The death in custody of the man who died at

HM Prison Albany – January 2005

Report by the Prisons and Probation Ombudsman for England and Wales

May 2005

This report concerns the death from natural causes of the man at Albany prison in January 2005. The man collapsed in his cell during the evening of 10 January and died despite the efforts by prison healthcare and the ambulance personnel to save him. A post mortem on 12 January concluded that he died of ischaemic heart disease and chronic obstructive pulmonary disease.

I would like to extend my condolences to his family and friends for their sad loss. I would also like to thank the Deputy Governor at Albany, and the Governor's secretary, and the other staff members and prisoners who assisted my investigator with her enquiries. We found everyone very helpful and co-operative. On arrival at Albany, there was a comprehensive dossier already prepared which was very helpful.

The investigation was carried out by my investigator. We are very grateful to the Isle of Wight Primary Care Trust for their assistance in assessing the clinical care of the man.

I make eight recommendations.

STEPHEN SHAW CBE **May 2005**
PRISONS AND PROBATION OMBUDSMAN

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Summary

The man was a 56 year old man, originally from the West Midlands. He died of ischaemic heart disease and chronic obstructive pulmonary disease in Albany on 10 January 2005. He had been in prison since January 2000 and in Albany since May 2000. He was serving an eight year sentence imposed at Wolverhampton Crown Court on 18 February 2000. The man had a history of chest pain on exertion going back to 1996, and he had worsening emphysema aggravated by smoking. Episodes of chest pain occurred during his imprisonment in Albany and he was admitted to hospital on two occasions. Doctors providing primary care in Albany prescribed medication to treat his symptoms as they presented or as recommended by the hospital physicians. During the last year of his life, he was described as increasingly frail and breathless.

On the evening of 10 January, the man asked a fellow prisoner to call for medical help. An initial appraisal of the situation by the duty Healthcare Officer prompted the summoning of an ambulance and paramedic team from the nearby hospital. Sadly he collapsed into unconsciousness and, despite the efforts of staff and the paramedic team, he could not be revived.

Following the sad death of the man, Management and staff at Albany acted in a professional and sympathetic manner. According to his sister’s wishes, his body was conveyed to Dudley in the West Midlands for the funeral. The prison made a substantial contribution to the cost of meeting the funeral expenses.

I make eight recommendations, three concerning healthcare, two about resuscitation, two about operational policy and one about staff welfare.

The investigation

The investigation began on 11 January when my investigator contacted the Deputy Governor. The Deputy Governor had set matters in hand to make contact with the man's next of kin (his sister) to inform her of his death and make funeral arrangements according to her wishes. On 12 January, notices were issued to staff and prisoners announcing the investigation and inviting anyone with information relevant to his death to contact my investigator.

My Family Liaison Officer (FLO), made contact with his sister on 31 January to establish what concerns, if any, she would wish my investigator to follow up on her behalf. The man's sister did not want the FLO to visit her at home. The sister's concerns were followed up by my investigator and the answers are contained in the report.

My investigator visited Albany on 25 and 26 January, familiarising herself with the prison, particularly A wing where the man resided and the healthcare centre. Three staff and one prisoner were interviewed. The records of the interviews were forwarded to Albany for those interviewed to check, amend as necessary and sign. Two were amended slightly and all were signed and returned to the investigator.

An independent clinical review of the man's healthcare was undertaken by the Isle of Wight Primary Care Trust. The Isle of Wight Primary Care Trust and my investigator conducted some further enquiries regarding records of the paramedics' care of the man and, with the Deputy Governor, regarding access for the ambulance.

HMP Albany

Albany was designed and built as a category C training prison on the outskirts of Newport, Isle of Wight in the early 1960s. Soon after it opened, a decision was taken to upgrade the security to make Albany part of the dispersal (now high security) system. A later review concluded that Albany should no longer be a dispersal prison and in 1992, it was re-designated as a category B closed training prison. Albany operates as an assessment centre for the core sex offender treatment programme.

Up to 526 prisoners can be held at Albany. The accommodation consists of five four-storey cell blocks designated A to E wings. There is an 11 cell induction unit and a nine cell segregation unit with two special cells. All wings are identical and hold a maximum of 88 prisoners in single cells with in-cell power and access to electronic night sanitation. In May 2003, a new ready to use unit (RTU) opened housing 80 category C prisoners.

The health services at Albany are currently managed by the Prison Service in collaboration with the services for Parkhurst and Camp Hill prisons. The service at Albany focuses on primary care and operates from 8.00am to 9.00pm daily. There is a well established working relationship with the Isle of Wight Primary Care Trust which is due to take over funding and commissioning the health services for the three prisons in April 2005.

Records show three Albany prisoners died in custody in 2004, in June, September and October. The circumstances of all these deaths were investigated by my office and all were from natural causes.

Events prior to 10 January 2005

The man was first received into custody on 7 July 1999 on remand at Blakenhurst, West Midlands. He was bailed the next day to an approved hostel where he stayed until he went to court in January 2000. He was convicted on 27 January 2000, and sent to Blakenhurst again. He was sentenced to eight years on 18 February and transferred to Albany on 16 May.

The man did not admit his offence and therefore refused to participate in treatment programmes. Records show that he was a very quiet prisoner, compliant with the regime and never breaching prison rules. He was on the standard level of the incentives and earned privileges scheme (IEP) for the majority of his time at Albany.

The man was quite disabled by his longstanding lung disease but was rewarded for his trustworthiness with the fairly 'sought after' job of wing laundry man. He ably fulfilled this role although it appears that fellow prisoners helped him out when he was tired and breathless. Records show staff were concerned about the man's lack of interest in the food provided. He often tried to miss meals altogether. He was also known to swap his issued meals with other prisoners in return for convenience food items such as instant noodles which he liked.

The man had no visitors while he was at Albany. At Blakenhurst, although he sent out visiting orders, no visitors were recorded except solicitors. Wing staff reported that he had said he was writing to the Queen and his MP but there was no evidence of this. The man's sister wrote to the prison on 12 January 2004 because she was concerned about what he had written in a Christmas card he had sent to her. She said he had written that he was very ill and had only five weeks to live. The man's sister had called the prison and been told he was in hospital and advised her to write for more information. A prison medical officer, replied on 16 January to the effect that he could not disclose anything to her without her brother's consent. The recollections of an officer as to his mood at Christmas 2003 were consistent with the content of his card to his sister. It is possible that he was becoming increasingly aware of the severity of his illness. He knew that his smoking habit was making his condition worse but apparently resisted advice to give up.

The man was from time to time resistant to medical intervention. For example, he refused to go to hospital on 27 May 2004, signing an ambulance service form to that effect. The man's health and the care he received had been subject to clinical review by the Isle of Wight Primary Care Trust. The full report, by the Director of Public Health, which includes the events leading up to his death, forms an annex to this report.

Events of 10 January 2005

On the evening of 10 January, at the time the wing was locking up for the night, sometime before 8.00pm, the man asked a fellow prisoner on the first floor landing (the 2s) to call for medical help. The Senior Officer on the wing heard a prisoner, calling him at 7.50pm. The Senior Officer called to the officer on the ground floor, to contact healthcare for medical assistance and went to the man's cell.

Healthcare officer was called by radio to attend A wing. He arrived from the healthcare centre but, not knowing the reason he was required, he was not carrying any equipment. Having formed an initial assessment of the man's condition, he returned to the healthcare centre to bring a blood pressure machine. On his return, he took some baseline readings and suspected angina or a heart attack, and asked for an ambulance to be called. The ambulance service received the call at 8.04pm and arrived at the prison seconds before 8.07pm. The ambulance service log shows that at 8.10pm the paramedics found 'all three prison doors open, crew unable to locate a prison officer. Control unable to contact Albany by landline. Police contacted as a precaution. Contact made with Albany at 20.20. Police advised.'

Our investigation found that Albany does not have a written protocol for the entry of a 'blue light' ambulance. However the Deputy Governor reported that all Communications Room staff undertake a training process that includes procedures when an ambulance is called on an emergency call. During daytime hours, the route to the location of the patient is manned by Operational Support Grades. These staff open interior gates before the ambulance arrives to allow easy access. However, in the late evening, when the man's death occurred, there would not have been the staff available to open the interior gates and this would have to be done by the staff who escorted the ambulance through. The prison's Gate Book confirmed that the ambulance arrived at the main gate at 8.08pm. In addition to the two main front gates leading into the prison, there would have been three further gates to open as the vehicle made its way to the rear of 'A' Wing. The distance and time taken to get the ambulance through these gates and travel the distance would have taken several minutes. Records made by the ambulance crew show that they took their first electrocardiograph (ECG) reading at 8.17pm. This indicates that the paramedics were on the wing before the time estimated by the wing staff, 8.20pm.

The Healthcare Officer stayed with the man while they waited for the ambulance. He was on his own with him for 10 minutes or so then the man started to collapse, becoming unconscious. The Healthcare Officer moved him on to the floor, on his back. He asked an officer, to get the bag with the oxygen cylinder from the healthcare centre. The man was not responsive. The Healthcare Officer maintained a clear airway for the man and, when it arrived, he administered oxygen via a ventimask. He could not feel a pulse at the wrist or

carotid artery but he thought the man was trying to breathe. Breathing stopped and the Healthcare Officer started mouth to mouth resuscitation. The Senior Officer witnessed the Healthcare Officer doing cardiac compression while oxygen was being administered through the ventimask. The other officer was present but the Healthcare Officer did not ask him to help. Other staff were downstairs meeting the ambulance.

Senior Officer gave evidence that there was difficulty releasing the electronic lock on the rear gate of the wing through which the paramedic team would enter. The gate was eventually opened manually by the Orderly Officer. The gate was opened before the ambulance arrived at the back of A wing.

The Healthcare Officer reported that he did mouth to mouth for 10 minutes then the paramedics arrived and took over doing full cardio-pulmonary resuscitation. The Healthcare Officer recalled that the paramedics connected a drip and ECG machine and intubated the man. The senior officer reported that the paramedics used a defibrillator to try and restart the heart. The ambulance service patient report form indicates that the paramedics applied defibrillation and administered a range of intravenous medication, such as epinephrine and atropine, in an effort to resuscitate the man. Sadly, the man could not be revived. The prison's locum doctor, arrived at 8.55pm and at 9.05pm pronounced him dead.

Events after the man's death

The Senior Officer reported that after the man was pronounced dead, the Healthcare Officer was distressed, admonishing himself. The Senior Officer encouraged and helped him to collect up his equipment so that it was not confused with the paramedics' equipment. He asked the prison's locum doctor to take care of the healthcare officer. When the prison's locum doctor asked about the welfare of the wing staff, the Senior Officer said he believed they were alright with the exception of the officer who had known the man particularly well. The Healthcare Officer said in his evidence that he returned to the healthcare centre, wrote his statement and waited for the police.

The Deputy Governor arrived at 9.00pm and commenced a death in custody incident log. The police were contacted at 9.49pm and attended at 10.00pm. They interviewed the Healthcare Officer before he was allowed to go home. The man's body was removed by the undertakers at 00.36am.

The following morning, the Deputy Governor, undertook all the required actions to inform all parties as set out in Prison Service instructions. He had to utilise the help of the police to trace the man's next of kin, the man's sister, for whom he had no telephone number. Once she had been located, he both spoke and wrote to her and took trouble to arrange to meet her wishes about the funeral taking place in the man's home town. The Deputy Governor also put the Care Team into action supporting staff who wished for their help. Later, the Deputy Governor wrote to the Healthcare Officer and the officer who knew the man particularly well thanking them for their actions in respect of the man.

The Communications Room staff, who monitor the computerised electronic locking, reported their concerns over the difficulty with the A wing gate encountered by the Senior Officer. The Deputy Governor alerted the works department who conducted a thorough test of the equipment and procedures the next evening (so that conditions were similar to the previous evening) and have continued to make daily checks. No reason for the difficulty encountered by the Senior Officer has emerged nor any repeat of the problem.

Concerns expressed by the man's sister

The man's sister, asked for three concerns to be investigated. First, that her brother was located a long way from his family making it difficult for them to visit him. In particular, she wished to know whether the prison were aware that he was extremely ill and, if they were, why they did not contact her to inform her, or re-locate him closer to his home to allow visitors.

The Deputy Governor responded to these questions. He said that although the prison healthcare team were aware of the seriousness of the man's condition, it would be unusual to inform relatives unless the prisoner asked them to do so.

The prisoner would need to give written permission for them to breach medical confidentiality. The man did write in a Christmas card to his sister in 2003 that he was very ill. The man's sister wrote to the prison for further information. A doctor responded that he could not tell her anything without his written consent. There is nothing on record to indicate that the man's sister wrote to him about her concern.

With regard to relocation closer to home, the prison's response was as follows. The man was allocated to Albany because, as a Category B prisoner with the need to address his offending behaviour, Albany was the nearest prison to his home that could meet his particular needs. He appeared content at Albany and there is no record of a request from him for a transfer.

Secondly, the man's sister asked us to investigate fully the level of care and access to healthcare that he had in light of some paperwork she had found in his possessions referring to a complaint he had made about not being able to see a nurse when he requested it. The man submitted a complaint on 25 November 2003 because he felt that two staff on the wing had blocked his request for urgent medical advice/assistance. He felt his condition was life-threatening. He reported that a third member of staff had offered to help him. A nurse had then attended and called the doctor. He later went to hospital by ambulance for treatment and returned to the prison the next day. The complaint was investigated at the time by the Deputy Governor who both spoke and wrote to the man. The staff were spoken to in order to prevent any recurrence. The Deputy Governor noted that the incident was at odds with the history of the man's experience of A wing, where he had been located without incident for over three years.

The man's sister's third concern was whether her brother had made an appeal against his conviction. There was no evidence of an appeal being made but we were able to pass the man's solicitor's details to the man's sister for her to follow up her concern with them.

Post Mortem Report

The post mortem findings were communicated to my investigator verbally by the Coroner's Officer on 25 January 2005. The pathologist's examination had concluded that the man died of ischaemic heart disease and chronic obstructive pulmonary disease.

Key Findings

From Senior Officer's interview evidence, it appears that the man had chest pain for some time, perhaps from 6pm, before he alerted a fellow prisoner to call for medical help. One can only speculate on his reasons for delaying in this way or any impact it might have had on the outcome of his critical situation.

The incident of the apparent failure of the electronic unlocking of the back gate was immaterial to the circumstances of the man's death. I am satisfied that Albany's management have taken all necessary steps to ensure there is no fault in the computerised or mechanical equipment. It is of concern, however, that the ambulance crew had difficulty locating prison staff to gain access.

From the Isle of Wight Primary Care Trust clinical review, it is clear that on arrival at Albany the man had established emphysema, limited exercise tolerance and a history of recurrent chest pain. The Isle of Wight Primary Care Trust noted that over the last 18 months of his life the man's health deteriorated and he might have developed clinical depression. Healthcare provided within a prison is expected to be of a standard equivalent to that provided through general practice by the NHS. The man appears to have had ready access to healthcare staff including prison doctors. His emphysema was reasonably managed and he was offered further investigation, which he declined. The man's recurrent chest pain was also reasonably managed and again he was offered further investigation, which he declined. His death was unexpected. Had he been at home (especially if living alone), medical help would not necessarily have arrived more quickly.

The Healthcare Officer was placed in a position of great responsibility. Although he had been a first aid instructor in the past he had not received any recent updating on basic life support. He admitted that he had never been in this position before. He did his best but he was hindered by two factors. First, he had no idea what he was being called to attend and a delay was incurred by him returning to the healthcare centre for the sphygmomanometer before taking the man's blood pressure and calling an ambulance. Secondly, he had to send an officer to get the oxygen and other equipment, incurring another delay. In addition, the Healthcare Officer was acting alone and attempting solo resuscitation is fraught with difficulty, trying to balance cardiac compression with mouth to mouth breathing. Such intervention requires regular updating and practice on a 'dummy'. It would be beneficial if prison staff were clear about their level of responsibility in the event of a heart attack. With only one healthcare worker on duty in the evening and none at night, there could be occasions when an initial life support intervention by other prison staff might be crucial in saving lives.

The man's cell was on the second floor. There was a large disability logo on his cell door to alert staff in case of fire or other incident where he might need special measures. Albany holds a number of prisoners with varying disabilities. It is

impossible to give them all ground floor accommodation so the policy of clearly marked cells has been introduced. The man's cell was very much his own space – personal effects like curtains were in evidence. He was also located very near the laundry room where he worked.

In his interview, the prisoner who knew the man well said he felt that the healthcare staff should have brought services, such as the diet supplement drinks, to the man. When we spoke to healthcare staff they felt that the man was able to attend the healthcare centre for his medication, including the drinks. Records show a prescription for the drinks, Ensure Plus, only in December 2003/January 2004. It may not have been the issue it appeared to be in the prisoner's opinion.

From the evidence of the staff and the records, the man presented no problems during his imprisonment, complying with the rules and working at his allotted job as wing laundryman. He was popular with other prisoners as evidenced by the donations for flowers for his funeral and the attendance at his memorial service in the prison chapel.

The care team was engaged to support staff affected by the incident and the Healthcare Officer gave evidence that he had received all the help he needed. However, the Isle of Wight Primary Care Trust found that the arrangements for supporting staff involved in critical incidents should be kept under review. This was prompted by the Healthcare Officer reporting the distress he had experienced in a recently concluded inquest relating to a Parkhurst prisoner.

Recommendations

There are three recommendations framed by Dr Bingham as a result of the clinical review he undertook. They are:

1. NHS General Practice has been moving towards chronic disease clinics run by specialist nurses. This is desirable for the Island's prisons and should be worked towards over the next two to three years.

2. The Island's prisons should have a rolling programme of cardio-pulmonary resuscitation updating.

3. The support to officers involved in critical incidents needs to be kept under review.

In addition, I recommend that:

4. The Governor seeks advice from the PCT as to the clinical competence required for a member of healthcare staff to be deployed as the sole healthcare worker on a shift.

5. The Governor should instigate a review of the procedure for calling for medical assistance to minimise the risk of the attending healthcare worker being insufficiently equipped for the incident.

6. The Governor seeks advice from the PCT as to the feasibility of procuring a defibrillator of the type now commonly used in public buildings and shopping precincts for the benefit of prisoners, staff and visitors.

7. The Governor should consider what instructions should be published to staff regarding initiating, or assisting with, basic life support in the case of collapse.

8. The Governor should consider whether the existing protocols for emergency services gaining access to the prison are sufficient to their purpose and whether all relevant staff are familiar with them.