

**Investigation into the death of a man in May 2006 in hospital whilst in
custody at HMP Gartree**

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

September 2006

This is the report of an investigation into the circumstances of the death of a man in May 2006. The man died in hospital whilst under Prison Service escort from HMP Gartree. He was 44 years old at the time of his death.

Her Majesty's Coroner for Leicester and South Leicestershire decided that a post mortem should not be held. The man had been ill for several months with degenerative liver disease.

I extend my sincere condolences to his family and friends for their loss.

The man had been continuously in custody since 2000, first on remand, then as a convicted prisoner. He had been sentenced in 2001 to life imprisonment.

I would like to thank the Governor of Gartree, and her staff for their help and assistance during this investigation. I am also indebted to Melton, Rutland and Harborough Primary Care Trust for conducting a clinical review.

Counting those reproduced from the clinical review, this report makes four recommendations. I have also been pleased to identify several examples of good practice.

The four recommendations have been accepted by Gartree and an action plan for their implantation has been developed.

This version of my report, published on my website, has been amended to remove the name of the man who died and those of staff and prisoners involved in my investigation.

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Prisons and Probation Ombudsman

September 2006

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SUMMARY

The man died at 10am on 10 May 2006 in hospital. He had been in custody at Gartree since June 2002, serving a life sentence. In total, he had served five years of his life sentence (his tariff or minimum term was 14 years).

The man first became unwell in January 2005 and attended an outpatient appointment at hospital for investigations. These revealed that he was suffering from alcohol induced cirrhosis. The man attended nine outpatient appointments for treatment and further investigations in hospital. He spent a month in hospital in autumn 2005. Later followed by five days in hospital, then transferred to a second hospital, in February 2006.

In April 2006, the man was again admitted to hospital for 27 days, returning to Gartree on 30 April. On 7 May, he returned to hospital as his condition had seriously deteriorated and he was extremely unwell.

The man died three days later, with his partner and family at his bedside.

INVESTIGATION PROCESS

On 11 May 2006, my investigator visited Gartree to open the investigation. My investigator met with two governors and a Principal Officer (PO). Terms of Reference and Notices were handed to the PO to inform all staff and prisoners of the Ombudsman's investigation.

My investigator visited the healthcare unit where the man spent the last few months of his sentence and saw his cell. Later, my investigator reviewed parts of the man's prison record and requested copies of that record and his medical notes.

On 18 May, my investigator returned to Gartree and met with the Governor. She also met a Senior Officer (SO), the representative of the Prison Officers' Association (POA), and with the Chair and a member of the Independent Monitoring Board (IMB). My investigator received a copy of the man's prison record and medical notes.

On 6 June, my investigator conducted interviews with a nurse and with a prisoner who is the healthcare orderly. My investigator also spoke with a prisoner on C wing at Gartree who was a friend of the man.

On 7 June, one of my Family Liaison Officers, wrote to the man's partner, to explain the investigation procedure and to invite any questions or comments. Up to the present time, no questions have been raised by the family in relation to this report or the investigation process.

On 27 June, my investigator spoke to the Head of Healthcare in relation to policy guidelines on infectious diseases.

HMP GARTREE

HMP Gartree is located three miles north of Market Harborough in Leicestershire. It opened in 1966 as a category C prison. After a period as a high security prison, it was re-graded in the early 1990s to a category B training prison for adult males. It holds life sentenced prisoners in the first and second stage of their sentence. Gartree has an operational capacity of 475 prisoners.

The healthcare unit has 14 cells and provides 24 hour nursing care. Melton, Rutland and Harborough Primary Care Trust (MRHPCT) are the providers of healthcare services following a transfer from the Prison Service in April 2005. Two of the 14 cells in the unit are dedicated to inpatient beds; the remaining 12 are used for prisoners.

Gartree was last inspected in May 2005 by Her Majesty's Chief Inspectorate of Prisons (HMCIP). The report of that inspection was generally positive about healthcare services. An extract reads, 'The atmosphere between patients and staff was professional and relaxed, and inpatients to whom we spoke praise healthcare staff.'

At the time of the inspection, MRHPCT had just taken over as provider of healthcare services. In regard of joint work with the NHS, the report records, 'the PCT had appointed a lead to cover the three prisons in its area, There was excellent contact between the lead in healthcare, and an updated needs assessment report had been published in April 2005.'

This was the first death to have occurred of a prisoner at Gartree since I became responsible for all such investigations in April 2004.

EVENTS LEADING TO THE DEATH OF THE MAN

After his transfer from Manchester to Gartree in 2002, the man spent two and a half years on C Wing and was regularly visited by his partner and other family members.

It was noted in his medical records that he had a history of asthma. All the man's out patient and in patient appointments were under Prison Service escort from Gartree.

At the request of the prison's Senior Medical Officer, the man attended hospital on 2 December 2004. He had been suffering from breathlessness, and from abdominal and leg swelling. At his hospital appointment, the man was diagnosed with presumed cirrhosis.

On 31 January 2005, the man was seen at a hospital for an umbilical hernia. A Consultant Surgeon noted that surgery was not to be contemplated due to the man's underlying liver problem. He suggested that an appointment with a specialist in Gastro-Enterology would be advantageous.

On 4 February, the man attended hospital for medical investigations. On 8 February, a letter was sent to the Senior Medical Officer at Gartree by a Consultant Hepatologist. On examination, Mr Ganson was found to have some stigmata of chronic liver disease, gross ascites (large fluid accumulation within the abdominal cavity) and peripheral oedema (swellings and fluid retention). Further investigations and tests were arranged.

The man again attended hospital on 27 April as a day patient for an endoscopic procedure. On 31 May, the man attended hospital where the results of his endoscopy confirmed he had cirrhosis with oesophageal varices (veins that can bleed in the gullet). A medication regime was arranged for the man and a letter from the Department of Infectious Disease was sent to the Senior Medical Officer at Gartree reviewing the man's present medical condition.

On 15 July, the man once more attended hospital. The Consultant Hepatologist wrote to the Senior Medical Officer suggesting the feasibility of a course of Interferon/Ribavirin drug therapy for the man, and enquiring about the prison's ability to monitor regular blood tests. On 21 July, the Medical Officer at Gartree, replied to the Consultant that the monitoring of Interferon/Ribavirin medication with regular blood tests would be possible within the confines of the prison.

The man attended hospital on 11 August 2005 for an ultra sound scan. As a result of the scan, he was again seen by the Consultant Hepatologist at hospital on 6 October. The Consultant noted that a MRI scan had been arranged for him.

On 28 October, the man reported to staff that he had been vomiting dark blood during the early hours of the morning. At 6.15am, he was taken by prison escort to a hospital's Accident and Emergency Department. At 11.40am, the man was admitted into ward 15 at the hospital.

Over the next four weeks, the man remained at the hospital. A routine test taken showed signs of MRSA (this is an organism that is resistant to commonly used antibiotics). Extracts from his medical notes show an entry from the Head of Healthcare at Gartree, requesting that a representative from the prison attend a review of the man's medical care at the hospital for an assessment of his discharge and care plans. The man's prognosis was noted as being poor. The Head of Healthcare also decided that guidelines and precautions for officers in relation to MRSA should be published for information and action when escorting the man. Information leaflets were sent by healthcare to the detail office to be given to staff on escort duties in relation to the man.

On 28 November, the man was discharged from hospital to healthcare at Gartree. A care plan was opened to record his needs which included daily weight, urine output and regular blood tests. The man was mobile and able to attend to his own personal hygiene. He attended the hospital out patient department on 19 December. His condition was reviewed and his medication revised.

On 12 February 2006, the man was admitted to a hospital Accident and Emergency department because he could not be roused at 9am. A CT scan revealed no abnormality, but his condition was described as serious. Blood samples were taken and sent for toxicology. On 14 February, the man's medical notes recorded an entry that his present condition is 'probably encephalopathy' (a condition associated with liver disease causing confusion and unconsciousness). On 15 February, the man was transferred to a specialist unit at a nearby hospital. He was in liver failure. However, the next day the man felt much better and was able to attend to his daily needs. On 17 February, he was discharged from hospital back to Gartree.

On 28 March, the Head of Healthcare recorded in the man's medical notes that he was being considered for placement on a waiting list for a liver transplant. On 30 March, a case conference was held with a specialist hospital, in reference to the transplant. It was agreed that certain conditions would need to be met in preparation for a liver transplant. An approximate time frame was documented in the man's medical notes.

On 1 April, the man was found vomiting in the early morning. An hour later, he was vomiting blood. He was transferred to hospital for a full medical assessment. In the afternoon, he was received back into healthcare at Gartree.

On 3 April, the man was again admitted to hospital. On 5 April, he was re-admitted back to hospital. The man remained in hospital for 27 days. He went back to Gartree on 30 April.

At 3pm on 7 May, the man was admitted to hospital after vomiting blood. Restraints were removed to allow medical staff to attend to him but replaced shortly afterwards. At 6.50pm, the escorting officers contacted the duty governor for an agreement that the man could receive a visit from his family. This was approved by a governor.

The man was receiving high level medical interventions during the afternoon and evening. At 10.30pm, medical staff asked for restraints to be removed and not be re-placed as he required emergency assistance. The restraints were removed by officers on bed watch. At 7.40am the following day, authorisation was given by a governor that restraints should not be re-applied.

At 2.30am on 8 May, the man had a cardiac arrest and was transferred to the critical care unit of the hospital and sedated. A Catholic priest visited the man at 5.30pm to deliver the last rites in accordance with his wishes.

On 9 May, his condition was described as critical. At 7pm, the hospital doctor informed the bed watch officers that the man's organs were 'shutting down'. The hospital was happy for visitors to stay by his bedside. This was agreed by a governor.

At 9.40am on 10 May, the doctor informed the escort officers that the man was nearing the end of his life. He died at 10am, with his family by his bedside. Death was certified at 10.15am.

On 22 May, Gartree held a memorial service for the man at the same time as his funeral was taking place. The memorial service was attended by 60 prisoners. The chaplain and a governor attended the man's funeral.

A collection at Gartree, to which prisoners and staff contributed, raised £430. Part of this money was used to buy flowers for the man's funeral and the remainder was passed to his family.

In accordance with Prison Service Order 2710, the prison offered financial assistance towards funeral expenses.

CLINICAL REVIEW

The clinical review into the man's medical care was carried out by the Director of Public Health, assisted by the Prison Healthcare Development Manager, of Melton Rutland and Harborough Primary Care Trust.

The review process included an examination of medical notes, prison healthcare policy and interviews with healthcare staff and the man's Consultant Hepatologist.

The review finds that in February 2005, the man was diagnosed positive for hepatitis C antibodies and alcohol induced cirrhosis of the liver. Further investigations, treatments and medication were organised. Over the following 12 months, he spent time as an inpatient in hospital and was admitted to healthcare at Gartree in November. A full plan was developed with regular reviews for the man's medical and nursing care.

As noted earlier, in November 2005, whilst an in patient in hospital, the man contracted MRSA following a procedure to treat his oesophageal varices and ascites. After his discharge from hospital, the man was treated for MRSA at Gartree in accordance with the prison's infectious disease policy.

In March 2006, the possibility of a liver transplant was raised by the man's Consultant. A case conference at a specialist hospital took place. The Head of Healthcare at Gartree liaised with the Consultant over the potential of a liver transplant for the man. Unfortunately, he continued to deteriorate and he was admitted to hospital as an emergency on 7 May. The man died three days later following a cardiac arrest.

The clinical review concludes that the overall care and treatment of the man appears to have been very good. He was referred to secondary care in a timely manner, received care appropriate to his needs and was considered for treatment and a liver transplant - all evidence that he received equitable care. The Consultant Hepatologist communicated directly with prison healthcare staff on a number of occasions, and when the man was in hospital, prison healthcare staff kept in close contact with hospital staff, detailing progress and treatment in his medical record. The man's next of kin were involved and kept informed of his condition.

However, the clinical review points to several areas where standards of record keeping need improvement:

- Gaps in the medical and nursing record which made it difficult to track the patient's movement between prison and hospital on occasions;
- Some entries in notes were signed with illegible signatures or not signed at all;
- There was some inconsistency in reporting of weight, sometimes recorded in metric and sometimes in imperial measures;

- Recording of information on medical charts, including omission codes not always used, no dates on cessation of drugs, patient information not always correctly filled in.

The review also makes the following observations:

- There was good communication between the hospital and prison generally, but on occasion hospital discharge summaries appear incompletely filled in and difficult to read.
- The physical environment of the healthcare unit at Gartree is not fit for purpose and required refurbishment. It is somewhat isolated, at one end of the prison and in effect functions as a stand alone wing, with no free access to the main prison.
- There was good post-incident support. A debriefing session was held for healthcare staff and a memorial service was held for prisoners and staff.

The review includes the following recommendations:

- Consider design of reception screening tools, including use of open questions.
- 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 care and treatment is more complex, a communication sheet, separate from record of care sheet, would be valuable to aid sharing of relevant information quickly.

The clinical review concludes with the following examples of good practice:

- It is clear that the man had a thorough assessment of his needs undertaken as appropriate. He was seen regularly and both medical staff and nursing staff made efforts to keep him informed and discuss treatment options with him. Linked to this, he was encouraged to be self caring as much as possible
- The man's next of kin were informed promptly of his deteriorating condition by prison staff and his family were able to be with him when he died
- Overall, the prison healthcare team in Gartree and the secondary care teams in the hospitals come across as having cared for the man very well, from both a clinical and personal perspective.

FINDINGS

The clinical review provides an in-depth and informative account into the man's medical and nursing care. He was suffering from degenerated liver disease, which, despite quality medical support, ended his life 15 months after diagnosis. He received appropriate medical and nursing care whilst in custody at Gartree.

The information on the man's care plan indicates the high level of support he received from healthcare staff. I am pleased to commend those staff for their care and support of him and his family.

I am also pleased to note that the man's family were allowed to visit him during his last stay in hospital and, during his last 24 hours, were allowed to remain at his bedside. During his previous periods in hospital as inpatient, his family were also allowed to visit him and officers on the bed watch appear to have acted in a dignified and courteous manner at all times.

The healthcare orderly at Gartree, wrote to my investigator to express his gratitude to the staff in healthcare for the help and support that was offered to his friend. My investigator subsequently interviewed the orderly. He said the nursing staff had looked after his friend in the best possible way under a prison regime. (It is also clear that the orderly himself offered the man very considerable support.) However, the orderly felt that release on temporary licence could have been considered taking into account the man's terminal illness.

A governor told my colleague that release on temporary licence was not considered due to the man's category B status, and he had only completed six years of a 14 year tariff.

I recommend that the healthcare orderly's prison file records the exceptional help, assistance and support he gave to the man whilst he was in healthcare.

A prisoner on C wing, who was another friend of the man, also spoke to my investigator. The prisoner felt a transfer from Gartree to a prison local to the man's family should have been considered. The journey from the family's home. If the man was feeling unwell, he would cancel the visit early in the day so the journey would not be wasted.

While I understand the point made by the prisoner, there are no Prison Service protocols or policies that cover the transfer of seriously ill prisoners to prisons closer to their family home. Moreover, in the man's case, he was receiving intensive medical treatment at the hospital with a familiar medical team. He had also been placed on the liver transplant list at a specialist hospital. A transfer to a prison within his family's area would have meant a change in medical support unfamiliar to his case and losing his place on the transplant list.

RECOMMENDATIONS AND GOOD PRACTICE

- I recommend that the healthcare orderly's prison file records the exceptional help, assistance and support he gave to the man whilst he was in healthcare.

Recommendations from the clinical review:

- Consider design of reception screening tools, including use of open questions.
- 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 care and treatment is more complex, a communication sheet, separate from record of care sheet, would be valuable to aid sharing of relevant information quickly.

Points of Good Practice

- I commend the healthcare staff of Gartree for their care and support of the man and his family.
- I am also pleased to note that the man's family were allowed to visit him during his last stay in hospital and, during his last 24 hours, were allowed to remain at his bedside. During the man's, previous periods in hospital as in patient, his family were also allowed to visit him and officers on the bed watch appear to have acted in a dignified and courteous manner at all times.

Good Practice identified in the clinical review:

- It is clear that the man had a thorough assessment of his needs undertaken as appropriate. He was seen regularly and both medical staff and nursing staff made efforts to keep him informed and discuss treatment options with him. Linked to this, he was encouraged to be self caring as much as possible.
- The man's next of kin were informed promptly of his deteriorating condition by prison staff and his family were able to be with him when he died.
- Overall, the prison healthcare team in Gartree and the secondary care team in the hospitals come across as having cared for the man very well, from both a clinical and personal perspective.