

**Investigation into the death of a man in hospital, in June 2004
whilst a serving prisoner at HMP Kingston**

**Prisons and Probation Ombudsman for England and Wales
May 2005**

This is the report of an investigation into the death of a man in June 2004 at hospital, whilst a serving prisoner at HMP Kingston.

The man had no family and friends outside the prison system and saw the staff and prisoners at HMP Kingston as his family. The Governor and staff recognised this and ensured that he was treated with humanity and dignity in life and death.

This report makes a formal recommendation commending the Governor and his staff, for the care and compassion shown to the man at all times.

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Summary

The man was born in 1929. His earliest recorded offence dates back to July 1946 when he was found guilty of stealing apples. His offences gradually became more serious and in April 1987 he was charged with murder. In October 1987 he was found guilty and sentenced to life with a tariff of 15 years.

By April 2004, the man had still not been recommended for release, however he had been recommended for a progressive move to open conditions. His health had seriously deteriorated by this time and his next move was to the local hospital.

Whilst in hospital, the man was treated with compassion and sensitivity by the accompanying officers. He was on an escorted absence and not subject to mechanical restraints. Officers ensured that they met his social needs, giving him assistance with many of the activities of daily living. The man was visited regularly by the Prison Chaplain, who ensured his spiritual needs were met.

Following his death, the Governor recognised the man had no family or friends outside of prison and sensitively arrange for his funeral service to be held in the prison amongst his 'family'. Following the service a cremation had been arranged and his body was accompanied by the workshop officers who had got to know him well.

The man's referral to secondary care services was timely and appropriate when he presented to Healthcare. Unfortunately, he had terminal lung cancer from which he was to deteriorate very quickly. During his last few weeks whilst in the local hospital, he was treated and managed by the Governor and his staff in a manner reflecting very well both on the individuals concerned and the Prison Service as a whole.

The cause of death was given by the pathologist at post mortem as:

- 1a) Carcinomatosis
- 1b) Carcinoma of the lung
- 2) Cerebrovascular accident and ischaemic heart disease.

The Investigation Process

Responsibility for investigating deaths in prison passed to the Prisons and Probation Ombudsman on 1 April 2004. This includes deaths from apparently natural causes.

The man died on 30 June 2004 whilst a serving prisoner at HMP Kingston. My Deputy Ombudsman, BSc. RGN, visited the establishment and reviewed all the available documentation. She also met with healthcare staff, the lifer manager and the Governor.

The Deputy Ombudsman reviewed the clinical aspects of the man's care as part of the investigation process.

During the investigation, the Governor and his staff afforded full access to all necessary documentation and personnel.

Background of the man

The man was born in London, in 1929. He was the only child of his parents and was but five years old when his father died. The man was brought up by his mother and grandmother. He left school at the age of fourteen with no formal qualifications.

The man's first job was as a messenger boy with the Post Office. He subsequently was dismissed from this job having been caught and found guilty of stealing apples. Aged 17½, he joined the army but was medically discharged after only nine months. He had gone absent without leave on a number of occasions. The man described this period of his life as difficult.

By December 1950, the man had spent a period of time at a Borstal Training Centre. He continued to spend periods of time in custody, ranging from three months to seven years. His pattern of offending gradually became more serious. He moved from petty theft to violent crime.

The man married in 1965 but this was not a success and he had separated within a year. He had no children from his marriage and stated that he had struggled to hide his homosexuality.

By the early 1970's, the man's pattern of offending had become more frequent and he was spending longer periods in custody. In 1981, he was sentenced to four years imprisonment on each of the following charges: Aggravated burglary, false imprisonment and threatening to kill. Following the release from this sentence he kept out of trouble, working as a painter and decorator and living with his mother. His mother died in 1986 and he then lived alone in council accommodation.

In April 1987, the man was charged with the murder of his lodger using a crossbow following a discussion about undertaking a robbery on the local Post Office. He was considering this offence due to financial difficulties. As noted, the man was working as a painter and decorator but said he was financially worse off than when he was on benefits.

Reports say the man was an articulate man of average intelligence, but who distrusted authority and grew up feeling isolated and ostracised by the society in which he lived. Reports also suggest that his emotional development was severely retarded by the absence of an identifiable adult male during his formative years.

Background to HMP Kingston

HMP Kingston is situated about two miles from the centre of Portsmouth and opened in 1877 as a local prison for the Portsmouth area. In the years preceding the Second World War, it held preventive detainees who were transferred to HMP Parkhurst at the outbreak of the war in 1939. During the war it was used by the Royal Navy as Naval Detention Quarters. Kingston closed in 1945 and remained empty until 1948 when it became a recall centre for borstal trainees. In 1969, following alterations Kingston became a training centre for Category B life sentence prisoners.

Custodial history of the man

The man was first remanded into custody at HMP Lincoln in April 1987, charged with the murder of his lodger on 25 April that year.

In October, the man appeared at Crown Court for his trial. During the summer of 1987, in preparation for his trial, the man was seen by a Forensic Psychiatrist to prepare a report for the court. He was not considered to be suffering from mental illness and therefore fit to stand trial. The man pleaded not guilty to the murder charge. However, in October 1987 he was found guilty and received a life sentence with a tariff of 15 years.

The man was initially admitted on remand to the healthcare centre at HMP Lincoln and had an uneventful first six months. He appeared cheerful and his only complaint was his uncomfortable bed. He had no major medical concerns. Shortly after his sentence, he transferred to the residential units at HMP Lincoln.

In March 1988, the man transferred to HMP Gartree. He was noted to be fit and well and fit for work. He remained generally well, only consulting healthcare for occasional dermatitis and wax in his ears.

In September 1989, the man complained of some wheeziness at night. He smoked half an ounce of tobacco a week. He was examined by the medical officer and nothing abnormal was discovered. However, he was prescribed a ventolin inhaler for use at night to relieve his symptoms.

In February 1991, the man was seen by the medical officer for completion of his lifer report. Once again, he was found to be generally fit and well. It was felt that his imprisonment was not harming his health but a referral was made to the local consultant dermatologist for an opinion of his dermatitis.

By September 1992, the man had been working as the hospital orderly for 20 months. He enjoyed the work and got on well with staff and patients. He did not complain and was trustworthy and predictable. His only clinical complaints were occasional dizzy spells which were felt to be transient ischaemic attacks.

In May 1993, the man suddenly went deaf in both ears. On examination, he was found to have wax in both ears and he was appropriately treated with ear drops.

In July 1993, a movement order was received from Lifer Unit for the man to transfer to HMP Nottingham. He did not want to transfer. However, in October 1993 he was transferred to HMP Blundeston. On reception at Blundeston, the man was noted to be fit and well with his only complaint being his continued dermatitis requiring treatment with dermovate cream.

In October 1994, arrangements were made for the man to return to HMP Gartree for accumulated visits. He transferred on 26 October, returning to Blundeston on 25 November. Whilst at Gartree, the man had a vasovagal attack which resulted in him falling whilst in his cell. He suffered no major injuries and his clinical observations were satisfactory.

Between November 1994 and February 1998, the man had an unremarkable period at Blundeston with few complaints or problems. His health remained good with occasional outbreaks of dermatitis and deafness due to wax. These were all treated appropriately and in a timely manner.

The man transferred to HMP Kingston on 3 February 1998. On reception he was noted to be fit and well with no complaints.

In October 2000, 13 years after his sentence, the man had a further life sentence report prepared. This followed a Parole Board review in October 1999 when he was identified as remaining a high risk due to limited remorse and lack of victim empathy. It was therefore recommended that he remain in closed conditions. The man did not have any living relatives and his visits came from the prison visitor scheme.

During 2000 and 2001, the man saw healthcare more frequently for a number of minor complaints, all of which were treated and managed appropriately. The main complaints continued to be his skin and ears.

In January 2003, the man was seen for a further Parole Board report. He had been in custody nearly 16 years by this stage and remained a Category B prisoner. He had not undertaken any of the recommended offending behaviour courses as he continued to maintain his innocence, stating that the incident was an accident and not premeditated. The man was 73 years old at this point and was starting to show signs of physical frailty due to old age. However, he did continue to work in one of the workshops at Kingston.

In July 2003, the man was becoming increasingly breathless and was referred to the local hospital. In November, he had a lung biopsy performed at the hospital. The results of the biopsy were unclear and the man was referred to another hospital for a further opinion. By early January 2004, despite the request for a second opinion being made in November 2003, nothing had been received.

Also in November 2003, the report of the preliminary decision of the Parole Board was sent to the prison. The man was now 74 years old and had served 16½ years on a 15-year tariff. A decision had been taken to have an oral hearing to determine the likely risk factors, relationships with the prison authorities and identify the rehabilitative and resettlement needs.

An appointment was made for the man to attend the Respiratory Centre at another hospital, in January and February 2004. The hospital cancelled both appointments and sent a re-appointment for early March. The man attended this appointment and was

once again referred to the Cardiothoracic Centre at the local hospital. No confident histological diagnosis had been made. However, the man was experiencing haemoptysis on a daily basis and had lost weight since his previous consultation.

The man was given an appointment to attend the respiratory centre for a further consultation on 16 April 2004. This appointment went ahead as scheduled. The man was advised that he would require a further biopsy in about six – eight weeks. The man was admitted to the local hospital in May 2004 under the care of a Consultant Thoracic Surgeon.

On 4 May 2004, a letter was sent to the man from the Parole Board advising him that they were not recommending his release. The Parole Board did however state that they would be recommending his transfer to open conditions. The letter recognised there were concerns about the man's failing health, but felt that the transfer to open conditions would offer the benefit of 'being tested in a more realistic environment' in preparation for release.

Events leading up to the death of the man

The man was seen by the Consultant Thoracic Surgeon's team on 10 May 2004 with regard to the left lung resection and frozen section operation he was to have. The procedure and potential associated risks were fully explained to him. He gave his next of kin as the mother of another prisoner, who had become a close friend of his.

On 15 May, following his thoracotomy at hospital, the man was transferred back to Kingston. On his return the man was noted not to be his usual self and was having falls. The Clinical Nursing Manager promptly referred him to the Department of Medicine for Elderly People at hospital. He was seen and examined by the Consultant Geriatrician on 19 May. The Consultant Geriatrician believed that the man might have had a peri-operative cerebrovascular event but requested a CT scan to confirm the diagnosis and eliminate possible cerebral metastases.

The man's suture was removed on 25 May. The following day, healthcare visited him to administer his medication. The man was found to have four days medication in-possession indicating he had not been taking his medication as per his prescription. The healthcare worker wrote down for him what medication he should be taking and at what time during the day. A note was also made of his right-sided weakness.

A further entry on 1 June notes that there was no improvement with feeling and movement on his right side. By 6 June, the man appeared to have further right sided weakness and so was moved to 'E' wing for increased care and observation. He was seen by the medical officer on 7 June 2004 who diagnosed a possible cerebrovascular accident and referred him to the local hospital. The man was subsequently admitted.

Whilst in hospital, the man was subject to a single officer escorted absence due to the low level of risk. Furthermore, it was appropriately decided not to use mechanical restraints.

The bed-watch records demonstrate the high level of emotional and physical support given to the man by the staff. All staff showed compassion and empathy supporting him with the activities of daily living. Whilst in hospital, the man requested that he make his Last Will and Testament. An officer facilitated this and after his death the Governor ensured that the man's requests were adhered to.

The man died peacefully with the officer and the Prison Chaplain present on 30 June 2004. The Governor had visited the man two hours before his death.

Events following the death of the man

The man died at 4.15pm on 30 June 2004. Following certification of the death, his body was removed to the hospital mortuary. The Coroner was immediately informed of the death as he remained a serving prisoner. However, the coroner's officer did not attend the hospital until 8.15pm leaving the officer sitting outside the mortuary until this time. This was due to some confusion over roles and responsibilities, that has now been resolved.

Whilst in hospital, the officer had arranged for the man to make his Last Will and Testament in which he left everything he had to the mother of his friend – a serving prisoner. Following his death, timely and appropriate arrangements were made to forward his small amount of cash and personal belongings in accordance with his final wishes.

The man had no family and friends outside of the prison system. The Governor therefore arranged for the funeral service to be held at HMP Kingston on 13 July. It was well attended by staff and prisoners. Following the funeral service, his body was taken to the local crematorium accompanied by staff from the workshop where he enjoyed working on the sewing machines.

Following the man's death all procedures were followed in a professional way. All staff who had been with the man since his admission to hospital were seen and counselling made available to them if required.

Conclusions

The man was sentenced to life in 1987 for the murder of his lodger. He had always denied this was deliberate and had claimed it had been an accident. This meant he refused to participate in identified offending behaviour courses. The Parole Board considered that he continued to pose a risk. It was only in 2004, two years after his 15-year tariff had expired, that he was recommended for transfer to open conditions.

In May 2004, the man was diagnosed, aged 75, with terminal lung cancer. He was treated promptly and appropriately by primary and secondary care services. However, his health deteriorated rapidly and he was admitted to the local hospital on 7 June 2004. On 30 June, the man died peacefully in hospital.

Whilst in hospital, the man was assessed as a low security risk and therefore managed as a single officer escort without restraints. The accompanying staff treated him with dignity and respect, ensuring that his social care needs were met in a timely and appropriate manner. This is evidenced by the comprehensive entries in the bed watch log.

The staff accompanying the man whilst in hospital should be commended for the sensitive and compassionate manner in which they supported him.

Following his death it was quickly identified that the man had no family or friends outside the prison system. The Governor therefore made arrangements for his funeral service to be held at HMP Kingston followed by a cremation. Staff from the workshop where the man had worked whilst at HMP Kingston accompanied his coffin to the crematorium for the cremation.

Recommendations

The Governor and his staff should be commended for the arrangements they made for the man to be treated with dignity both during his final days in hospital and after his death.