on 4 October identified that an escort chain was to be used and the man should be accompanied by two officers. However, when the man returned to hospital on 20 November, the risk assessment was revised. The Head of Security at Garth, recorded that no restraints were to be used. The following day, the deputy governor gave permission for a single officer to remain on bedwatch duty.
30. The Principal Officer recorded in the bedwatch log that, around 7:00pm on 2 December, the man's condition started to deteriorate. He noted in the log at 7:40pm that nursing staff had to change the man's bed linen due to the amount of bleeding. A prison officer came on duty at 9:00pm. The Principal Officer conducted a handover with the prison officer and waited until he was certain that the prison officer was settled before leaving the hospital.
31. At around 9:45pm, the man's condition worsened and he started to vomit blood. Nurses were in constant attention during this period. This situation was very distressing for both the man's sister and the prison officer. When interviewed as part of this investigation, the prison officer said that they supported each other during this difficult period and vacated the room after each episode of

vomiting to enable the nursing staff to attend to the man. The man's sister and the prison officer were both in attendance when the man passed away at 11:32pm. The prison officer immediately informed the prison that the man had died. The prison later made arrangements for a taxi to take the man's sister home.

32. The Residential Manager was appointed as Garth's family liaison officer. He contacted the family on the day after the man's death to offer condolences and support. The residential manager maintained contact with the family and assisted with the arrangements for the funeral. The prison offered financial assistance with the cost of the funeral. The man's sister was very complimentary about the support she received from Garth before and after her brother's death.
33. The post mortem report records the man's death as being due to natural causes as a consequence of chronic liver failure.

ISSUES CONSIDERED

Clinical care

34. A review of the man's medical care was undertaken by a clinical reviewer on behalf of Central Lancashire Primary Care Trust. The review found that the man suffered from significant long-term chronic diseases. From the medical records, it was clear that the man was seen regularly by healthcare staff and, when necessary, referred to secondary care services.
35. The man's family had a number of concerns relating to his treatment while in custody. The family felt very strongly that the man would not have died had he received earlier treatment and diagnosis. They felt that he had not received appropriate treatment in the light of his condition. The family described the man as having suffered an excruciating death.
36. The family drew attention to the fact that the man had been complaining of a lump in his groin for 18 months prior to his death. They described how the man's stomach kept getting bigger and bigger until he had difficulty standing, and eventually collapsed. The man then had to have a large amount of fluid drained from his stomach.
37. In a statement to the Governor in response to the concerns raised by the family, The Head of Healthcare at Garth said that the lump in the man's groin was a hernia. It had been assessed by a surgeon but no surgery took place due to the development of problems with the man's liver. The Head of Healthcare explained that it was apparent from the man's medical records that his liver problem was a result of his diabetes and that this was a common associated condition. The Head of Healthcare said that the man also had oesophageal varices (varicose veins in his throat) which were caused by his liver problems. The Head of Healthcare confirmed that the varices would have caused the man to bleed from his mouth. She appreciated that this would have been distressing for those who were present when it happened.
38. The Head of Healthcare said that the man had a large amount of fluid (ascities) drained from his stomach and this again was a side effect of his liver problems. His stomach was drained on a number of occasions but she considered that it could not be treated in any other way. There was no permanent cure because the man's liver condition was terminal. The Head of Healthcare confirmed that the man's stomach had been large for a number of years but he had been overweight. She could not establish when the ascities started but explained that it usually occurs when problems with the liver become pronounced.
39. The clinical reviewer draws attention to the fact that a prisoner's individual care is co-ordinated by the General Practitioner (GP) and Medical Officer. They make the initial referrals for medical investigations to external specialists. The clinical reviewer notes that a number of nurse led clinics also operate in Garth, including coronary heart disease, diabetes and mental health. The man attended the relevant clinics at Garth and his condition was regularly reviewed by staff. The clinical reviewer says that the Head of Healthcare acknowledged

that whilst the prison healthcare service had ensured access to specific health conditions, less attention had been paid to co-ordinating healthcare across these specialities. The clinical reviewer recommends that there should be consideration of a system to co-ordinate methods of monitoring and investigations across different health specialties. Co-ordination is especially important when a prisoner has a number of different long term medical conditions which require different treatments.

HMP Garth should clarify the role of the medical officer within prison health care.

40. Regarding the man's diabetes, the clinical reviewer says that the Head of Healthcare advised her that different prisons have different arrangements for the management of the condition. Garth had received advice from a dietician specialising in diabetes which had led to the availability of particular foods. The Head of Healthcare confirmed that prisoners received three meals a day and additional food can be bought from the prison shop. The Head of Healthcare said that the man received specific advice from a diabetic nurse specialist. She explained that prisoners have hand held kits for testing their blood glucose levels. Insulin pens are also held in possession and prisoners maintain their own records which they can discuss with health specialists. The clinical reviewer recommends that Garth has a clear description of the procedure for the management of diabetes at Garth and that this is kept in the prisoner's health record. The clinical reviewer recommends that there is also a clear indication in the prisoner's health record when advice has been obtained from a nurse specialist.

HMP Garth should develop a clear description for procedures for management of diabetes which should be kept in the prisoner's medical record.

In response to this recommendation Garth said they had, for some time, held a clear policy for diabetes management. Diabetic records are maintained within the clinical record and were in the man's case. However, each prisoner also has a patient held record as this reflects best practice within the wider community.

When advice is obtained from a nurse specialist, the action should be recorded in the prisoner's medical record.

In response to this recommendation Garth said that when advice is obtained from a nurse specialist the action should be recorded in the prisoner's medical record. Garth considers that this is currently practised as that advice is always documented within the clinical records and was in the man's case. The notes were also clearly signed by the nurse specialist.

Appointments with the consultant

41. The family were also concerned about the difficulties the man encountered when making appointments to see the Consultant in Diabetes and

Endocrinology, as there were no staff available to escort him. In response the prison said that this paragraph could give the impression that the man had responsibility for arranging his own hospital appointments. This was not the case, although the man did write to the Consultant in Diabetes and Endocrinology on a regular basis.

42. The Head of Healthcare said that there had been an occasional problem with escorts for the man. On a couple of occasions, emergencies took precedence and the man had also refused on more than one occasion to travel to hospital. The Head of Healthcare drew attention to the fact that the man had signed his own discharge on one of his hospital stays prior to his death.
43. When interviewed by the Ombudsman's investigator, the Head of Healthcare said that when the man was referred to a liver specialist part of his preparatory treatment involved bowel preparation. There were delays caused to the man's treatment because he was concerned about being transported in a taxi as his bowels could open quite easily. The man requested an ambulance, but after the Ambulance Service refused to provide transport for a non-emergency case, he relented and travelled by taxi. The Head of Healthcare was aware that a couple of appointments were cancelled as the man was in hospital at that time.
44. The clinical reviewer recommends that Garth should have a clear policy and procedures concerning appointments with hospital specialists. There needs to be clarity about the role of prison staff at hospital appointments and an indication of what conditions or circumstances constitute a priority for attendance at a hospital appointment. She also seeks clarity about whether prison transport, taxi, hospital transport or ambulance should have been arranged. The clinical reviewer judges that a copy of the policy and procedures should be placed in the prisoner's record. There should also be confirmation of the prisoner's understanding of these arrangements.

HMP Garth should develop clear policy and procedures concerning appointments with hospital specialists.

45. In relation to the delays in referring the man to a Consultant Physician and Gastroenterologist, the clinical reviewer says that it was unclear who should have initiated a referral. The clinical reviewer notes that the Consultant in Diabetes and Endocrinology had identified that a 'haematological' (relating to haematology, the branch of medical science which studies the morphology of the blood and blood forming tissues) opinion was required and reported this to the Medical Officer at Garth. The clinical reviewer recommends that Garth consider a system for co-ordinating health care across different specialities, hospitals and health organisations. The clinical reviewer believes this might be assisted by a nurse within the prison healthcare service adopting a role, similar to that of the mental health 'care co-ordinator', for prisoners with mental health problems.

HMP Garth should consider a system for co-ordinating health care across different health specialities and agencies.

46. The clinical reviewer recommends a review of how hospital specialists communicate with prisoners and vice versa. This should include a review of the role of the medical officer in initiating and following up referrals to hospital specialists. The clinical reviewer says that consideration should be given to whether correspondence is also copied to family members or the prisoner's legal representative. She also comments on the value of using 'ordinary language' in correspondence from hospital specialists.
47. The clinical reviewer spoke to the Head of Healthcare about terminal care for prisoners at Garth. The Head of Healthcare advised the clinical reviewer that few deaths had occurred at the prison but as the average age of prisoners was rising, this issue would be an increasing concern. The clinical reviewer recommends that procedures for providing terminal care for prisoners are identified where this is feasible and within the capabilities of healthcare staff.

HMP Garth should develop arrangement for providing terminal care at the prison.

48. The family said that they wrote to the prison to ask if they could do more to help and were told that Garth was doing everything possible for the man. However, the family felt that initially Garth did not take the man's condition seriously enough.
49. The Head of Healthcare replied that she could not find any evidence that Garth had failed the man. The man's condition had been managed externally for a long time and he had been referred for an operation but this had been delayed by issues relating to the management of his diabetes. The Head of Healthcare said that the man had been under the care of three consultants at the local hospital, a diabetologist, a surgeon and a liver specialist. She said that Garth did make enquiries about the progress of the man's medical care. The Head of Healthcare added that she spoke to the man's sister on a couple of occasions as well as writing to her about the care being provided to her brother. The Head of Healthcare noted that, although the man had chronic health problems, he wanted to continue working beyond retirement age. He stopped working only a couple of months before he died.
50. I believe that Garth attempted to deal with issues relating to the man's medical care but this endeavour was hindered by poor communication between the prison and external agencies. In her review, the clinical reviewer recommends a system for co-ordinating healthcare across different health specialities. I consider that a delay of over 15 months before the man's liver problems were reviewed was not acceptable. In response to the draft report, Garth reviewed the medical records again and considers that the delays in the referral were due to the consultant at the hospital. Garth said that whilst the letters received from the consultant are seen by the doctors at the prison, the follow up action is assumed to be coordinated at the hospital. On one occasion in May 2007, when the man complained about the delay in referral this was followed up by Garth. Therefore Garth considers that whilst there were delays in the man receiving his treatment for his liver problems those were not solely due to local systems.

51. The family are very complimentary about the support they received from Garth towards the end of the man's life and after he died. They visited the man when he was in the healthcare wing and saw that he enjoyed being there. The family made it clear that they did not hold the prison responsible for what happened to the man and understood that there may have been factors outside Garth's control which affected his treatment and diagnosis. The family also said that Garth was one of the best prisons they had encountered.

Role of the bedwatch officer

52. When interviewed by my investigator, the prison officer said that when he arrived for duty on 2 December the man was still being attended to after vomiting blood. The prison officer said that the Principal Officer stayed with him for a while after his shift ended and then left. The prison officer recalled that when he first saw the man, he appeared not to be aware of the situation or his surroundings. At one stage, when the man's sister left the room for a moment, the man stretched out his arm, called the prison officer's name and asked for pain killers. The prison officer said that he found this very disturbing as he then realised that the man was aware of his surroundings and what was happening to him. This made the situation very personal for the prison officer and made him feel hopeless about the assistance he could offer the man.
53. The prison officer said that he was upset at what he witnessed and about what he was expected to do after the man passed away (still completing the bedwatch logs, telephoning the prison and remaining with the body). He felt that there should have been a second officer to share these tasks. The prison officer said that he had two roles whilst in the hospital, he was there as a prison officer and he was also there to support the man's sister. The prison officer also thought that he should have attended the hospital in plain clothes, especially as the man's condition was terminal. I draw this matter to the Governor's attention.
54. The prison officer said that he had not received an immediate offer of support from the prison although he was permitted to finish his shift early on the day after the man's death. The prison officer confirmed that support was offered by the prison within 48 hours of the man's death and that he had taken up the offer.
55. My investigator raised the issue of support for the prison officer with the prison. Garth replied that a Residential Governor came to the hospital after the man passed away, to offer support to the prison officer. He stayed with the prison officer until the man's body was moved to the mortuary. The prison officer was then allowed to leave the hospital.
56. I understand the decision making process behind the revision of the risk assessment which reduced the escort to one officer. I can also understand the reason why the Principal Officer felt it appropriate to leave the prison officer alone when he (the Principal Officer) finished his shift. The Principal Officer had witnessed a single episode where the man had vomited blood and

he stayed on to ensure that the prison officer was content with the situation. The nature of the man's death was very difficult for both the prison officer and the man's sister to deal with.

57. I acknowledge that, although it was delayed, support was offered to the prison officer and that he took up the offer and benefited from it. I was surprised that the prison officer was scheduled to report for duty on the day following the man's death. I acknowledge that the prison officer reported for duty earlier than scheduled that day and that he was relieved from duty early once the impact of the man's death was appreciated. I recommend that HMP Garth reviews its death in custody/care team policy, in case this situation arises in the future, so that whenever a death (natural or self-inflicted) occurs staff are offered support at the earliest juncture.

I recommend that a review takes place of HMP Garth's death in custody and care team policies.

CONCLUSION

58. The man moved to Garth in 1996 and, after being transferred to a local hospital, he died of natural causes in December 2007.
59. In reviewing the bed watch log, it is clear that the staff involved with the man's care behaved with sensitivity. The decision to remove mechanical restraints, following a risk assessment, was right and proper given the circumstances. The security arrangements at the hospital seem to have been suitable, and struck a good balance between public protection and sensitivity to the situation.
60. I would like to commend both the Principal Officer and the prison officer for the support they gave to the man's sister during her brother's difficult last hours. The man's death was traumatic for all who witnessed it and I am sure that the man's sister appreciated the support she received from the officers during that difficult time.
61. I recommend that Garth reviews its death in custody/care team policy, in case this situation arises in the future, so that whenever a death (natural or self-inflicted) occurs staff are offered support at the earliest juncture.
62. Whilst he was in custody the man developed serious medical needs which required support to be provided by Garth. I consider that his medical care was not entirely satisfactory and in some instances was not equivalent to the care he would have received in the wider community. It is not possible to confirm whether earlier treatment of the man's liver problems could have led to a different outcome. The delay in treating the man's liver problems was nevertheless not acceptable and action should have been promptly taken to move this issue forward.
63. The findings of the clinical review and my own investigation highlight that improvements to medical practices at Garth could be made. I have endorsed the recommendations from the clinical review. These will need to be addressed by the Central Lancashire Primary Care Trust in partnership with the Governor of Garth.

RECOMMENDATIONS

1. I recommend that a review takes place of HMP Garth's death in custody and care team policies.

Accepted - Garth's death in custody and care team policies were reviewed in April 2008. Care Team policies are now reviewed at quarterly meetings.

2. HMP Garth should develop clear policy and procedures concerning appointments with hospital specialists.

Accepted - There is a process in place but this needs to be more clearly developed and approved via the partnership board.

3. HMP Garth should consider a system for co-ordinating health care across different health specialities.

Partially accepted - Improvements could be made locally to better co-ordinate the primary care services at Garth. This will be made easier through the use of System One; however there is no capacity to co-ordinate this within the hospital trusts.

4. HMP Garth should develop a clear description for procedures for management of diabetes which should be kept in the prisoner's medical record.

Already in place - Garth has for at least six years, had a clear policy for diabetes management which the clinical reviewer did not request. Diabetic records are maintained within the clinical records and were in the man's case, however each prisoner also has a patient held diabetic record as this reflects best practice within the wider community.

5. When advice is obtained from a nurse specialist, the action should be recorded in the prisoner's medical record.

Partially accepted - This is current practice at Garth. This is always documented within the clinical records and was in the man's case. The notes are clearly signed by the nurse specialist.

6. HMP Garth should develop arrangement for providing terminal care at the prison.

Accepted - Garth does have a palliative care policy but this needs to be further developed. Difficulties arise when attempting to provide comparative care for prisoners with child/sexual offences as community services are often unwilling or unable to offer residential care.