

**Investigation into the circumstances surrounding the death in custody of a
prisoner on 25 March 2005 at HMP Woodhill**

Report by the Prisons and Probation Ombudsman for England and Wales

June 2005

This is the report of an investigation into the circumstances surrounding the death of a male prisoner on 25 March 2005 at HMP Woodhill. He was an elderly man whose death appears to have been entirely natural.

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 been passed to me to bring independence and greater consistency to the task.

The investigation was conducted by one of my investigating officers. My clinical reviewer carried out an independent clinical review.

My colleagues and I would like to extend our condolences to the prisoner's family for their loss.

One of my Family Liaison Officers has contacted the prisoner's ex- wife, and she told us that she did not want any involvement in the investigation.

This report makes no recommendations. However, I have been pleased to note the care that the prisoner received from all staff at Woodhill. This comes through very strongly in the clinical review and I hope the Governor will make this known to his colleagues.

Contents

	Page
Summary	4
Investigation Methodology	5
Background	6
HMP Woodhill	6
The prisoner	6
Events prior to the prisoner's death	7
Events of 25 March 2005	7
Level of Compliance	9
Findings and Conclusions	10
Recommendations	11
Good Practice	11

Summary

The prisoner died on 25 March 2005 at the age of 75, in the healthcare wing of HMP Woodhill. He was on remand facing two charges of assault. This was not his first time in prison. He was described as an obstructive man who was unable to deal with his most basic needs such as showering. The healthcare staff would help him to keep clean.

He died of natural causes as a result of Bronchopneumonia caused by chronic obstructive airway disease. His death was not connected to the fact that he was in prison or to the level of care that he received there.

This report makes no recommendations, but commends the healthcare staff and unit staff for their care and treatment of the prisoner.

Investigation Methodology

The prison sent copies of the records relating to the prisoner's death to my office on 5 April 2005, at the request of my investigator. On 6 April 2005, my clinical reviewer visited the prison and met with the Head of HealthCare and the healthcare management team. She also reviewed the available clinical documentation. A further visit to the prison took place on 18 April 2005, when they met with Governor, Chair of the Independent Monitoring Board (IMB), Head of Healthcare, and POA Branch Secretary. They were briefed on the nature and scope of the investigation and additional documentation was collected at this time.

Prior to attending the prison, notices to staff and prisoners, terms of reference and the governor's notification letter were sent to the prison liaison officer, for distribution and to be displayed around the establishment. These announced the investigation and invited staff and prisoners to share with my investigator any concerns or views they wished to express.

I received a number of letters from prisoners, but after a closer look at the contents it became apparent they were about complaints that were not related. The complaints that were about healthcare and treatment problems were passed to the Head of Healthcare at Woodhill to investigate internally. My clinical reviewer met with one of the complainants at length and there was no evidence to substantiate the claims made.

My clinical reviewer carried out a review of the management of the prisoner's health needs while in custody.

One of my Family Liaison Officers has written to the prisoner's ex wife to establish contact with his family. She informed her that she did not want any involvement with this investigation.

Background

The Prisoner

The prisoner was born in February 1930. He was 75 years old when he died. He had been married for 25 years. The couple were divorced in 1999. At the time of his death he was on remand at HMP Woodhill on two assault charges, waiting to return to court on 29 March 2005.

This was not his first time in prison. He served his first sentence in January 1955 for assault and actual bodily harm. Between 1964 and 1990 he incurred a further 10 charges for offences of a violent nature or with a threat of violence, resulting in further custodial sentences.

In November 1994, he was convicted and sentenced to 10 years in prison. He was released in March 2001 on a non-parole licence. He was recalled to custody in May 2001 for breach of this licence. He was finally released from prison in July 2004 at the completion of his sentence.

On 4 March 2005, he was remanded back into custody by Aylesbury Magistrate's Court on two charges of assault.

The prisoner had suffered from poor physical health for a number of years and was known to have a significant number of medical conditions. Clinically, he was difficult to manage as he was often non-compliant with his medication and treatment.

HMP Woodhill

HMP Woodhill is a core local within the High Security Estate. It holds adult male prisoners, both sentenced and unsentenced, including young offenders. It was built in 1992.

Woodhill is only one of two prisons with a Close Supervision Centre designed to hold some of the most dangerous prisoners in the system.

Events prior to the prisoner's death

The prisoner arrived at Woodhill on 4 March 2005. He was subsequently moved from normal living accommodation in house block 4b to the Healthcare Centre, because his health and general wellbeing were causing concern. This was so that constant observation and medical help could be given.

He was receiving treatment for: -

- Bronchitis Emphysema
- Incontinence of Urine
- Varicose Eczema

During his time at Woodhill, he was unable to attend to his personal needs and would refuse to help take care of himself. He would become difficult and decline to take a bath or shower even when assisted by the healthcare staff. He wore poorly fitting incontinence pads, urine soaked and stained with faecal matter, which he refused to change.

When he arrived at the Healthcare Centre the staff opened three individual care plans to ensure that the clinical and hygiene needs were met appropriately. This medical care carried on through the next day.

In the evening of 24 March, he was seen to be breathing fast and his breathing was laboured. The nursing staff gave him oxygen and a nebuliser and he then settled down.

Events of 25 March 2005

On the morning of 25 March, at approximately 3.10am, the prisoner was seen to have lowered himself onto the floor of his cell. Staff entered his cell to assist him back into his chair, as he preferred to sleep there rather than on his bed. Once the medical checks had been completed, he was given four litres of oxygen, and at 4.00am his breathing had improved.

He refused both breakfast and lunch. However, he was drinking water and did take his evening meal. At 7.00pm, his breathing was very rapid and shallow and he was administered oxygen for 15 minutes until his breathing slightly improved. It was at this point that the healthcare staff informed the doctor who instructed that the prisoner was to be administered:

- | | | |
|----------------|--------|----------------|
| • Prednisolone | 40mg | Statutory Dose |
| • Salbutamol | 5mg | Statutory Dose |
| • Atrovent | 500mcg | Statutory Dose |

- Erythromycin 250mg 4 Times Daily.

The duty nurse arrived on the Healthcare Centre at approximately 8.56pm, and went to the prisoner's cell to check on his condition. She could see that he was having difficulty and went straight to the office to contact the duty Principal Officer, to gain access to the cell so that medical help could be given.

A night officer arrived at approximately 9.00pm to unlock the cell. He then assisted the nurses to move the prisoner onto the bed. The nurses then checked his pulse and blood pressure and no reading could be found. They then began Cardio Pulmonary Resuscitation (CPR) at a rate of 2 breaths to 15 compressions. Oxygen was given and at 9.07pm the control room was informed that an ambulance was urgently required.

The control staff immediately called for an ambulance, as well as contacting the Duty Governor and the on call doctor. At this time the prisoner's watch was removed and secured in a sealed property bag.

The nurses continued to carry out CPR and to check for pulse and blood pressure until the paramedics arrived at 9.28pm and took over. One of the nurses gave the paramedics all relevant information and CPR continued.

At approximately 9.33pm, CPR was stopped to allow the paramedics to use their defibrillator and to administer medication. At 9.45pm, the nurses continued the CPR. At 9.54pm, the paramedics confirmed that the prisoner had died.

At 10.00pm, the Duty Governor arrived at the cell. The paramedics left the cell at 10.05pm and left the prison. The prisoner's property was removed from the cell and placed into sealed bags, and the cell was sealed awaiting the arrival of the police.

The police arrived at the prison at 10.40pm and confirmed that the Coroner's Officer need not attend the prison. The police officers were taken to the Healthcare Centre and into the cell.

The doctor arrived at the prison at 11.03pm. He confirmed the death at 11.05pm.

The Roman Catholic priest contacted the prisoner's niece to inform her that he had died. An address for his ex-wife was not available. The niece informed the prisoner's ex-wife and they both confirmed that they did not want any involvement in the investigation.

Level of Compliance

Standards of healthcare in prison are intended to mirror those available in the outside community. The prisoner's records indicate that he was given an appropriate level of care, and his medical and social needs were recognised and dealt with appropriately.

Prison Service Order 2710 sets out what action must be taken following a death in custody. Woodhill fully complied with this Order.

All necessary information was collated for the purposes of this investigation.

Findings and Conclusions

The prisoner received appropriate treatment and clinical interventions for a number of clinical conditions including:

- Bronchitis Emphysema
- Incontinence of Urine
- Varicose Eczema

Healthcare staff opened appropriate individual medical care plans to ensure that he received the correct treatment and level of care.

He was a difficult man who was unable to attend his own needs by keeping himself clean. He regularly refused to shower or take a bath even when assisted by healthcare staff. I believe that the staff both in the Healthcare Centre and on the accommodation units cared for him with compassion and sensitivity in difficult circumstances.

Recommendations

I make no recommendations in this case

Good Practice

The prisoner's treatment and care whilst in custody at Woodhill were managed well. The help he received from both unit and healthcare staff is to be commended.

