Investigation into the circumstances surrounding the death of a prisoner at HMP Albany in 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 in September 2004.

I would like to extend my sincere condolences to the man's family and friends for their loss.

He was a 60-year old man who suffered severe heart problems for some time. The onset of his death could not have been predicted and he received appropriate medical care whilst in Albany.

I would like to thank the Governor at Albany Prison at the time of our investigation. I would also like to thank the other members of his staff who assisted us, in particular the Deputy Governor.

Stephen Shaw CBE
Prisons and Probation Ombudsman

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Summary

The man who died was born in November 1943. He was sentenced to nine years imprisonment in July 1999 and transferred to Albany prison in March 2000.

He had a long history of heart problems and was treated and monitored for these whilst at Albany. No fewer than 17 appointments were made at outside hospitals. The healthcare afforded to the man was of a generally good standard. Staff were also proactive in helping him give up smoking. However, some poor record keeping makes it difficult to ascertain the full level of care he received.

In September 2004, after having his lunch, the man was found lying face down on the floor of his cell by his friend. Help was summoned and resuscitation was attempted, but to no avail. The man was taken to hospital where he was pronounced dead. The post mortem indicates that he had died of "myocardial fibrosis" and "hypertensive and ischemic heart disease".

All contingency plans were followed and wing staff acted appropriately and with care in their treatment of the man's friend after his death.

I conclude that, while the man's death could not have been predicted, it did not come as a total surprise given his longstanding heart problems.

I make five recommendations.

Investigation process

All the indications were that this was a death from natural causes. In these circumstances, it may be sufficient for a clinical review to be carried out by an independent health care professional, rather than 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 man's case, I decided that the circumstances did not require a full investigation.

My investigator visited Albany and met with the Deputy Governor. She visited the man's cell and spoke informally with staff and prisoners from the wing, including his close friend.

My investigator met with a representative from the Independent Monitoring Board (IMB). She also offered to meet with representatives from the Prison Officers' Association (POA).

Access to all of the man's prison records, including his medical records, was provided to the investigation.

A clinical review was carried out by a nurse employed by my office.

One of my family liaison officers contacted the man's niece and kept her updated on the investigation and report.

The events leading up to the man's death

From 2001, the man attended 17 appointments at outside hospital. A detailed account of his medical treatment is documented in the clinical review. The man's appointments had been, in the main, for treatment and monitoring of his heart condition. He was monitored closely, and saw doctors in the healthcare unit frequently. There were occasions where results of medical tests were not documented in the IMR.

The man attended physiotherapy, and wore a corset to help with his back pain. In January 2004, he complained about the comfort of his corset and a new one was promptly ordered.

Healthcare staff had been proactive in helping him give up smoking.

On 31 March 2004, a Cognitive Evaluation was conducted. There is no note in the IMR regarding this appointment, or the findings. The report indicated that the man had "significant problems with word recognition but did not exhibit any signs/symptoms that would suggest the presence of organic brain disease. His physical health is only fair and he is in a high-risk category." There is no explanation as to what was meant by 'high-risk' and to what it related.

In April and May, the man suffered several episodes of chest pain. GTN spray was used to relieve this. When he reported that the GTN spray was not helping he was taken to hospital. He subsequently had a chest x-ray, but no result is documented in his prison medical record.

The man was often short of breath after performing the most simple of tasks. He was therefore appropriately located on the ground floor. He did not like to mix with other prisoners, and tended to just have one trusted friend. He therefore preferred not to go on exercise or association and kept himself to himself.

The Crisis Management

On the day he died, the man had gone to work at the charity shop in the morning as usual. He came back at about 11.45 am and went to collect his lunch with his friend. They were in the queue for about five minutes. He then returned to his cell with his lunch, and the cell doors were locked. At about 1.35 pm the doors were unlocked. His friend reported that the man often fell asleep at lunchtime and so he would knock on his door to wake him before going back to work.

When the man's friend knocked, he heard no response and opened the door. He saw that the man was on the floor, and there was a little blood coming from his face. This is thought to be from the fall he suffered. The man's friend went straight to the staff office to summon help. An officer contacted healthcare, and a senior officer went to see the man, and radioed for urgent healthcare assistance. After being unable to find a pulse or detect the man's breathing, the senior officer used his radio to order an ambulance.

Healthcare staff arrived quickly and commenced CPR, but to no avail. The ambulance crew took the man to hospital, where the duty doctor pronounced him dead at approximately 2.45pm. The post mortem indicates that he had died of myocardial fibrosis and hypertension and ischemic heart disease.

Post Incident Response

Staff followed the contingency plans for a death in custody correctly and informed the police to contact the man's niece.

The man's friend had his clothing seized in case of any police matter, which at the time he found distressing. However, he reported that staff on the wing had been extremely supportive and checked him closely since the man's death.

Findings and Conclusions

The man had a history of serious heart problems. He was referred to and seen by relevant healthcare professionals. In the main, it would appear his healthcare treatment was good. However, poor standards of record keeping make it difficult to fully assess the level of continuing care afforded to him (I note, for example, that the clinical review found no records of regular monitoring of blood pressure and pulse.) I therefore ask the Healthcare manager at Albany to take note of the clinical review, and I endorse all recommendations from the review.

He was appropriately located on the ground floor and worked in a position suitable for his healthcare needs. He liked to keep himself to himself and had few close friends.

Staff acted appropriately in attempting to revive the man, and in their subsequent care for his friend in dealing with his loss.

He was a sick man, but the actual onset of his death could not have been predicted.

Recommendations

There are five recommendations endorsed from the clinical review for the attention of the Governor and Healthcare manager.

1. I recommend that after each entry in the IMR the name of the person making the entry is clearly printed in the IMR alongside initials or full signature, to make it easier to refer back to the writer if necessary.

2. I recommend that referrals should be actioned and appointments made when required. These should be as soon as possible when urgent and all information should be documented clearly in the IMR.

3. I recommend that tests carried out and their results should be entered clearly in the IMR, along with instructions for the next test date.

4. I recommend that regular monitoring of observations should be carried out in patients with a history of cardiac problems.

5. I recommend that healthcare professionals are reminded of their responsibilities for appropriate standards of records and record keeping.