INVESTIGATION INTO THE DEATH OF A MAN

AT QUEEN ALEXANDRA HOSPITAL ON 20 AUGUST 2004

WHILST IN THE CUSTODY OF HMP KINGSTON

REPORT BY THE PRISONS AND PROBATION OMBUDSMAN FOR ENGLAND AND WALES

APRIL 2006

This is the report of an investigation into the death of a man, who died at the Queen Alexandra Hospital in Portsmouth on 20 August 2004 whilst in the custody of HMP Kingston. He was 74 years of age.

He had been convicted of murder on 27 June 1991 and was serving a sentence of life imprisonment.

This investigation was undertaken by a colleague. My Deputy Ombudsman reviewed the medical treatment he received during his time at Kingston and in the Queen Alexandra Hospital.

I would like to express my condolences to his family and apologise for the long time it has taken to issue this report. Unfortunately, there was a delay in Kingston producing his medical records.

Both my investigator and I would like to thank Governor of Kingston and his staff for their cooperation during this investigation.

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

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Summary

The man was sentenced to life imprisonment for murder on 27 June 1991. He began his sentence at HMP Wakefield, moving to HMP Albany in 1993 and then to HMP Kingston in September 1997. He was not successful in three applications to the Parole Board for release on life licence and never left the prison system before he died.

He suffered his first collapse in November 1999. He was taken to the Accident and Emergency Department at Queen Alexandra Hospital in Portsmouth. It is not clear from his medical records what the cause of this episode was and he did not suffer from a repeat 'giddy' spell until March 2001. At this stage, blood samples were taken for analysis. In April 2001, it was noted that he had become frail and was experiencing transient ischaemic attacks.

During 2003, he was showing clinical signs of prostate problems. In November that year, he was diagnosed with hyperparathyroidism, with periods of confusion.

By early 2004, his health had begun to deteriorate further. He was referred to an outside hospital for specialist opinion. It was concluded that he might have been suffering from early dementia and possibly a degree of temporal lobe epilepsy. X-rays and a CT scan were arranged which revealed there was no space-occupying lesion.

During the summer months, his health continued to deteriorate and he required help from prison and healthcare staff to maintain his daily activities. Care was taken to ensure that he was monitored on a daily basis by healthcare staff when they performed their medication rounds.

On 6 August, he was found by a member of healthcare in his cell having suffered from a heart attack and stroke. He was taken to Queen Alexandra Hospital where he remained for 14 days under a bedwatch. Sadly, he never recovered and passed away during the early hours of Friday 20 August.

Investigation Process

My Deputy Ombudsman, opened this investigation in September 2004 at HMP Kingston. My deputy, who is a registered clinician, also reviewed the medical care that the man received both in HMP Kingston and in the Queen Alexandra Hospital. A colleague, completed the investigation and is the author of this report.

Her Majesty's Coroner held an inquest on 14 April 2005. The jury returned a verdict of 'death by natural causes'. The cause of death was recorded as a stroke, cerebral infarction and ischemic heart disease.

Unfortunately, there was a considerable delay in HMP Kingston producing the man's prison and medical records and this has resulted in the very late issuing of this report into the circumstances surrounding his death.

One of my family liaison officers wrote to a nominated principal point of contact in his family on 1 February 2006 to inform them of the investigation and apologise for its delay.

HMP Kingston

HMP Kingston is situated in Portsmouth. It was built in 1877 to the Victorian radial design with four wings – A, C, D and E.

In the years before the Second World War, the prison was used to hold preventive detainees who were transferred to HMP Parkhurst at the outbreak of the war in 1939. During the war, the Royal Navy used the prison as a 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, it became a training centre for Category 'B' lifer prisoners. E wing is a dedicated wing for elderly prisoners.

Her Majesty's Chief Inspector of Prisons last visited Kingston in late 2005; the report from this inspection has yet to be published. The previous inspection prior to the man's death was in 2002. This unannounced inspection noted Kingston to be a broadly safe prison with a good range of work and activities and an effective healthcare centre. However, it found that the administration and management of life sentences, and the quality of interventions for lifers, to be deficient. There was a backlog of sentence reviews and the review boards themselves were largely mechanical. The psychology department was understaffed and one of the offending behaviour programmes was given a zero rating for quality.

The inspection noted that E Wing's environment had deteriorated since the last visit. As a result of increasing available spaces, some elderly prisoners were held in small rooms. Movement was restricted and there was insufficient privacy – cells were divided by wooden partitions – little natural light, poor ventilation and in some cases no power points. Staff were not specifically trained to work with and motivate the elderly prisoners. However, the prison had plans to improve these facilities.

Since June 2004, there have been five deaths at Kingston, including that of this man. Four of these were from natural causes. The reports on the deaths from natural causes have commended staff at Kingston for their dignified and sensitive care of those who die in their custody.

Clinical history

The man was charged with murder in July 1990, aged 60, and initially remanded into Hull prison. On reception, he was seen by healthcare workers and his physical and mental health assessed. He stated that he had had an accident about a month before his reception and had been admitted to Hull Royal Infirmary. It is not clear from the clinical records exactly what injuries he had sustained in the accident, but he was worried about a cut on the back of his foot. He also said that he had seen a psychiatrist recently at the Royal Hallamshire Hospital, but it is not evident for what reason and no further explanation of this seems to have been undertaken.

At the end of November, he was transferred to HMP Leeds, as his trial had been committed to Leeds Crown Court. Healthcare staff at Leeds found him to be fit and well. He continued to refuse to talk much about his offence. He denied having been involved in the death of the person who he sometimes stayed with and pleaded not guilty at his pleas and direction hearing. In June 1991, he was found guilty of murder after his trial and sentenced to life imprisonment.

In August 1991, he was found fit to transfer to the lifer unit at HMP Wakefield. On arrival at Wakefield, he was again seen and assessed by healthcare staff and no problems were noted.

In January 1993, the man was seen for a routine health screening. The health screener concluded the physical and mental examination by saying that he was in 'Good mental / physical state for his age. Coping well'. In August that year, he was transferred to Albany prison on the Isle of Wight and again no physical or mental health problems were identified.

In January 1994, the man was admitted as a day case to St Mary's Hospital for a cystoscopy for possible kidney stones. There are no further entries in his clinical record until 1996 when he was seen for his Lifer Report, so it is not possible to establish how well he recovered from this surgical intervention or if he had a recurrence of the problems that precipitated his referral in the first place.

In September 1997, he was transferred to the elderly prisoner unit at HMP Kingston. He did not report any medical problems on his reception. In November 1999, he was found collapsed in the shower and subsequently taken to the Accident and Emergency Department at Queen Alexandra's Hospital, Portsmouth. It is not clear from the medical records what the cause of this episode was.

In March 2001, he had a 'giddy' spell. On examination, his clinical signs were found to be satisfactory and he was advised to rest. Bloods were taken for analysis. A month later, the medical officer, noted in his report for the Parole

Board that he had become ‘frail’ and was experiencing transient ischaemic attacks. The Medical Officer wrote that the man’s mental state was satisfactory and he was ‘co-operative’.

By March 2003, the man was showing signs of prostate problems. However, he declined the clinical examination to confirm the diagnosis. In August 2003, he was continuing to experience urinary problems and had become incontinent of urine. He was appropriately prescribed two courses of antibiotics in quick succession in an attempt to treat the problems.

The clinical record notes that in November 2003, he was diagnosed with hyperparathyroidism, with periods of confusion. He had not started any treatment at this stage, as a scan was awaited. He was also noted to have mild renal impairment.

By early February 2004, the man’s overall health had begun to deteriorate further. He felt generally unwell and was unsteady on his feet. He was referred to the Elderly Care Unit at the local hospital for a specialist opinion and clinical assessment. The Consultant Geriatrician, visited Kingston to see him on 21 April. The Consultant concluded that the man might have early signs of dementia and questioned if he might have some degree of temporal lobe epilepsy. He therefore arranged for him to have x-rays and also a CT scan. Over the following months, His health continued to deteriorate and he required additional help and support from staff to maintain his activities of daily living.

The subsequent CT scan revealed, that whilst there was no obvious space occupying lesion, there was evidence of some ischaemic changes and other damage, likely to have been secondary to previous trauma. There are no further entries in his clinical record until August.

Events leading up to the death

The man had become unwell during June and July 2004. He had begun to feel pains in his legs and sometimes refused to shower for fear of falling over. He was offered assistance, but declined. During late July, he had periods of vomiting and incontinence. He also experienced a loss of appetite.

On Thursday 5 August, it was noted in his medical record that he was incontinent of urine again and had left his food untouched. It was noted that he should see the doctor the following day.

At 7:20am on Friday 6 August, a Clinical Nurse Manager at Kingston looked in on him before beginning her medications round. This had become usual practice since he had become unwell and occasionally incontinent. The Nurse said "good morning" and he responded. At this stage he appeared fine and there was nothing unusual about his appearance.

Other members of healthcare staff arrived on the wing to assist with distributing and ordering medication ready for the doctor to sign off. Once the treatment round had come to an end, healthcare staff saw prisoners who required medical attention.

At approximately 9:00-9:15am, healthcare staff returned to their office. En route, the Nurse went across the corridor to check on him again (this had become her usual practice). This time she found him lying diagonally across his bed with his arms and legs "floundering". The nurse spoke to him but he was unable to provide an understandable reply. His words were slurred. The nurse called for a colleague to bring the emergency response bag.

The nurse took his blood pressure, pulse and temperature. She moved him into the recovery position and tried to get him to respond to questions and directives, such as "lift arm/leg" and "open/shut hands'. He was unable to respond and had no demonstrable strength in his left hand side.

The nurse diagnosed that he had suffered a stroke and called for an emergency response over her radio. Her colleague informed Security and the Orderly Officer whilst she stayed with the man. The ambulance arrived at 9:45am and the nurse briefed the paramedics on the situation.

The man was placed on to a stretcher at 9:55am. By 10.00am, a temporary release from prison form was completed and a security assessment made for the level of escort and restraint required. A Governor decided that only one officer would need to remain with him at the hospital and he would not be required to wear restraints. At 10:05am, he was put in the ambulance and taken to Queen Alexandra Hospital.

Two officers escorted the man to hospital. The ambulance arrived at Queen Alexandra's Accident and Emergency Department at 10.25am. It had not been confirmed at this stage why the man had collapsed. A consultant attended to him at 10:20am. During this initial assessment, he was diagnosed as having suffered a stroke and a suspected myocardial infarction (heart attack) and referred to a specialist unit.

At 11.15am, he was given an x-ray and admitted to Pink Ward. One of the escorting officers opened the bedwatch logbook. He remained with the man until 1.30pm whereupon the second escorting officer continued the bedwatch. During the afternoon, the man was taken for a scan and then moved to Blue Ward. At 3:20pm, a doctor confirmed that he had suffered a major stroke with a possible heart attack. It was noted that he could deteriorate rapidly.

The doctor came to see the man at 11:37am on 7 August, and confirmed that he had suffered a severe stroke. The plan at this stage was to make him as comfortable as possible and observe him for a few days. He was given an oxygen mask to aid his breathing. Checks were made to ascertain who was listed as his next of kin. Unfortunately, he had never given these details to the prison and he was unable to respond to questions.

He remained in a state of consciousness, but with no verbal response for a period of three days. During this time he was moved from a shared ward to a single room and back again on several occasions. The prison chaplain visited him daily.

The man became restless in the early hours of 10 August and was moved back into a single room. At 9.50am, he was attended to by four doctors who said that they would need to conduct more tests and that he was likely to be in hospital for the next six weeks. He was taken for a chest x-ray at 4.45pm. At 6.00pm, he became restless again and refused to use oxygen administered by a nasal tube but was settled by 7.00pm.

On 11 August, he was showing signs of minor improvements and, although still largely unresponsive, was making some noises and showing movement.

Hospital staff were unhappy at not being able to find his next of kin details and on 13 August contacted Kingston to see if more enquiries could be made. A request was made to the National Probation Service, Humberside, for any details they might have. During his sentence, he had refused to engage with the Probation Service but they did hold records on him. They found that he had a brother in Grimsby but had no address.

On 14 August, his condition began to worsen. He was given an injection of diamorphine for his pain at 4:00pm. Nursing staff became increasingly

concerned as he was having difficulty breathing on his own. A Senior Officer was on bed-watch duty at the time and rang the prison to inform them of the situation. A nurse sat with the man and held his hand to comfort him.

The man worsened over the next day as he continued to struggle with breathing on his own. It was noted by an officer in the bed-watch log on the afternoon of 15 August that it was believed he might pass away in the next few days. He was retaining water on both his left and rights-hand side and his breathing continued to be laboured.

On 17 August, he was awake for slightly longer than usual and appeared to be a little better than on previous days. He was lying on his left-hand side to allow his lungs to drain, but the level of water retention remained the same.

Over the next couple of days, he remained on his medication for pain relief and nursing staff continued to drain fluid from his lungs. He was made as comfortable as possible and a nurse regularly sat with him to hold his hand. This was a particularly sensitive gesture and provided additional comfort to the daily visits by the prison chaplain.

He passed away in his sleep at 4:30am on 20 August 2004.

Events after death

At 4:35am the bedwatch officer called the prison to inform them of the man's death. The Death in Custody contingency plan was put into action. The police arrived at the hospital at 5:40am to complete 'sudden death' forms and to speak with the nursing staff. The Area Office and press were notified at 8:00am. A second officer relieved the first officer of his duties at the hospital and stayed until the death had been certified. The Care Team at the prison were asked to make contact with the first officer later that day.

A doctor pronounced the man's death at 9:23am. His body was removed and taken to the mortuary at 11:15am.

A request was made to the Humberside Probation Area to try and find further details of any next of kin. This time they were able to confirm that the man had a son who, at the time, was in the custody of HMP Hull. Their records showed that his son had previously tried to make contact with his father in 1994, but the man did not wish to resume relations. On 22 August, contact was made with Hull to confirm that his son was in their custody and to inform him of his father's passing.

On 4 September, a Deputy Governor spoke with the son. He asked that his step-sister, be the prison's principal point of contact. The Deputy Governor spoke with the step sister and offered the prison's support in organising and contributing towards the funeral, an offer which was duly accepted. The man's property was returned to the family on 13 September. The funeral took place on 23 September.

Her Majesty's Coroner held an inquest at the Magistrates' Courts Building in Portsmouth on 14 April 2005. The jury returned a verdict of 'death by natural causes'. The cause of death was recorded as a stroke, cerebral infarction and ischemic heart disease.

Findings and conclusions

The clinical care the man received was at least as good as he could have expected in the wider community. I make no recommendations in respect of his clinical care.

There are gaps in the prison's incident reporting which should be addressed. There are no reports within the prison's records of the morning when he was found having suffered from a stroke apart from a small handwritten entry in his medical record that states that a nurse attended to him in his cell at 9:15am. Noting the gap in incident logging, my investigator contacted the nurse in January 2006 and asked that she provide a written statement of what happened that morning. Fortunately, the nurse was able to recall the events and provide a detailed account. However, it would have been better had she been asked to provide a statement immediately after the event.

The prison had been unable to trace the man's next of kin prior to his passing away. Attempts had been made, but proved difficult a he had chosen to cut himself off from his friends and family during his time in custody. However, Humberside Probation Area were able to help find next of kin details. On the day he died they provided details for his son, who was in the custody of HMP Hull. Yet despite having knowledge of the son's whereabouts, it took two days before Kingston informed him of his father's death.

Recommendations and Good Practice

- **The Governor of Kingston should remind staff of the importance of ensuring that next of kin are immediately informed of a death in custody.**

- **The decision to allow the man to be subject to just a singleton bedwatch and not made to wear restraints was both humane and correct given his poor condition.**

- **The Governor should commend those staff who undertook bedwatch duty for their consideration and care for the man.**

Response to the report

1. The Prison Service has accepted the recommendations put forward in this report.

Actions to be taken are:

- HMP Kingston's Death in Custody Contingency Plan will be amended in line with Prison Service Order 2710 in order to reinforce the importance of ensuring that next of kin are informed of a death as soon as possible.

- The Governor at HMP Kingston will commend staff during a Full Staff Briefing at the prison for their consideration and care of this man whilst undertaking bed watch duty.

2. The family received a copy of the draft report, but have not responded.