

The death in custody of a prisoner

HMP Kingston – 31 July 2004

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

April 2005

This is the report of an investigation into the circumstances of the death of a prisoner at HMP Kingston on 31 July 2004.

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

In this case a member of the PPO's staff has carried out the investigation. The Deputy Ombudsman, carried out an independent clinical review.

The prisoner died in his cell, at HMP Kingston. The Post Mortem report concluded that he died of Ischaemic Heart Disease and Coronary Artery Atherosclerosis. He was serving a life sentence 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 in charge of Kingston Prison at the time of my investigator's visit, and the other members of his staff who assisted us. My investigator found staff helpful. In particular, all the documentation he required had already been gathered together for him.

Stephen Shaw CBE
Prisons and Probation Ombudsman

April 2005

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Summary

The prisoner died at the age of 77 at HMP Kingston, in his double cell, following a coughing fit. The man was serving a life sentence, for murder. His death was not connected to the fact that he was in prison or to the level of care that he received there.

This was not his first time in prison. He was familiar with prison life, having spent about 40 of his adult years in custody. The prison describes him as a quiet but determined man, with good custodial behaviour.

The prisoner died of natural causes as a result of Ischaemic Heart Disease and Coronary Artery Atherosclerosis.

The report makes no recommendations.

Background

HMP Kingston

HMP Kingston was originally built in 1877 to the Victorian radial design. The prison currently caters for Category 'B' lifer prisoners, and includes a wing for elderly lifers.

The Prisoner

The prisoner was born in Birstal, Yorkshire, in August 1926. He was 77 years old when he died on 31 July 2004.

He served in the Army between 1942 and 1946, during which time he became a heavy drinker. After leaving the Army, he held down a number of unskilled jobs, interrupted by periods of imprisonment. He last worked in about 1986 as a crane driver.

On 8 November 1995, at Leeds Crown Court, the prisoner was sentenced to life imprisonment for murder. His victim had been a friend of his for years and was a man of his own age, who was also a heavy drinker. He regularly met with him and often loaned him money. On the day of the murder, the prisoner consumed 12 or 13 pints of beer. Following an argument over money, there was a scuffle and he stabbed his friend. He was arrested soon afterwards and charged with murder.

The prisoner was familiar with prison life, having spent about 40 of his adult years in custody. He had been at Kingston since 21 September 2000. The prison describes him as a quiet but determined man, with good custodial behaviour. He was waiting for a transfer to HMP North Sea Camp, a prison with a lower security category, following a parole review recommending his transfer to the least secure conditions.

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 investigator visited Kingston Prison, reviewed the documentation and had a very helpful discussion with the Governor and Deputy Governor.

My investigator visited the unit where the prisoner spent much of his time in prison. He 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 my investigator's attention.

My investigator had an informal conversation with the prisoner's cellmate. He said that the prisoner was very complimentary about the care he had received at Kingston. Despite the death of his fellow inmate, the prisoner's cellmate was full of praise for the prison staff, and the way they treated prisoners, particularly at the time of the death. His cellmate has written an incident witness statement.

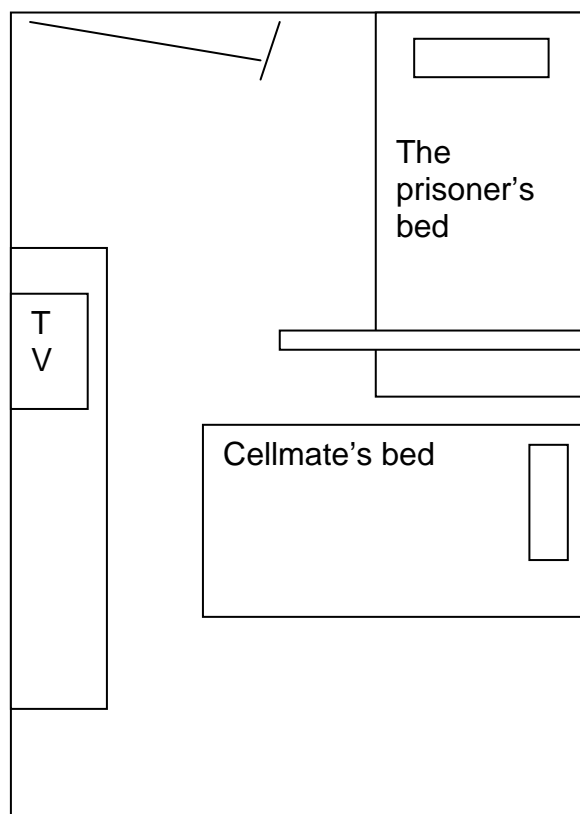
My investigator was given access to all the prisoner's prison records, including his medical records, and was given copies of everything that was required.

Following a telephone call, my investigator sent a letter to the prisoner's sister and next of kin, inviting her to get in touch, if she wished, to make any comments or ask questions. She said that she felt her brother was well cared for in the prison, and that he had confirmed this in telephone conversations with her. The prisoner said that being in prison, without doubt, prolonged her brother's life.

The Deputy Ombudsman carried out the clinical review.

The Events Leading up to the prisoner's Death

The prisoner was located in E – wing, the Older Prisoners Unit, which is made up of double occupancy rooms, which are used for elderly prisoners sentenced to life imprisonment. The rooms are partitioned in the middle, to provide some privacy.



After lunch on 31 July 2004, the prisoner and his cell mate were lying on their beds. The cellmate was watching cricket on television, and reading a book. He assumed the prisoner was doing the same.

At about 2.30pm, the cellmate needed to leave the cell. When he passed the prisoner, he asked him if he was alright, as his eyes were open. There was no response. Realising there was a problem, he checked more closely, and pressed the emergency cell bell which sounded the alarm.

On hearing the alarm a Senior Officer (SO) and an Officer responded. The SO called for immediate medical assistance. The Staff Nurse and another Officer attended and attempted resuscitation.

The Communications Room called the Ambulance Service. It is not clear who asked for an ambulance, but one arrived at 2.40pm, with Paramedics attending the scene at 2.42pm. The Paramedics could find no signs of life.

A doctor arrived at 3.35pm and pronounced death. At 4pm the prison Chaplain gave last rites. The Deputy Governor telephoned the prisoner's sister.

Post Incident Response

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

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

The prisoner's cellmate said that he had been offered appropriate support. This was important as he had actually been in the shared cell when his friend passed away.

A doctor held a Post Mortem on 4 August. He concluded that the prisoner died of Ischaemic Heart Disease and Coronary Artery Atherosclerosis.

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 being given an appropriate level of care, and his medical and social needs were recognised and adequately dealt with. The medical aspects of his care are described in the independent clinical review. The Deputy Ombudsman also concludes that appropriate care was given to the prisoner.

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

Inquest

On 25 November 2004 the Coroner at Portsmouth, heard the Inquest into the prisoner's death. The Inquest lasted an hour and 40 minutes and concluded that the prisoner died in Kingston Prison of natural causes.

There were no issues or problems raised by the Coroner.

Findings

The prisoner died of natural causes as a result of Ischaemic Heart Disease and Coronary Artery Atherosclerosis.

The prisoner and his sister were happy about his treatment at the prison. During telephone conversations, he told his sister that he was well cared for by Kingston. His cellmate confirmed that he held this view.

Conclusions

The prisoner was well cared for in Kingston Prison. In my judgement received an equivalent level of healthcare when he was there as he would have done had he been living outside in the community.

Recommendations

I have no recommendations to make in this case.