The Death in Custody of a man
HMP Elmley - 12 March 2005

Report by the Prisons and Probation Ombudsman for England and Wales

March 2006

This is the report of an investigation into the circumstances of the death of a man in hospital on 12 March 2005. He had been taken to hospital, on 28 February 2005, following a number of previous hospital admissions. The man had been unwell for some time with heart related conditions. His death was not unexpected.

The investigation was led by a member of the Fatal Incidents Investigation Group, a qualified nurse also reviewed the medical care given to the man whilst he was in prison.

I would like to thank the management and staff at HMP Elmley for their assistance and co-operation during the course of this investigation.

I would also like to extend my sincere condolences to the family of the man and to those touched by his death.

This version of my report, published on my website, has been amended to remove the names of the deceased and the names of staff and prisoners who were involved in my investigation.

Stephen Shaw CBE **March 2006**
Prisons and Probation Ombudsman

CONTENTS

	Page
Summary	4
The investigation process	5
Background	6
Events leading up to the man’s death	7
The prison’s response following the death	8
Issues considered during the investigation	9
• Compassionate release	
• Transfer to a hospital/hospice with 24 hour nursing care	
Conclusions	10
Recommendations	11

SUMMARY

The man was an 83 year old man who was serving a four year sentence at HMP Elmley. He died in hospital on 12 March 2005 following a long period of ill health. His death was not connected to the fact that he had been in prison, nor to the level of care that he received whilst in prison.

The man was admitted to HMP Elmley on 31 July 2003. His release date was 30 March 2006. He did not enjoy good health, and suffered from various medical conditions many of which were cardiac related.

HMP Elmley is a local prison which holds both people on remand and sentenced prisoners. It has a 29-bedded healthcare centre which is in operation 24 hours per day. The man was located permanently on the healthcare centre due to his poor general health. As his condition began deteriorating, he required more medical and nursing input and care.

The man was referred and admitted to hospital on several occasions with congestive cardiac failure, chest infection and after a possible heart attack. A consultant physician, wrote to the Senior Medical Officer at the prison stating, “he is in end stage of heart failure and his life expectancy is poor.” The consultant recommended that the man should live in “a care home setting with 24-hour input and that consideration should be given to his release on parole.” Unfortunately, despite enquiries via Swale Primary Care Trust, there were no vacancies at a local hospital or at a hospice at that time.

There were some concerns raised by the family regarding the medical and nursing care and attention that the man received whilst in prison. They were concerned that the prison was unaware of his heart condition. The man was expected to “do stuff that he could not do;” for example, “walk up and down stairs.” The family was also concerned that his angina spray was taken away due to the fact that he overused it. They also felt that family visits should have taken place in the healthcare centre. The family also expressed concerns that they were not always informed when he was taken into hospital.

The man received one-to-one 24-hour nursing care towards the end of his life and the treatment and care which was given was comparable to that which would have been available to him in the community.

THE INVESTIGATION PROCESS

My practice in investigations into a death from apparently natural causes is to conduct an initial review to determine the extent of the investigation required.

My colleague first visited HMP Elmley on 18 April 2005 and met with the Healthcare governor. She was given a full briefing about the circumstances surrounding the man's death and was informed that members of his family were aware of his poor prognosis, and had visited him in the hospital. My investigator also met with a Prison Officers' Association representative. A notice to staff and a notice to prisoners was issued by the prison, inviting anyone who might have information relating to the man's death, to make themselves known to the enquiry team. No-one came forward in response to these notices.

My colleague was given photocopies of all the files and records relating to the man. These included the medical records upon which she based her clinical review.

One of my family liaison officers contacted the man's family to see if they had specific questions about his care.

The man's family did express some concerns about the care that he received whilst in prison. These concerns were mainly clinical and are listed as follows:

1. The family believed that the prison was unaware of the man's heart condition and that he was made to walk up and down stairs.

2. The family said the spray used for the relief of the man's angina was taken from him due to overuse.

3. They said that family visits should have taken place in the healthcare centre.

4. The family alleged that they were not always informed when the man was taken to the outside hospital.

5. They said that, although they had received some of his property, some items of clothing was still missing.

My colleague revisited HMP Elmley on 18 May 2005 and spoke with Deputy Head of Security and Operations to discuss the family's concerns.

BACKGROUND

The man left school at the age of 14 with no qualifications. He joined the navy and left when he was in his late 20s. The man married, and he and his wife had six children. He did not feel that they were a particularly close family as he spent a lot of time working away in London.

At the time of his conviction, the man had been divorced for seven years. His accommodation was a bed sitting room which was paid for by housing benefit. The man's ex-wife continued to stay in touch and her intention was to assist him to keep his flat until his release from prison.

The man had no previous convictions. He said he did not use drugs or alcohol, and had no mental health issues. He was convicted and given a six year prison sentence on 31 July 2003. The man spent all of his sentence at HMP Elmley, and due to his poor physical health was given a sitting down job working in the post room.

On 31 October 2003, he successfully appealed against his six year sentence. This was reduced to a total sentence of four years.

EVENTS LEADING UP TO THE MAN'S DEATH

The man was an 83-year old gentleman who was serving a custodial sentence at HMP Elmley. He began this sentence on 31 July 2003. The man had a number of medical problems, many of which were cardiac related. He had been prescribed medications which were entirely appropriate.

There were a number of occasions when he or was seen by the Medical Officer following complaints of shortness of breath and chest pains, and treatment was given as prescribed.

From December 2003, the man's condition appeared to worsen when reports of chest pain and shortness of breath became more frequent. He was admitted to hospital and remained there for three weeks, was discharged for one day and readmitted for a further four weeks.

The Medical Officer received a letter on the 2 February 2005 from the consultant physician at the hospital, stating that the man was in the last stages of heart failure and that his life expectancy was poor, he recommended that the man would benefit from being transferred to a care home setting with twenty four hour clinical input. The consultant physician also wrote that consideration should be given to the man's release on parole.

Unfortunately, there were no beds available in the community at that time, and the man was not eligible for parole or release on license.

He was given one to one continuous twenty-four hour nursing care in the Hospital wing at the prison. He was admitted to hospital for a final time on 28 February 2005, but sadly died on 12 March 2005.

THE PRISON'S RESPONSE FOLLOWING THE DEATH

Elmley has a comprehensive "Death in Custody" booklet which includes an action sheet and follow up check list, coroner's address and contact numbers. My investigator found the booklet both useful and informative.

Notices informing members of staff and prisoners of the man's death were posted throughout the prison.

The post mortem was carried out on behalf of the Coroner's Office, at hospital, and lists the following as the cause of death:

1. Pulmonary Embolus
2. Deep Vein Thrombosis
3. Peripheral Vascular Disease

A member of Chaplaincy conducted a memorial service and offered prayers for the deceased and his family members.

ISSUES CONSIDERED DURING THE INVESTIGATION

Compassionate Release

The man was considered by the prison for early release on medical grounds under section 30 of the Crime Sentences Act 1997. The general principles governing early release on compassionate grounds are:

- the release of the prisoner will not put the safety of the public at risk
- a decision to approve release would normally be made on the basis of facts of which the sentencing or appeal court was aware.
- there is some specific purpose to be served by early release.

Due to the nature of the man`s offence, release on compassionate grounds was not considered appropriate. I think that decision was correct in the circumstances.

Transfer to a hospital/hospice with 24 hour nursing care

The consultant physician at the hospital, advised that the man should be transferred to a more appropriate location such as a hospice which would offer 24-hour nursing care. Healthcare staff therefore contacted the local Primary Care Trust, Swale PCT, regarding the possibility of finding long term care within the local community. There were two options available: a hospice, and a local hospital. Unfortunately, neither was able to offer the man a bed at that time. I consider that the prison did all that they could to transfer him to a more appropriate hospital setting offering 24 hour nursing care.

CONCLUSIONS

I consider that Elmley cared for the man to the best of their ability within a prison setting. Management and staff were sensitive to his needs and took all reasonable steps to accommodate them. The care given to the man from medical and nursing staff is to be particularly commended. He was permanently located on healthcare from 10 September 2004 due to increasing attacks of angina. Following the consultant physician's advice regarding his need for 24-hour nursing care, and the inability to secure a bed in a hospital in the community, an agency nurse was employed by the prison for continuous one-to-one nursing care. This continued until his transfer to hospital on 28 February 2005.

The man was an elderly man who had a significant number of medical conditions, mainly cardiac in nature. Treatment and prescribed medication was appropriate in his case.

Initially, the man worked in the post room following a recommendation from the doctor that he "could be found a sitting down job". This was appropriately implemented.

All steps were taken in an effort to transfer the man to a local hospital that could offer 24-hour nursing care. Unfortunately, there were no beds available.

I do not think that he was disadvantaged by remaining in the hospital wing within the prison.

RECOMMENDATIONS

1. The Governor should remind healthcare staff of the importance of informing the families of prisoners when admission to outside hospitals takes place.

2. The Governor should consider what alternative venues he can offer for visits to take place for prisoners who are elderly or infirm.

3. The Governor should write to the Primary Care Trust to consider devising a protocol allowing for the transfer of prisoners who are terminally ill to a more appropriate location.