

Investigation into the circumstances surrounding the death of a prisoner at City Hospital, Nottingham while in the custody of HMP Lowdham Grange in January 2008

Report by the Prisons and Probation Ombudsman
for England and Wales

July 2008

This is the report of an investigation into the death of a man at the City Hospital, Nottingham on 26 January 2008. He died of natural causes. At the time of his death, he was in the custody of HMP Lowdham Grange.

The man had been ill for some time and was referred to City Hospital in late January 2008 after his condition at the prison had deteriorated. Once admitted to hospital, he continued to worsen despite the best efforts of the medical team. A nurse conducting routine checks discovered that the man had died at 6.50pm and a doctor confirmed his death at 8.00pm. The man was a Dutch citizen and 60 years old.

I would like to offer my sincere condolences to his family and friends for their loss.

One of my investigators conducted the investigation on my behalf. In addition, Nottinghamshire Primary Care Trust appointed a doctor to conduct a clinical review into the man's healthcare whilst in custody.

I would like to thank the Director of Lowdham Grange, and his staff for their co-operation and assistance with the investigation. I would particularly like to thank the appointed liaison officer, who has been immensely helpful in providing all the necessary documents to my investigator.

The man had been in reasonably good health before his arrival at Lowdham Grange just after Christmas 2007. The deterioration in his health was sudden and clearly distressing. It progressed fairly quickly and the reasons for his condition were being investigated at the time of his death. The initial post mortem indicates that his death was caused by a series of tumours on the brain resulting in severe swelling.

I make no recommendations as I am satisfied that the man's health needs were appropriately addressed. Indeed, I commend staff on their prompt attention and rigorous adherence to procedures in the management of his illness.

He had been subject to ACCT monitoring and support and I judge that this was appropriate. However, it seems most likely that his mood and behaviour were symptoms not of a depressive illness but had an organic cause. My report also raises questions about the use of restraints on seriously ill prisoners.

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Prisons and Probation Ombudsman

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SUMMARY

The man was remanded into custody in July 2006. Following a lengthy trial, he was sentenced to 15 years imprisonment in December 2007. Although initially held at HMP Hull, he transferred to HMP Leeds at the start of his trial. At both prisons, his only medical complaint was in relation to his diet. He had undergone an operation in 2001 during which he had had a 'gastric band' fitted. One of the after-effects of the operation was that he needed to eat regular small meals. At both Hull and Leeds, he was given a job in the kitchens, which meant that he was able to take his meals as required.

Given his vulnerability because of the lengthy sentence he had received, the man was placed on Assessment, Custody, Care and Teamwork (ACCT) monitoring by HMP Leeds. (The ACCT process provides individual prisoners with greater levels of observations and interactions if staff consider them to be at risk of either self-harm or suicide.) However, the ACCT document was closed at the first review. The ACCT was re-opened on 24 December 2007 by a member of the kitchen staff who felt that he was not his usual self. The assessment highlighted that the man was not sleeping and had concerns about his impending transfer to HMP Lowdham Grange.

On his arrival at Lowdham Grange in December 2007, he explained about his gastric band and arrangements were made for his diet and weekly weight checks. The ACCT monitoring was also reviewed during which he said that, although initially apprehensive about going to Lowdham Grange, he felt fine now that he was there and sharing a cell with his co-defendant. The man also said that he had never self-harmed or tried to take his life and would not do so. The officer conducting the review recorded that at times the man appeared confused. The document was closed.

In January 2008, the man's cell mate, told staff that he had concerns about his wellbeing. A further ACCT document was opened and an assessment carried out. During the assessment, the man gave few responses, but when asked whether he felt depressed he said yes. An appointment was made for him to be seen by the doctor. The following day, he was seen by the doctor who prescribed a course of anti-depressant medication and referred him to the Mental Health Inreach Team (MHIRT).

He continued to deteriorate and a week later, he was sent to the Queen's Medical Centre in Nottingham. He saw a doctor and blood samples were taken but he returned to prison within two hours. He had also become incontinent, and this was causing staff concern as they had difficulty encouraging him to change out of his soiled clothing.

The healthcare centre and MHIRT continued to monitor the man, and wing staff gave daily support, but his condition rapidly deteriorated. As a result and following a period of particularly bizarre behaviour, he was again admitted to City Hospital, Nottingham in late January. Once admitted, the man was handcuffed despite his deteriorating condition. Nursing staff monitored him closely and initially he had long periods of consciousness, although his behaviour remained unusual.

The day after being admitted, doctors informed prison managers that the man was likely to be 'brain dead' and unlikely to last the next 24 hours. At this point, the restraints were removed and two staff remained at his bedside. At 6.52pm, a nurse carried out a routine check on him and discovered that he had died. The doctor confirmed the man's death at 8.00pm on 26 January.

I make no recommendations, but my report explores the use of restraints, in relation to gravely ill or dying prisoners. I also draw the Director of Lowdham Grange's attention to the recently revised National Security Framework (NSF) relating to such matters.

THE INVESTIGATION PROCESS

1. My investigator opened the investigation on 31 January 2008. Lowdham Grange issued notices to staff and prisoners informing them of the investigation process and inviting anyone who had relevant information to come forward. No responses were received.
2. The investigator visited the prison on 26 February. He met the appointed liaison, and was shown around the prison, including the residential area where the man had been located. The investigator also visited the healthcare centre where he spoke with the Clinical Manager, who had dealt with the man during his time at the prison.
3. One of my Family Liaison Officers (FLOs) contacted the Dutch Embassy on 11 February to try to obtain details of the next of kin in Holland. During his visit, the prison passed to the investigator contact details for the man's ex-wife. The FLO sent a translated letter to her, together with both English and Dutch versions of the PPO leaflet. The FLO also supplied her e-mail address so the family could make contact with my office. At the time of writing this report, the family has not been in contact. They will be informed of the draft report and sent copies if they wish to receive them.
4. HM Coroner was informed of the investigation. A copy of this report will be sent to the Coroner to assist with his enquiries. The investigator also requested a copy of the post mortem report.

HMP LOWDHAM GRANGE

5. HMP Lowdham Grange opened in 1998. It is one of four private prisons run by Serco Ltd. When it originally opened it had the capacity to hold 500 prisoners, but has recently been extended. Located near Nottingham, it is a long-term category B prison. Its role is to hold medium to long-term serious offenders with sentences of over four years with at least 12 months left to serve.
6. Healthcare services in Lowdham Grange are provided in-house with good links to the local Primary Care Trust (PCT). Many staff work 12-hour shifts. There are no in-patient facilities, but there is 24-hour cover with one nurse on duty overnight (7.00pm – 7.00am). A local doctor is contracted to provide three clinics a week, and provides all the out-of-hours medical cover.
7. HM Chief Inspector of Prisons, Ms Anne Owers, last inspected the prison in March 2006. Ms Owers found Lowdham Grange to be a largely safe establishment, with mutually respectful staff-prisoner relationships. Of healthcare, Ms Owers commented that the accommodation was inadequate and there were concerns regarding the forthcoming increase in the prison population and the department's ability to cope with the extra numbers. Staffing levels were struggling to meet the clinical demands of the patients and mental health services were stretched. However, links with the Newark and Sherwood Primary Care Trust were very good and the PCT provided excellent clinical and managerial support to the prison.
8. The local Independent Monitoring Board (IMB) commented in their 2006 annual report that Lowdham Grange had responded well to challenges presented to it.
9. Since 2004, my office has investigated four deaths from natural causes at Lowdham Grange. The recommendations made following these investigations bear no relevance to the death of this man.

KEY FINDINGS

The man's initial custody and time at HMP Leeds

10. In July 2006, the man was remanded into custody at Harrogate Magistrates' Court, having been charged with importation of drugs. Following his remand, he went to HMP Hull. He settled in quickly (this was probably helped by having his co-defendant with him who also spoke Dutch).
11. He had concerns about his diet as he had undergone a gastric bypass operation in 2001. This meant that he was only able to eat soft food and needed a small meal every two hours. When he spoke to staff about this in August 2006, he told them that he had not eaten properly for about 50 days. Healthcare staff arranged with the kitchen for him to be provided with the appropriate diet. It was also recorded that he was 50 per cent deaf. This, along with his limited spoken English, made it difficult for him to understand and converse with other prisoners and staff.
12. Apart from the issues with his gastric banding, the man reported very few other medical problems. However, he said that he had suffered from backache, headaches and neck pain for over 20 years. He was prescribed medication to treat these but had little other contact with healthcare.
13. While at Hull, he was employed in the kitchens. This enabled him to meet his dietary needs, as he was able to have his meals as he required them. He settled into his job well and was considered a good worker.
14. The man was transferred to HMP Leeds via Leeds Crown Court in October 2006, to remain there during his trial. On his arrival, he said that he had no immediate concerns but again mentioned his stomach problems. Over the next week, he moved back and forth to court but finally managed to submit an application to work in the kitchens about a week after arriving.
15. In November, he was introduced to his personal officer. The man explained that he had found it necessary to contact his solicitor regarding his dietary needs. He said that he had seen the doctor three weeks earlier but nothing had been done. He told his personal officer that he was very concerned as he was losing weight and feeling unwell.
16. In December 2006, he began work in the kitchens. He was very pleased about this but was still waiting to see the doctor regarding his diet. (The wing history document (P16) suggests that he was still waiting to see the doctor in January 2007.) However, he continued to work well in the kitchens and this enabled him to eat at the necessary times.
17. He was convicted in February 2007, but sentencing was postponed while the trials for other defendants took place. On his return from court, he appeared well and gave no cause for concern. He continued his work in the kitchen and made good progress. This resulted in him being recommended for enhanced

18. In December 2007, he attended Leeds Crown Court for sentencing and received a 15 year sentence. Due to the length of sentence, an Officer opened an Assessment, Custody, Care and Teamwork (ACCT) document. The Officer's reasons for opening the ACCT were that the man was very tearful in the treatment room when he attended to collect medication.
19. To find out how the man was feeling, another Officer carried out an assessment. The man said that he had no thoughts of self-harm, despite feeling low. He said that he was able to cope by talking with his cellmate, who was also Dutch, and by working in the kitchen seven days a week. He said that regular contact with his solicitor would help, as he wanted to contact his family. He spoke about gaining category D status and eventually moving to an open prison. The Senior Officer (SO) saw the man following the ACCT assessment and discussed with him the issues that had been raised. The decision was taken to close the document with a follow up in seven days.
20. He continued to work in the kitchen and appeared to be coming to terms with his sentence. However, in late December a member of staff in the kitchen re-opened an ACCT document. The reasons were that the man was normally upbeat but had become very apathetic at work. The member of staff was concerned and felt that the length of his sentence might have only just registered with him. During the assessment, he confirmed that he was finding it difficult to come to terms with his sentence. He also said that he was not sleeping.
21. The assessor felt that the man did not understand some of his questions despite having his cellmate with him to interpret. The assessor recorded that he thought the man was having trouble concentrating and looked very distant and vague. The man said that he had never attempted suicide or self-harmed and had no thoughts or intentions of doing so. The assessor felt that his mental state might have been affected by lack of sleep which was making him feel spaced out. Following the assessment, the assessor concluded that the man would benefit from medication to help him sleep and referred him to Mental Health In-Reach Team (MHIRT).
22. Following the assessment, an SO carried out a case review. During the review, the SO recorded that the man appeared withdrawn and his demeanour was vacant. The man said that he realised that he might spend the rest of his life in prison. His impending transfer to Lowdham Grange was discussed and he said that he was concerned about relocating without his co-defendant. The SO made a routine referral to the MHIRT who saw the man later that day and arranged for him to be prescribed sleeping tablets. The next case review was scheduled for the end of December.

23. Over the next few days, staff observed the man and recorded that he seemed very quiet. On Christmas Day, an Officer recorded in the ACCT that he had spoken to the man and felt that he was a long way from being his normal self. The ACCT document remained open when he transferred to Lowdham Grange in December 2007.

The man's time at HMP Lowdham Grange leading up to his death

24. When the man arrived at Lowdham Grange in December, a member of the healthcare team saw him. His previous medical records were checked and his current medication recorded. He explained about his gastric band and how this affected his diet. Arrangements were made for him to receive the correct diet and to have weekly weight checks.
25. The open ACCT document that accompanied him was reviewed. A Safer Custody Officer (SCO) carried out a further assessment the day after he arrived during which the man said that he had been a little apprehensive about coming to Lowdham Grange, but now that he was there he liked it. Again, he said that he had never self-harmed and did not intend to do so. The SCO recorded that the man appeared confused at times, but was unsure whether this was down to the language barrier or poor hearing. The man talked about his family and said that he was having a few problems in contacting his girlfriend. The SCO explained that a case review would be held but the man said he did not want to attend.
26. However, in fact he did attend the review despite his earlier statement that he did not wish to. Also present were members of the healthcare team. The man explained that he was happy to be at Lowdham Grange and was in a cell with his co-defendant. In view of this and because there had been no previous self-harm, the ACCT document was closed with a follow-up scheduled for early January 2008.
27. The doctor also saw him in December. As well as discussing his gastric band, the doctor made a referral for him to attend the diabetic clinic. The next contact the man had with healthcare was in January 2008 when he was given his first Hepatitis B vaccination.
28. In January, the SCO went to see the man in order to carry out the post closure interview of the ACCT. During the interview, he said that he had no thoughts of self-harm or suicide and was due to start work in a couple of weeks. He also said that his cellmate and co-defendant, had been a great help and support to him.
29. However, the following week, his cellmate told the Operational Manager, that he was concerned about the man's wellbeing. He said that the man was in a low mood, acting strangely and out of character. He also said that he was hardly speaking. In view of this, another ACCT document was opened.
30. The SCO again carried out the ACCT assessment. When the man was asked what he considered his problems to be, he hardly responded. The SCO

31. Again, he changed his mind and actually attended the review, along with his cellmate who translated for him. The man hardly responded to anyone during the review and his cellmate said that this was unusual behaviour for him. The decision was taken for him to be observed every 30 minutes until the doctor could see him.
32. The man was seen the next day by the prison doctor. She recorded that he was depressed but not suicidal, with psychomotor retardation (slowed psychic or motor activity). She started him on a course of anti-depressant medication. It was also recorded that the man should have regular contact with the Registered Mental Health Nurse (RMN).
33. Later that morning, a PCO went to check on the man and found him in his cell. He had soiled himself and was just sitting playing with the taps on his sink. The PCO told my investigator that it took the man several seconds to acknowledge his presence. The PCO informed the nurse of this. The man's lunch meal was collected for him, but he just stood outside his cell holding the railings and not acknowledging anything.
34. After lunch, staff took him across to the healthcare centre where he was seen by a nurse. The nurse asked him what he felt his problems were. He complained of having had a headache for around three weeks but felt this was down to anxiety over his long sentence. The nurse also recorded that the man indicated during the interview that he might have been having problems on the wing. In view of his seemingly bizarre behaviour and the nurse's concerns, she increased his ACCT observations to every ten minutes. She also said that if he deteriorated further it should be increased to constant observations over the weekend. The meeting lasted for about 20 minutes, then he returned to the waiting room. While he was waiting, he vomited and nursing staff attended to him.
35. After returning to the wing, staff continued to be concerned about his distracted behaviour. They asked for someone to see him, so a Senior Psychologist went to conduct an assessment. During the assessment, the man chose not to answer questions relating to his mood. It was recorded that he had good eye contact and was happy to discuss his children. When asked directly about self-harm, he was emphatic that he would not self-harm or take his own life as he had five children.
36. During the evening and throughout the night, the man was observed at regular intervals as part of the ACCT procedures. At 10.00pm, while checking on him, a PCO was informed by the man's cellmate that he had lifted him off the floor and back into bed. The PCO informed the duty nurse, but no entry or information on any follow up action is recorded in the medical record.

37. The following morning, the man's cellmate spoke to another PCO about what had happened the night before. He explained that the man had been cleaning around the sink area at about 9.30pm when he had suddenly collapsed onto the floor. He was conscious but according to his cellmate he was unable to move. The cellmate said he had helped the man back onto his bed, but had not informed any night staff or pressed the cell call bell. However, this contradicted the entry made by the PCO in the man's ACCT the previous night. When asked to clarify this, the cellmate said that he had not fully understood the original question and in fact had notified a member of the night staff. However, he said that no healthcare staff had arrived. The PCO informed the unit manager who in turn informed healthcare.
38. A nurse went to see the man at the request of wing staff. It was recorded that he had not eaten since the previous morning. The nurse checked his blood pressure which was 170 over 100, and recorded that he appeared vacant at times and that his speech was slow. The nurse visited him throughout the course of the day to check his pulse and wellbeing. The man managed to eat his lunch and evening meal and appeared settled. However, it is recorded in both the medical record and ACCT that he remained vacant and appeared at times to be disorientated.
39. At 7.00am the following morning while carrying out the ACCT checks, staff observed the man in the toilet. On the next three checks, he was still in there. Although reassured by his cellmate that he was alright, staff notified the healthcare centre. A nurse came to see him in his cell at about 9.00am. When the nurse arrived he was still sitting on the toilet. The nurse recorded that he appeared disorientated, unable to dress himself and had a vacant expression. He had also been incontinent several times. The nurse said that the man should be taken to the local hospital for further investigation into his condition.
40. Staff kept a close check on him while arrangements were made for him to be taken to hospital. At 11.30am, the escort arrived at the Queen's Medical Centre, Accident and Emergency (A&E) Department. As staff helped the man from the vehicle he collapsed and had to be supported. Once in A&E, he was seen fairly quickly by a nurse and a doctor. An Electrocardiogram (ECG) (a recording of the electrical activity of the heart) was carried out along with blood tests. By 1.40pm, he was outside the hospital with staff awaiting transport to return to Lowdham Grange.
41. Staff recorded that during the escort the man had been incontinent twice. They arrived back at the prison at 2.45pm, and he was seen by a nurse. The nurse recorded that, in addition to the tests carried out at the hospital, a sample of urine was needed, and the man was to be reviewed by the prison doctor.
42. On the wing, he was spoken to by the SCO again. The SCO wrote that there was poor eye contact, and when she spoke to him he continuously wrung his hands. The SCO asked the man's cellmate to ask him if he was afraid or whether something had happened. The man replied no to both. His cellmate told the SCO that a lot of prisoners on the wing were concerned about the

43. Staff continued to monitor him for the remainder of the day and it was recorded that his behaviour continued to be 'strange'. During the night, he appeared to be agitating his cellmate as it was stopping him from sleeping.
44. The next day, a review of the man's ACCT monitoring was held. Healthcare and wing staff together with the Safer Custody Officer attended the review. The man would not respond to questions put to him by either the SCO or the Operational Manager and just stared at the ground. However, he did respond when spoken to by the nurse. The review team felt that it would be better for non-uniformed staff to conduct reviews in future as he appeared to respond better to them. The SCO concluded that the man's physical appearance had changed significantly since his first arrival at the prison. She said that he was unshaven and scruffy with a slumped posture, a dramatic difference to the powerful man who had arrived just before Christmas. His cellmate was moved at his own request as he felt unable to deal with his friend's increasingly strange behaviour. Due to his cellmate being moved to another cell, the observations on him were kept at every ten minutes.
45. In mid-January, the man's behaviour became increasingly bizarre. The intention was for him to be transferred to the healthcare wing. However, this did not happen as he was naked when staff went to collect him. He spent most of the day naked in his cell, often sitting or standing in his toilet recess. This continued into the following day. He responded to staff when they asked if he was alright, but only by raising a hand. During the afternoon of the following day, the man was finally moved to the healthcare centre.
46. A nurse saw him on his arrival at healthcare. A blood sample was taken and she arranged to review him on the next day. When the nurse saw him the following day he appeared brighter but was still not himself. The nurse spoke with him about his incontinence and whether he knew when he needed to pass urine. The man replied that he did but refused to answer any further questions and just stared at the wall.
47. He returned to the residential wing but continued to deteriorate over the coming days. A week later, a psychiatric assessment was carried out due to the decline in his mental state. When asked, the man did not confirm or deny any depressive symptoms but did say that he was not suicidal. The review concluded that his symptoms were suggestive of a depressive illness and that he required long-term anti-depressant medication, daily support and to be reviewed in a week.
48. A nurse was called to see him on the wing at 11.30pm that night. When she arrived she found him slumped on the floor. The nurse was able to gain a 'sluggish' response and persuaded him to stand up. On investigation, it

49. Staff continued to support him and attempted to engage him in conversation. However, this was becoming increasingly difficult. The man was regularly wetting himself and staff found it difficult to encourage him to change his wet clothing.
50. In late January, the MHIRT attended the wing to see the man. On entering his cell an odour was noted and patches of urinary incontinence were visible on his bedding. During the assessment, he displayed facial animation in response to jokes but no verbal response. The MHIRT arranged for his clinical record from his earlier visit to the Queen's Medical Centre (QMC) to be obtained. This was to provide a baseline for ongoing investigations. It was also decided that the doctor should see him as an urgent case that afternoon.
51. At lunchtime, the man did not collect his meal so an officer took it to him. When a member of staff checked on him about 30 minutes later, he was standing at his table picking at his food with his trousers down. The Deputy Healthcare Manager was called to the wing to see him at 2.55pm, and found him sitting on his bed with his trousers down. He was also eating food from a bowl, regurgitating it, and eating it again. Staff continuously coaxed him and offered help. The healthcare manager contacted the doctor to see the man for an assessment.
52. The doctor saw the man at 4.00pm. After consultation with other members of the medical team regarding the deterioration in his condition, it was decided that he should be admitted to the City Hospital, Nottingham.
53. The man was admitted to City Hospital at 5.40pm that day. Following his arrival, blood tests and other routine checks were made before he was allocated a bed. During this time, he remained handcuffed by a standard handcuff and an escort chain. (This is known in the Prison Service as 'double cuffing'.) The man slept for most of the night but continued to be incontinent. Nursing staff attended to him regularly throughout the night.
54. Over the next two days, his condition remained very much the same and he was given a scan. Following this, the consultant explained to the man that he might have an abscess on his brain. The consultant told him that this would explain the problems that he had been experiencing. The man acknowledged what was being explained but was unable to respond verbally.
55. At 2.30am the following day, the man fell asleep. Nursing staff continued to check on him regularly. At 9.20am, a nurse informed the escort staff that he could remain like this for some time. Initial plans were made to move him to intensive care but it was decided that this would not be of any benefit to him. A doctor informed the escort staff that they believed him to be possibly 'brain dead' and that he did not have long to live. This information was passed on to the prison. In view of the man's deteriorating condition, the security manager

56. At 6.52pm that day, while carrying out a routine check on the man, a nurse discovered that he had died. A doctor certified his death at 8.00pm.

Events following the man's death.

57. The prison contacted the Dutch Embassy which had been listed in lieu of the man's next of kin. In turn, the Embassy contacted the Dutch Ministry of Foreign Affairs to inform the family.
58. The prison remained in touch with the Embassy and obtained contact details for his ex-wife. The prison offered to meet the funeral costs and, at the request of the family, arranged for his body to be flown back to Holland. (Initially it was thought that the prison would arrange the funeral and the man's ashes would then be handed over to the Dutch Embassy.)
59. The post mortem concluded that he died of a glioblastoma multiforme in the frontal lobes of the brain and an early associated bronchopneumonia. Glioblastoma multiforme is the most common and aggressive type of brain tumour.
60. Staff at Lowdham Grange were offered the support of Staff Care and Welfare if they felt that they needed it. The man's cellmate and co-defendant, was informed of his death sensitively and also offered support.

ISSUES

ACCT monitoring and follow up actions

61. The opening of the ACCT document was appropriate given the behaviour displayed by the man. The assessments and follow up multi-disciplinary case reviews were well documented. It was clear that all efforts were made to support him and that early healthcare and Mental Health in Reach involvement made a difference to his care. It should also be noted that the regular contact also enabled staff to identify the effect that the man's illness was having on the cellmate and to make the necessary arrangements for him to be moved.

The ACCT reviews, together with recording and sharing of information between all departments at Lowdham Grange, should be highlighted as good practice. These robust procedures and practices identified the needs of the man, as well as recognising and preventing further unnecessary distress to his cellmate.

Healthcare intervention

62. The healthcare staff at the prison, along with the MHIRT, had regular contact with the man from the onset of his symptoms. The treatment given for depression was appropriate, given the way he presented. However, the nursing staff kept this under review, and when his condition deteriorated they acted quickly in referring him to outside hospital. These actions are supported by the clinical reviewer who says in his review:

“The working diagnosis whilst the man was in HMP Lowdham Grange was that he was suffering from depression, and this is not surprising since he had not long been sentenced. The physical symptoms associated with his depressive illness, namely the psychomotor retardation, withdrawal, lack of spontaneity, enuresis, poor appetite and obsessional behaviour were all consistent with a diagnosis of depression. However, when he began to vomit and display increasingly bizarre behaviour he was referred to Accident and Emergency at the CHN [City Hospital, Nottingham]. There, a working diagnosis of a urinary tract infection was made, largely because of the history of incontinence and from the results of some blood tests; but there was no confirmatory urine sample taken. Ten days later the man declined further and was sent back to the CHN, again as a possible urinary infection.”

63. The reviewer goes on to say that in his opinion:

“The healthcare staff were wary that the physical decline could not be solely attributed to the depression and that additional, and as yet unknown, pathology existed. The fact that the unknown pathology turned out to be a brain tumour was not considered and noted in the inmate record.

“With hindsight, the diagnosis of a brain tumour could have been considered earlier in the course of this illness but the working diagnosis of depression was reasonable, and in any event, the fatal outcome would not have changed.”

No criticism should be levelled at the healthcare department for failing to diagnose the man’s brain tumour whilst he was in their care. However, this case should be included for discussion at the next clinical audit meeting at HMP Lowdham Grange’s healthcare department.

64. In terms of the medical treatment provided, the reviewer finds no significant shortcomings in how the man was managed whilst at HMP Lowdham Grange.

Transfer to City Hospital, Nottingham

65. When he was transferred to City Hospital, the man was escorted by two members of staff and ‘double cuffed’. I acknowledge that he was a category B prisoner who had just been sentenced to 15 years imprisonment. However, I would have expected the prison to have taken into account the man’s medical and physical condition when completing the risk assessment and the healthcare department to have provided information. It appears that neither were considered and therefore he was treated as any other category B prisoner.
66. As a result, a 60 year old man with an illness that had already stripped him of his dignity was made to sit with his hands cuffed together and another chain adjoining him to officers for three days. Reviews of the risk assessment over the following days continued to indicate the same cuffing arrangements, despite the deterioration in his condition. I recognise the prison’s actions in removing the restraints in late January 2008. However, it was not until the duty manager became aware that the man was not likely to live beyond 24 hours that this decision was made.
67. The balance between public protection and the compassionate management of seriously ill or dying prisoners is a difficult one to strike and one that I frequently address in my reports. In four recent reports on the deaths of prisoners held at Birmingham, Gartree, Maidstone and Norwich, I have been critical of the lack of flexibility in local policy on bed watches. There are, of course, many factors to consider when arranging a bed watch and I appreciate they involve discretionary judgements. In this man’s case, the management checks and risk assessment reviews were carried out frequently, and in accordance with the National Security Framework (NSF) guidelines.
68. As previously mentioned, I have addressed these matters in earlier reports. In one of them I emphasised that consideration should be given to including in the NSF explicit instructions on how to deal with gravely ill or dying prisoners in outside clinical environments. The Prison Service accepted this recommendation. In addition, a review of the use of restraints during hospital escorts and bed watches has been undertaken following the case of ‘G’ in the High Court last November (2007). The policies within the NSF have been

GOOD PRACTICE

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