The death of a man

in custody at HMP Ranby in November 2004

Report by the Prisons and Probation Ombudsman for England and Wales

June 2005

This is the report of an investigation into the circumstances of the death in November 2004 of the man at hospital, whilst temporarily released from HMP Ranby.

The man's death was caused by lung cancer.

One of my investigators carried out the investigation and a clinician also from my office carried out the clinical review.

My colleagues and I would like to extend our condolences to the man's family for their loss. I would also like to thank the Deputy Governor of Ranby, who forwarded all relevant information to my investigator.

The clinical review questions whether Ranby was an appropriate location for the man. I share that view. However, I should also like to draw attention to the compassionate way the man and his son were repeatedly co-located. This showed a level of individualised care that reflects extremely well on the individual prisons and the Prison Service as a whole.

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Prisons and Probation Ombudsman **June 2005**

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Summary

The man died at the age of 77, in hospital, having been admitted ten days earlier. 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 man's first time in prison. He spent most of his custody located in the prison Healthcare Unit. The prison describes him as a polite man, with positive custodial behaviour.

The man died of natural causes as a result of lung cancer.

The report makes three recommendations.

Background

HMP Ranby

Ranby is a category C male adult training prison, near Retford in Nottinghamshire. It was converted in the early 1970's from its original use as an Army camp. While some old billets remain, purpose built accommodation has since been added.

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 the man's case, I decided that the circumstances did not require a full investigation. I did so after my investigator contacted Ranby Prison, reviewed the documentation and had a very helpful discussion with the Deputy Governor.

My investigator wrote to 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 man'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 man's next of kin, his younger son, inviting him to get in touch, if he wished, to make any comments or ask questions. The man's younger son wrote to my investigator and provided a very useful chronology of events and background information. Information supplied has been considered in this investigation.

One of my clinicians carried out the clinical review.

Events leading up to the man's death

Following sentence in 2004, the man was taken to the local prison. He was subsequently transferred to HMP Ranby on 16 July 2004. This was despite the fact that Ranby does not have 24-hour Healthcare Centre cover.

Following a recurrent and deteriorating complaint of shortness of breath, in October 2004 the man was admitted to hospital for assessment and an ECG. His family was not formally told that this had happened. However, they found out that evening in a telephone conversation from his son.

The family saw the specialist in charge of the man's case on 27 October. The family was told that the man had cancer of the lung that was quite well advanced. A junior doctor indicated that he might have only weeks to live.

On 28 October, the family contacted the prison and spoke to the Governor. They discussed the possible early release of the man from custody due to his condition. A meeting was arranged for 2 November to discuss this further.

The hospital discharged the man to Ranby on 28 October. He was taken to hospital again on 30 October for pain relief but was not kept in.

At the scheduled meeting on 2 November, the family was relieved to find that the Governor was working towards releasing the man. Following the meeting, the prison regularly contacted the family and kept them informed of progress.

The medical facilities at Ranby were judged as not adequate for the man's needs. On 4 November, he was transferred to the healthcare centre at HMP Lincoln that has 24-hour inpatient facilities consistent with his needs. His son was transferred with him. Shortly after his arrival, the man was admitted to hospital. Lincoln released him on a compassionate temporary release licence.

On 9 November 2004, the prison doctor, from Ranby wrote to the Home Office, in support of an application for the man's early release, on compassionate grounds.

On that day, the man was transferred to hospital where a further complication of pneumonia was diagnosed. The prison considered the man's condition had deteriorated to such an extent that he posed no risk of escape and released him from custody, on a compassionate temporary licence.

Responsibility for the man was transferred back from Lincoln to Ranby, who maintained regular contact with the hospital and the family.

The man died in hospital later that month.

Post Incident Response

All the necessary information was gathered together for the purposes of this investigation.

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 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 man.

I note, however, that while entries in medical records were fairly good, some were difficult to read and they were not always signed.

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

Findings and Conclusions

The man had a number of medical problems. Prior to his being given a prison sentence, he was found to have a shadow on one of his lungs. The man died of natural causes as a result of lung cancer.

Apart from the initial notification, when the prison neglected to tell the family the man had been admitted to hospital, the family liaison arrangements appear to have been effective.

Most of the man's health problems whilst in prison were attributed to the lung cancer. The medical and nursing staff in the various establishments cared for the man's needs and his treatment and care appeared to be appropriate. However, I consider that the man would have benefited from an earlier transfer to a prison with 24-hour inpatient facilities.

A request was sent to the Home Office in an effort to obtain an early release on compassionate grounds. Regrettably, the man died before any further action could be taken. I make no formal recommendation on this point, as I have not investigated it further. However it is manifest that any consideration of release on compassionate grounds needs to be conducted urgently.

Recommendations

I make the following recommendations: -

- Healthcare staff should be reminded that entries in medical records should be signed and legible.
- Patients requiring 24-hour medical and nursing assessment and care should be located to establishments, which have a 24-hour inpatient facility.

Good Practice

It was very good practice that the man and his son were repeatedly co-located. This demonstrated kindness and sensitivity in the best tradition of public service.