

The death in custody of a prisoner

HMP Ranby – 12 September 2004

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

May 2005

This is the report of an investigation into the circumstances of the death of a prisoner at HMP Ranby on 12 September 2004.

All deaths of prisoners in custody are investigated, including those due to apparent natural causes. The responsibility for carrying out these investigations traditionally fell to the Prison Service itself, but has now been passed to the Prisons and Probation Ombudsman (PPO) to bring independence and greater consistency to the task.

In this case members of the PPO's staff have carried out the investigation. Bassetlaw Primary Care Trust (PCT) arranged for an independent clinical review to be conducted.

The man died in his cell at HMP Ranby. The Post Mortem report concluded that he died of a heart attack (1a. Acute myocardial infarct 1b. Thrombotic occlusion of the left anterior descending coronary artery). He was serving a seven-year prison sentence at Ranby at the time of his death.

My colleagues and I would like to extend our condolences to the prisoner's family for their loss. I would also like to thank the Governor of Ranby and those members of his staff who assisted us. My investigators found staff helpful, and were grateful for the fact that, all the documentation they required had been gathered together for them.

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Summary

The prisoner died at the age of 44 at HMP Ranby, in his cell. He was serving a seven-year prison sentence for aggravated burglary. His death was not connected to the fact that he was in prison or to the level of care he received there.

The prisoner was a person with few previous medical problems. However, in the days preceding his death he experienced chest and arm pain, which he attributed to indigestion and over exertion in the gymnasium.

This was not the prisoner's first time in prison. Ranby describes his custodial behaviour as good.

The prisoner died of natural causes as a result of a heart attack (1a. Acute myocardial infarct 1b. Thrombotic occlusion of the left anterior descending coronary artery).

The report includes four recommendations.

Background

HMP Ranby

Ranby is a category C male adult training prison, near Retford in Nottinghamshire. It was converted in the early 1970s from its original use as an Army camp. While some old billets remain, purpose built accommodation has since been added.

The prisoner was located on a ground floor landing of A - wing. A - wing is an Enhanced Prisoners Unit, which provides special privileges for prisoners who have behaved particularly well. It has 24 single occupancy rooms, which have no integral sanitation. The landing is kept secure by a locked metal gate. Prisoners on this landing have keys to their own rooms. This allows them free access to the water boiler and toilet facilities. At night, staff do not patrol the landing.

The rooms do not have an emergency alarm button, as would traditionally be the case. If a prisoner needs emergency help, there is an emergency alarm button on the landing. In this case the button was 21 paces from the prisoner's room.

To be located on A – wing, prisoners must meet the good behaviour criteria for the Enhanced Regime and must be physically and mentally well.

The Prisoner

The prisoner was born in April 1960. He was 44 years old when he died on 12 September 2004. He had been in Ranby since 15 June 2004.

The prisoner was familiar with prison life, having been in custody twice before. The prison describes his custodial behaviour as good, a fact reflected in his allocation to A-wing.

Investigation process

All the indications were that this was a death from natural causes. The Ombudsman's Terms of Reference allow in these circumstances for a clinical review to be carried out by an independent health care professional, rather than conducting a full investigation. My approach in cases of apparent natural cause deaths has been to conduct an initial review to determine if a full investigation is justified. In this prisoner's case, I decided that the circumstances did not require a full investigation.

I did so after my investigators visited Ranby Prison, reviewed the documentation and had a very helpful discussion with the Governor. The investigators recommended that a full investigation was not warranted and I agreed.

The investigators visited the unit where the prisoner spent much of his time in prison. They met the Chairman of the local Prison Officers' Association (POA) and the Chair of the Independent Monitoring Board (IMB). Neither the POA nor the IMB had any issues they wished to draw to the investigators' attention.

The investigators were given access to the prisoner's prison records, including his medical records, and were given copies of everything that was required. They also conducted interviews with some staff and a prisoner.

Following a telephone call, my investigators sent a letter to the prisoner's wife and next of kin, inviting her to get in touch if she wished, to make any comments or ask questions.

Bassetlaw Primary Care Trust (PCT) carried out the clinical review.

The Events Leading up to the prisoner's Death

The prisoner had been at Ranby since 15 June 2004. In that time, the only medical complaint he had was constipation, which was successfully treated as an in-patient at Bassetlaw Hospital.

On 8 September, the prisoner complained to another prisoner, that he had chest pains. The other prisoner gave him some of his paracetamol, and advised him to see the doctor, but he seemed reluctant to do so. He said that the prisoner went to the Healthcare Centre on 11 September, but there is no record of this in the Inmate Medical Record (IMR).

On the afternoon of 11 September, the prisoner complained to a second prisoner of indigestion and a pain in the arm. Between them, they decided that the pain was due to over exertion in the gymnasium. He gave his friend some Deep Heat cream to help ease the pain, which it appeared to do.

Also on 11 September, the prisoner had a visit from his wife. She says that her husband told her that he had been treated for a heart attack the previous night. However, there is no evidence to support the prisoner's claim. There is no in-house medical cover overnight at the prison, only a doctor on call. If the prisoner had been treated the previous night, other prisoners would have been woken. His fellow prisoner confirms that this did not happen.

Later on in the evening of 11 September, the prisoner complained to his friend about chest pain. They again concluded that this was indigestion and over exertion in the gymnasium. For reassurance, the other prisoner gave him his GTN angina spray.

There is no evidence that the prisoner consulted with healthcare when other prisoners gave him medication.

The first prisoner last saw the deceased at about 11pm on 11 September. Although he complained of a pain in his arm, he was generally in good spirits. The other prisoner told his friend that, if the pain got worse, he should shout or bang on the wall and he would press the emergency call bell for help. He heard no such call. He is insistent that he would have pressed the emergency bell if his friend had needed help.

Between 5am and 6am on Sunday 12 September 2004, the night staff carried out the morning roll count. This was to verify that all the prisoners were in their rooms, and that there was the correct number of prisoners in the prison. This check did not require a response from the prisoners. Therefore staff completing the count did not check to ensure that the prisoners were alive.

Staff told my investigators that, at the weekend, the next roll count would have been at lunchtime.

It is normal at a weekend for prisoners to stay in bed longer than in the week. At about 10.15am, the first prisoner kicked the deceased's door to wake him,

as he says he would normally do. When there was no response, he presumed that he was still tired and left him in bed, without physically checking through the observation panel.

By about 10.40am, he was not out of his room, and he thought this unusual. Two prisoners therefore investigated further, opening the observation panel and seeing the prisoner sitting up in bed with the curtains closed and the television on. As he did not respond, they went outside the wing, put a “litter-picker” through the window and tapped him on the head. There was still no response, and so went to the wing office to alert two officers.

At about 10.45am, the officers went to the prisoner’s room. On entering the room, they checked for a pulse, but could not find one. One officer called on his UHF radio for emergency medical assistance. The prisoner was propped up against his headboard, with his hands by his side, but tucked inside his boxer-shorts.

The Healthcare Officer arrived quickly. It was clear to him that the prisoner had been dead for some time and that any attempt at resuscitation would not be appropriate.

A doctor arrived at 11.55am and pronounced death at 11.57am.

Post Incident Response

All the necessary information was gathered together for the purposes of the investigation, and arrangements were made for the investigators to see the relevant members of staff so that we could satisfy ourselves as to the way the prisoner had been cared for.

The Duty Governor of the prison broke the news of the prisoner’s death to his wife, whom he had named as his next of kin. This seems to have been appropriately and sensitively handled.

Staff involved in the incident were offered appropriate support.

A doctor held a Post Mortem on the evening of the prisoner’s death, and concluded that he died of a heart attack (1a. Acute myocardial infarct 1b. Thrombotic occlusion of the left anterior descending coronary artery). The doctor examined the prisoner’s three main arteries and found that one was completely blocked, the second was 90 percent blocked and the third 30 percent blocked. The doctor thought that this would be very difficult to detect, and would probably have shown little or no symptoms. If detected, the only effective treatment would have been a triple heart by-pass.

Inquest

The Coroner for Nottinghamshire, heard the Inquest into the prisoner's death on 10 December 2004. The Inquest lasted two hours and concluded that he died in Ranby Prison of natural causes. The Coroner raised no issues or problems.

Level of compliance

Standards of healthcare in prison are intended to mirror those available in the outside community. The prisoner's prison records indicate that while in prison he was given an appropriate level of care, and his health and social needs were recognised and adequately dealt with. The medical aspects of his care are described in the independent clinical review.

The doctor who conducted the clinical review, concludes that due care was given to the prisoner. There is only one issue arising from the clinical review. It comments that if the prison knew the prisoner's condition, then he would have expected him to be on medication appropriate for a heart condition. However, there is no evidence that the prison knew or suspected that he had any problems related to his heart.

Ranby's Local Security Instruction, Chapter 26, regulates how staff should account for prisoners. The instruction does not differentiate between weekday and weekend as staff do. It instructs night staff to count prisoners at 6.30am, and the day staff to do so at 7.30am. This was not completed in practice.

Since the prisoner's death, I know that it is now the practice to count and physically check that prisoners are alive. However, the Local Security Instruction has not been updated to reflect this.

Prison Service Order 2710 sets out what action prisons must take following a death in custody. Ranby fully complied with this order.

Conclusions

The prisoner died of natural causes. The cause of death was as a result of a heart attack. He died during the night of 11/12 September 2004, but was not discovered until about 10.45am.

The prisoner was well cared for in Ranby Prison. In my judgement, he received the equivalent level of healthcare that he would have received had he been living in the outside community.

The prisoner told his wife on 11 September that he had been treated for a heart attack. I do not know exactly what he meant by 'treated'. There is no record of him being treated by Healthcare. He was, however, given medication and advice from other prisoners. This is what I believe he was referring to.

Wing staff responsible for counting and checking prisoners did not comply with Local Security Instruction, Chapter 26. The instruction tells night staff to count prisoners at 6.30am and the day staff to do so at 7.30am. In practice, the night staff counted the prisoners between 5am and 6am. Day staff did not count the prisoners until lunchtime. Staff should be reminded to comply with the Local Security Instruction.

I support the changes that the Governor has made in ensuring prisoners are physically checked. However, the Local Security instruction should also be amended to reflect this.

There is only one emergency cell call button on the landing. There is no provision for a prisoner to call for emergency help without leaving his cell. In this case it made no difference as the prisoner was found in a relaxed position and did not attempt to get out of bed. However, my view is that in some circumstances, such as an asthma attack or a serious assault, not having emergency call bells in each cell could be detrimental.

On at least three occasions another prisoner gave the prisoner medication. These were not prescribed for him, nor were Healthcare consulted. These were well-intentioned acts, but prisoners are not permitted to share medication and it is a potentially dangerous practice. Whilst most people will have done likewise, I have made a formal recommendation designed to alert prisoners to the dangers of using medicines that belong to other prisoners or have not been prescribed for them.

Recommendations

1. I recommend that the Governor reminds prisoners that they must not share any medication issued to them, and that prisoners requiring medication should consult the Healthcare Centre.
2. I recommend that an emergency cell call system be installed in A wing.
3. I recommend that the Local Security Instruction be updated to reflect the requirement to count and check that the prisoners are alive.
4. I recommend that staff be reminded to complete the same checks during the weekend as during the week.