

**Circumstances surrounding the death of a man in hospital, on 6 June 2005,
while a prisoner at HMP Albany**

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

September 2005

This is the report of an investigation into the circumstances of the death of a man who died from natural causes in hospital, on 6 June 2005. At the time of his death he was 69 years of age and serving a ten year sentence at HMP Albany.

The person who is the subject of this report had suffered from several illnesses for some time. He had diabetes which was controlled by insulin, and also had a history of heart problems and obstructive airways disease. After being admitted to hospital on 26 May 2005 he was diagnosed with lung cancer.

I offer my sincere condolences to the prisoner's family for their loss.

The investigation was led by one of my colleagues. Isle of Wight Primary Care Trust (PCT) carried out a clinical audit of the prisoners care and treatment.

I am grateful to the Governor and the staff of Albany for their help with this investigation. I have found that the prisoner was well cared for by the prison and have made no recommendations in this report.

Stephen Shaw CBE
Prisons and Probation Ombudsman

September 2005

Contents

SUMMARY.....	4
INVESTIGATION	5
HMP ALBANY.....	6
THE PRISONER.....	7
EVENTS LEADING UP TO 6 JUNE 2005.....	7
ISSUES CONSIDERED IN THE INVESTIGATION.....	10
CONCLUSIONS.....	11

Summary

The man who is the subject of this report died, aged 69, in hospital, on 6 June 2005. He had been taken there by ambulance from HMP Albany on 25 May.

In 1999, the prisoner had been sentenced to ten year's imprisonment. He died shortly before his anticipated release in June 2005.

The man involved had a history of poor physical health. In the main, this had been managed successfully by medication. However, in the year before his death, he went into hospital on several occasions and developed severe breathing problems. Initially, these were treated with antibiotics, but when he did not improve an x-ray was requested. After investigation, he was diagnosed with lung cancer and deteriorated rapidly.

After initially being unable to contact the next of kin, Albany's enquiries through the National Probation Service confirmed that the man's wife had died some three years earlier. The man's daughter was later located abroad.

A post mortem examination found that he died due to lung cancer. An inquest into his death took place on 10 June 2005 and agreed that he had died from natural causes.

Based on the evidence I have seen, I conclude that this man's death was unavoidable. I also believe he was well cared for by the prison and the hospital. I make no recommendations.

Investigation process

My practice on being told of a death from apparently natural causes is to conduct an initial review to determine the extent of investigation required. In this case, my colleague visited HMP Albany where she was provided with the man's prison record and copies of the notices, reports and other records associated with his death.

She also gathered details of his next of kin, the Coroner's Officer, and the appropriate contact in the Isle of Wight Primary Care Trust (PCT). One of my Family Liaison Officers, subsequently contacted the man's daughter.

The Isle of Wight PCT carried out a clinical review.

Notices to staff and prisoners were distributed and displayed, telling them that an investigation would be taking place into the circumstances surrounding the prisoner's death, and inviting anyone who wished to see the investigator to make themselves known. My colleague was contacted by the prisoners friend.

No formal interviews were conducted with prison staff, though informal discussions did take place. There was a thorough review of all relevant records, and the findings of the clinical review were also considered.

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.

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 opened, housing 80 category C prisoners.

Personal Details

I understand that the man had been divorced and, at the time of his death, was not in touch with any member of his family. Enquiries through the National Probation Service indicate that his former wife died some three years ago.

In 1999, he received a sentence of ten years imprisonment. His prison records describe him as quiet and polite, someone who tended to keep himself to himself. Initially, he worked in the prison gardens. However, he had to give this up because of poor health and instead worked in the prison charity shop making tapestries.

It is apparent from his medical history that he had suffered for some time from a heart condition and various other health problems. He had spent periods in outside hospital during his term of imprisonment. He was also a heavy smoker.

In August 2004, the prisoner's application for parole was declined by the Parole Board. He was also informed that he would be liable to deportation on his release. His solicitors were appealing against the decision on his behalf. However, the uncertainties around his legal status had still not been resolved at the time of his death.

A friend of the man described him as a very kind man who enjoyed playing pool and cooking. He said he had other friends on the wing that he spent time with, chatting, playing cards and dominoes. He also suggested that he had a stubborn streak, and would not give up smoking, despite much advice to the contrary.

Events leading up to 6 June 2005

The man started his sentence at HMP Doncaster in 1999, following his conviction. On reception, he was seen by a healthcare officer and asked a series of standard questions about his health. It was noted that he suffered from diabetes and angina, and he received appropriate treatment from the prison's healthcare department. In July of that year, he was transferred to Albany. While there he was also treated appropriately for his conditions.

In January 2005, the man complained of a cough. He was prescribed antibiotics and a chest x-ray was requested. This showed the presence of an infection. When he was seen again on 14 March the infection had not cleared. It transpired that the man had not been taking the prescribed antibiotics, as he had reported that they made his angina worse. He was prescribed a different antibiotic, and a further chest x-ray was requested.

On 30 March, the man again attended for a healthcare appointment. He was still experiencing upper abdominal pain, but no definitive diagnosis was made. He stated at the time that he did not want to attend hospital for further tests. However, with still worsening pain, he was referred to the Accident & Emergency Department there on 19 April.

The prisoner was admitted to hospital and stayed there as an inpatient until 18 May. During this time, a lung abscess was diagnosed and he was treated with an intravenous antibiotic.

He returned to Albany and continued his treatment with an oral antibiotic for a further three weeks. There are two entries in his health notes between 18 and 25 May. These show that he continued to have abdominal pain and shortness of breath, and he was referred again to hospital on 26 May. During this time, it was noted that his diabetes was unstable and it was difficult to keep his blood sugar levels up.

Up until this time, the man had been restrained. However, bed watch staff were in contact with the security department at Albany, and a risk assessment on 6 June decided that the cuffs should be removed.

Later that day, nursing staff explained to the bed watch staff that the man was very ill, and not expected to live. At this time, the bed watch officers noted that he was not awake and that his breathing was distressed and noisy.

At 8:30pm, the officers on bed watch noticed that the man had stopped breathing, and informed the nursing staff. A doctor was notified and confirmed the man's death at 9:17pm.

Prison staff were present at his bedside, and appear to have conducted the bedwatch in a professional and sensitive manner. Medical staff at the prison

maintained an updated summary of the man's progress, and appropriate management checks were made.

The Inquest, held on 10 June, confirmed the cause of death as Acute Bronchitis and Lung Abscess, Chronic Obstructive Airways Disease, Ischemic Heart Disease and Diabetes Mellitus.

The Governor was successful in getting in touch with the man's next of kin, who confirmed that her father had expressed a wish to be buried. The Governor had put in place the arrangements for a cremation. However, on learning of the man's wishes, he was able to change the plans and arranged a burial instead.

The Governor, the Chaplain and other staff attended the funeral. Prior to the funeral, the chaplain held a mass in the prison chapel, which was attended by a number of the man's friends from the wing.

Issues considered in the investigation

The prisoner was an elderly man whose clinical condition was fully recognised while he was in custody. It appears that he received good care at the two establishments where he served his sentence.

The clinical review makes clear that the man's medical care was well managed.

On the discovery of the deterioration in his condition, Albany promptly requested an emergency ambulance. He was taken directly to the hospital's Accident and Emergency Department.

The decision to remove restraints, following a risk assessment, was entirely appropriate given the circumstances. The security arrangements at the hospital seem to have been suitable, and struck a good balance between public protection and sensitivity to the situation.

In reviewing the bed watch log, it is clear that the staff involved in the man's care behaved in general with sensitivity. However, there was one entry in the bedwatch log which used inappropriate terminology. My office is writing to the liaison officer at Albany to draw his attention to this matter.

Albany followed its contingency plans relating to deaths of prisoners. Statements were taken from staff, the Independent Monitoring Board was informed, and notices to staff and prisoners were issued. The post-incident response was fully compliant with Prison Service instructions and policies on managing a death in custody.

I also commend the fact that, following a discussion with the prisoner's daughter, the prison changed its plans for a cremation and arranged a burial in line with the man's own wishes.

Conclusions

The clinical review did not find any deficiencies in the prisoner's medical treatment while at Albany.

The man was settled in Albany and he had friends there. I have seen no evidence to suggest that he had any other problems that were affecting his mental or physical health.

During his time in Albany, the prison acted quickly and compassionately to deal with his illness and provided a good level of care.

The man who died was a 69-year-old who suffered poor health. He was a heavy smoker and I consider that his death was unavoidable. The prison dealt appropriately with his illness, and treated him respectfully as his life ended.

