

The death in custody of a prisoner

HMP Elmley – 18 September 2004

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

May 2005

This is the report of an investigation into the circumstances of the death of a prisoner at HMP Elmley on 18 September 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. Another person from my office, carried out the clinical review.

The prisoner died at hospital, whilst under escort from HMP Elmley. The Post Mortem report concluded that he died of Bronchopneumonia. The man was serving an eight-year sentence at the time of his death.

My colleagues and I would like to extend our condolences to his family for their loss. I would also like to thank the Governor in charge of Elmley Prison's Healthcare Unit at the time of my investigator's visit, and the other members of staff who assisted us.

Stephen Shaw CBE
Prisons and Probation Ombudsman

May 2005

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Summary

The prisoner died at the age of 85 at hospital, having been admitted from HMP Elmley four days earlier. He was serving an eight-year sentence. 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 the prisoner's first time in prison. He spent most of his custody located in the prison Healthcare Unit. The prison describes him as a quiet, frail, elderly man, with good custodial behaviour. He was a likeable man who nurses "took under their wing".

The prisoner died of natural causes as a result of Bronchopneumonia.

The report makes no recommendations.

Background

HMP Elmley

Elmley is a purpose built local prison serving all courts in the county of Kent. The establishment opened in 1992 and includes a Category C unit of some 240 prisoners built in 1997 and a Vulnerable Prisoner Unit delivering the Sex Offender Treatment Programme. In addition, there is a Drug Rehabilitation Unit and Detox Programme.

Elmley is one of three prisons situated on the Isle of Sheppey.

The Prisoner

He was born in Boughton, Kent, in December 1919. He was 85 years old when he died on 18 September 2004.

On 17 November 2000, at Maidstone Crown Court, the prisoner was sentenced to an eight-year term of imprisonment for rape. The prisoner's victims had been members of his family and, apart from his son, who visited him about two years before his death, he had no contact with his family. On that visit about two years ago, the prisoner told his son that he felt extremely well cared for by the prison.

I have been unable to establish much about the prisoner's life before he entered custody.

This was the prisoner's first time in prison. He spent most of his time located in the prison Healthcare Unit. The prison describes him as quiet and frail. His custodial behaviour was good and he was liked. It was said that nurses took him "under their wing".

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 Elmley Prison, reviewed the documentation and had a very helpful discussion with the doctor and Governor in charge of the Healthcare Unit.

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 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 son and next of kin. This invited him to get in touch, if he wished, to make any comments or ask questions. The prisoner's son said that he felt his father was well cared for in the prison. Indeed that, being in prison, without doubt, prolonged his father's life.

A member of my staff carried out the clinical review.

Events Leading up to The Prisoner's Death

The prisoner was located in the prison's Healthcare Unit. He was infirm, fell regularly, had suffered strokes in the past, and had a heart condition.

At 1:10pm on 15 September, the prisoner was discharged from the prison to attend hospital with a chronic chest complaint. Following an examination, the prisoner was admitted to a ward for observation and treatment. He remained under prison escort.

At 11:30am on 17 September, the prison was told that the prisoner had had a heart attack, and that his condition was deteriorating.

At 8:00pm on 17 September, the prison was told that the prisoner had had a further heart attack and that, due to his poor condition, the doctors had decided that if he had a further heart attack, they would not attempt to resuscitate him. On receiving this information, a Principal Officer (PO) telephoned the prisoner's son, and told him of his father's poor condition.

The following day, the prison was told that the prisoner was very poorly and that he might not survive the day. On receiving this information, a Reverend was briefed and he attended the hospital for a pastoral visit.

At 6:24pm on 18 September, the prison was told that the prisoner had died at 6:15pm, with his son at the bedside.

Post Incident Response

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

As noted, the PO broke the news of the prisoner's condition to his son, whom he had named as his next of kin. This seems to have been appropriately and sensitively handled.

A doctor held a post mortem on 27 September 2004. He concluded the prisoner died of Bronchopneumonia.

Level of Compliance

Standards of healthcare in prison are intended to mirror those available in the outside community. The man'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 clinical reviewer 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. Elmley fully complied with this order.

Inquest

On 19 January 2005 the Coroner of Mid Kent and Medway, presided over the inquest into the prisoner's death. The inquest was short and concluded that he died of natural causes, in Medway Maritime Hospital, whilst under escort from Elmley Prison.

There were no issues or problems raised by the Coroner.

Findings

The prisoner died of natural causes as a result of Bronchopneumonia.

He and his son were happy about his treatment at the prison. During a visit, the prisoner told his son that he was well cared for by Elmley.

Conclusions

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

Recommendations

I have no recommendations to make in this case.