Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Igor Vujkovic, a prisoner at HMP Maidstone, on 11 May 2024

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Igor Vujkovic died of epilepsy on 11 May 2024 at HMP Maidstone. He was 25 years old. I offer my condolences to Mr Vujkovic's family and friends.

The clinical reviewer concluded that the care Mr Vujkovic received at Maidstone was not equivalent to that which he could have expected to receive in the community. Although Mr Vujkovic told staff when he arrived that he had epilepsy, he was not referred to a GP nor was a care plan put in place.

Some prison staff were unaware that Mr Vujkovic had epilepsy. This potentially led to a delay in them realising that he had had a seizure when they saw him on the floor of his cell. Maidstone should improve information sharing between healthcare and prison staff so that wing staff are aware of prisoners with potentially life-threatening medical conditions.

Mr Vujkovic was in a single cell so no one was able to raise the alarm when he had a seizure. I am aware that some prisons consider it best practice to provide a shared cell to prisoners with epilepsy but this was not the case at Maidstone. I recommend that there is a regional policy on cell sharing for prisoners with epilepsy, which could help save lives.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Adrian Usher
Prisons and Probation Ombudsman **January 2025**

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Summary

Events

1. On 17 February 2023, Mr Igor Vujkovic was sentenced to five years and six months in prison for drug offences. On 17 April, he was moved to HMP Maidstone.

2. When he arrived at Maidstone, Mr Vujkovic told the reception nurse that he had epilepsy. He said he did not take medication and managed it in the community by using cannabis.

3. Mr Vujkovic was initially allocated a shared cell but was later moved to a single cell.

4. On 19 December, Mr Vujkovic saw a GP at Maidstone and said he had had three seizures in less than 20 days. Mr Vujkovic said he was not keen on taking anticonvulsants, so the GP prescribed an antidepressant to manage his stress levels.

5. Between 29 December and 29 March 2024, Mr Vujkovic did not collect his medication. He did not report any more seizures.

6. At approximately 6.50am on 11 May, during a routine check, an officer saw Mr Vujkovic lying on the floor of his cell. As she could not see Mr Vujkovic properly, the officer asked her colleague to also look through the observation panel. The second officer thought he could see Mr Vujkovic breathing so they both continued with their checks. When asked at interview whether they knew Mr Vujkovic had epilepsy, one said they did and the other said that staff on the wing did not know.

7. At approximately 8.49am, an officer opened Mr Vujkovic's cell and saw him lying on the floor. He called his name but Mr Vujkovic did not respond. The officer called a medical emergency code.

8. The prison called an ambulance while officers and healthcare staff tried to resuscitate Mr Vujkovic.

9. Paramedics arrived at approximately 9.08am. They assessed that Mr Vujkovic had been dead for some time and at 9.10am, declared him deceased.

10. The post-mortem found that the cause of Mr Vujkovic's death was sudden death in epilepsy.

Findings

11. The clinical reviewer concluded that Mr Vujkovic's care was not equivalent to that which he could have expected to receive in the community. Despite Mr Vujkovic telling the reception nurse when he arrived at Maidstone that he had epilepsy, he was not referred to a GP and no care plan was created for him. When Mr Vujkovic failed to collect his antidepressant medication multiple times, there was no follow-up or review.

12. Prison staff gave varying accounts of whether they knew Mr Vujkovic had epilepsy and how they had been informed. There did not appear to be a clear, well-

understood process for healthcare staff to share information with prison staff about prisoners with serious, life-threatening conditions such as epilepsy.

13. We are aware that in some prisons, cell sharing is advised for prisoners with epilepsy. The Head of Healthcare at Maidstone told us at interview that he did not agree with this as he considered it unreasonable to expect a cellmate to be responsible for another prisoner's care. We consider that there should be a consistent position on the appropriateness of recommending shared cells for prisoners with epilepsy. While there may be circumstances in which it would be inappropriate to expect a prisoner to share, it is also the case that a prisoner having a seizure is unlikely to be able to raise the alarm whereas a cellmate could, which could save a life.

Recommendations

- The Head of Healthcare should ensure that prisoners with epilepsy are referred to a doctor, placed on a long-term care pathway and have a care plan.
- The Head of Healthcare should establish a system for medication reviews with prisoners who fail to collect their medication on several occasions.
- The Governor and Head of Healthcare should review their information sharing protocol for prisoners with serious medical conditions such as epilepsy.
- The Commissioner for Health and Justice NHS England South East should work collaboratively with commissioned healthcare providers in custodial settings to formulate a regional approach and implement a process on when to recommend cell sharing for prisoners with life-threatening long-term conditions such as epilepsy.

The Investigation Process

14. HMPPS notified us of Mr Vujkovic's death on 11 May 2024.

15. The investigator issued notices to staff and prisoners at HMP Maidstone informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

16. The investigator obtained copies of relevant extracts from Mr Vujkovic's prison and medical records.

17. The investigator interviewed three members of staff at Maidstone on 1 July. She interviewed two further members of staff on 5 and 16 July by video call.

18. NHS England commissioned an independent clinical reviewer to review Mr Vujkovic's clinical care at the prison. She conducted joint interviews with the investigator on 1 and 5 July.

19. We informed HM Coroner for Kent and Medway of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

20. The Ombudsman's office contacted Mr Vujkovic's sister and his friend to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond.

21. We shared our initial report with HMPPS and the prison's healthcare provider, Oxleas NHS Foundation Trust. They found no factual inaccuracies. They provided an action plan which is annexed to this report. We agreed to an amendment to the fourth recommendation which is reflected in this report.

Background Information

HMP Maidstone

22. HMP Maidstone is a category C prison in the southeast of England. It holds foreign national offenders in a mixture of single and double cells. Oxleas NHS Foundation Trust provides healthcare services.

HM Inspectorate of Prisons

23. The last full inspection of Maidstone was in October 2022. Inspectors reported that many aspects of health care services were reasonably good and clinics were running well with relatively low non-attendance rates. Improvement had been made to the management of patients with long-term conditions. Regular clinics were held and staff had received additional training. Patients had care plans, most of which were individualised and appropriate for the patient's need.

Independent Monitoring Board

24. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 28 February 2023, the IMB reported that overall Maidstone was a safe prison. They found the prison was well run, prisoners, for the most part enjoyed a good relationship with staff and each other and violence continued to remain low. They found that Oxleas NHS Foundation Trust provided individualised care plans and regular clinics for prisoners with long-term conditions.

Previous deaths at HMP Maidstone

25. Mr Vujkovic was the fourth prisoner to die at Maidstone since May 2021. There are no similarities between the findings in our investigation into Mr Vujkovic's death and the findings from our investigations into the previous deaths.

Key Events

26. On 17 February 2023, Mr Igor Vujkovic, a Croatian national, was sentenced to five years and six months in prison for drug offences. On 17 April, Mr Vujkovic was moved to HMP Maidstone.

27. During his reception health screen, Mr Vujkovic told the reception nurse that he had epilepsy and that he managed it in the community by using cannabis. He said he was not prescribed medication and that his last seizure had been over three months before. Mr Vujkovic gave consent for his medical information to be shared. The reception nurse did not refer him to a GP to discuss his epilepsy or place him on a long-term care pathway.

28. Mr Vujkovic was assessed as standard risk for cell sharing. He was initially located in a shared cell on Weald Wing but on 3 November, he was moved to a single cell on Thanet Wing.

29. Mr Vujkovic saw a GP on 19 December and said that as he no longer had access to cannabis, he had had three seizures in less than 20 days. Mr Vujkovic said they were due to stress and they usually happened at night. He said he was not keen on taking anticonvulsants, so the GP prescribed mirtazapine (an antidepressant used to treat symptoms of depression and anxiety) to manage his stress. The GP made no further plans for Mr Vujkovic's care to be reviewed.

30. Between 29 December and 29 March 2024, Mr Vujkovic did not collect his medication. There is no evidence from the medical records that staff followed up with Mr Vujkovic.

31. Mr Vujkovic was due to be deported to Croatia on 20 May. Healthcare staff produced an epilepsy care plan on 25 April and shared it with the prison operations and removals team. The care plan said that Mr Vujkovic had last had a seizure over a month before and healthcare staff should be informed of all seizures. There is no evidence in the records that healthcare staff were informed of any further seizures.

Events of 11 May

32. At approximately 6.50am on 11 May, during the morning roll check, Officer A looked through the observation panel into Mr Vujkovic's cell and saw him lying on the floor. She saw he was lying with his head underneath the sink area and his feet pointing towards the door. Officer A thought she could see Mr Vujkovic breathing but found it difficult to see properly because of his position in the cell.

33. Officer B was nearby so Officer A asked him to come over and double-check on Mr Vujkovic. When Officer B looked through the observation panel, he thought he could see Mr Vujkovic breathing. Both officers then continued with the roll check.

34. During interview, Officer B said that he and Officer A had both tried to get a verbal response from Mr Vujkovic but had been unsuccessful. In contrast, when interviewed, Officer A said that neither she nor Officer B tried to get a verbal response from Mr Vujkovic. Officer B told the investigator that he was aware that Mr Vujkovic had epilepsy because his name and condition were listed in the wing office,

on the list of prisoners with PEEPs (Personal Emergency Evacuation Plans - for a person who may need assistance to evacuate a building or reach a place of safety in the event of an emergency). Officer A said that she was unaware that Mr Vujkovic had epilepsy and that Mr Vujkovic was not listed on the PEEP board. As far she was aware, no staff on the wing were aware that Mr Vujkovic had epilepsy.

35. Officer C was responsible for unlocking prisoners' cells on Mr Vujkovic's wing that morning. When he unlocked Mr Vujkovic's cell at approximately 8.49am, he saw him lying on the floor. He called his name but Mr Vujkovic did not respond. He called the Supervising Officer (SO) over, who immediately entered the cell.

36. The SO called Mr Vujkovic's name several times but did not get a response. He instructed Officer C to call a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties that alerts healthcare staff and prompts the control room to call an ambulance immediately). In interview, the SO said that he was aware that Mr Vujkovic had epilepsy because of a conversation they had when he was on Weald Wing.

37. The control room called 999 but they were unable to provide the call handler with the required information, such as whether the patient was breathing. The control room put the call handler through to the wing staff who were then able to provide the information required. This delayed the ambulance being dispatched by around four minutes.

38. The SO continued to call Mr Vujkovic's name and approximately one minute after the code blue was called other prison staff arrived. They turned Mr Vujkovic onto his back, checked for signs of life and started CPR. In his statement, the SO described Mr Vujkovic's body as showing signs of rigor mortis and hypostasis (blood pooling). (These changes take place around two hours after death).

39. Healthcare staff arrived promptly and continued CPR. They also commented that there were physical signs that Mr Vujkovic was dead.

40. Paramedics arrived at approximately 9.08am and declared Mr Vujkovic deceased at 9.10am.

Contact with Mr Vujkovic's family

41. On 11 May, the prison appointed a family liaison officer (FLO).

42. The FLO called Mr Vujkovic's next of kin, his mother, in Croatia at 12.10pm to inform her of his death. At Mr Vujkovic's mother's request, the FLO then called Mr Vujkovic's friend who was in the UK.

43. Later that day, the FLO spoke to Mr Vujkovic's family again and it was agreed that Mr Vujkovic's sister would be the main point of contact between the prison and the family.

44. The prison contributed financially to Mr Vujkovic's funeral in line with national guidance.

45. The FLO liaised with Mr Vujkovic's friend about returning Mr Vujkovic's belongings to his family.

Support for prisoners and staff

46. After Mr Vujkovic's death, a debrief was held for the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising and to offer support. Five of the prison officers involved were sent home for the rest of the day.

47. The chaplain visited prisoners who were friends of Mr Vujkovic to tell them of his death and to offer support.

Post-mortem report

48. The post-mortem report concluded that Mr Vujkovic's cause of death was sudden death in epilepsy.

Findings

Clinical care

49. The clinical reviewer concluded that Mr Vujkovic's care was not equivalent to that which he could have expected to receive in the community.

50. Despite Mr Vujkovic telling the reception nurse when he arrived at Maidstone that he had epilepsy, he was not referred to a GP, was not placed on a long-term condition pathway and a care plan was not created to support the management of his epilepsy. He saw the GP at Maidstone eight months later, reporting an increase in seizures. The GP also did not take steps to support the management of Mr Vujkovic's condition. We recommend:

    The Head of Healthcare should ensure that prisoners with epilepsy are referred to a GP, placed on a long-term condition pathway and have a care plan.

51. Mr Vujkovic was prescribed medication to help manage his stress levels after he reported having three seizures at night. However, when he failed to collect his medication multiple times, there was no follow-up or review. We recommend:

    The Head of Healthcare should establish a system for medication reviews with prisoners who fail to collect their medication on several occasions.

Management of prisoners with epilepsy

Information sharing

52. We consider that prison staff should be made aware of prisoners who have a serious, potentially life-threatening medical condition, such as epilepsy, and particularly so if it is poorly controlled. Prison staff would then be more alert to changes in the prisoner's behaviour and more likely to carry out a welfare check or ask healthcare staff to check on them if there was any cause for concern. At his healthcare reception screening, Mr Vujkovic gave consent for his medical information to be shared so there was no reason why prison staff should not have been made aware of his epilepsy. However, prison staff gave varying accounts of whether they knew Mr Vujkovic had epilepsy and how they had been informed.

53. The SO said he knew from a conversation he had had with Mr Vujkovic on a previous wing. Officer B said he knew from the PEEP board, though it was disputed by Officer A that Mr Vujkovic was listed. Our understanding of the purpose of a PEEP, a plan to assist individuals who may have difficulties evacuating a building in an emergency, would not ordinarily apply to a prisoner with epilepsy and in our view, would seem an ineffective way of notifying wing staff of prisoners with serious, potentially life-threatening medical conditions. It appears that there was not a clear, well-understood process for healthcare staff to share information about prisoners with serious medical conditions with prison staff.

54. We recommend:

The Governor and Head of Healthcare should review their information sharing protocol for prisoners with serious medical conditions such as epilepsy.

Cell sharing

55. We are aware that in some prisons, it is considered best practice to give prisoners with epilepsy a shared cell so that during periods when prisoners are locked in their cell, their cellmate can raise the alarm if necessary. When we asked the Head of Healthcare at Maidstone about the possibility of prisoners with epilepsy being allocated a cellmate, he said it would not be appropriate to ask another prisoner to take responsibility for someone else's care.

56. We consider that there should be guidance, at a regional level, about best practice for managing prisoners with life-threatening long-term conditions such as epilepsy, including the appropriateness of cell sharing. We recommend:

The Commissioner for Health and Justice NHS England South East should work collaboratively with commissioned healthcare providers in custodial settings to formulate a regional approach and implement a process on when to recommend cell sharing for prisoners with life-threatening long-term conditions such as epilepsy.

Governor to note

Delay in checking on Mr Vujkovic's welfare

57. We consider that Officer A and Officer B should have entered Mr Vujkovic's cell to check on him when they carried out the 6.50am roll check. We are aware that a roll check is primarily a count of prisoners and not a welfare check, so a verbal response is not normally needed. However, if the staff member notices anything untoward, they should satisfy themselves that there are no concerns about the prisoner's welfare. We would expect them to try to get a verbal response from the prisoner in those circumstances and in the absence of a verbal response, to go into the cell to check on the prisoner.

58. Officer A said that neither she nor Officer B tried to get a response from Mr Vujkovic. Officer B said they did but that Mr Vujkovic did not respond. They should have gone into the cell at this point to check on Mr Vujkovic. Even if they thought they saw him breathing, his position on the floor of his cell and lack of response should have prompted the officers to go into the cell. We cannot say if it would have made any difference to the outcome as there is a strong possibility that Mr Vujkovic was already dead at 6.50am, but we bring this issue to the Governor's attention.

Emergency response

59. There was a delay in the ambulance being despatched to the prison as when control room staff called for the ambulance, they were unable to answer the standard question, "Is the patient breathing?". They put the call through to Thanet Wing instead, which caused a four-minute delay. It made no difference to the outcome for

Mr Vujkovic as he was dead when found, but we bring this to the Governor's attention.

60. We are aware of ongoing work, commissioned by the Director General of HMPPS and in collaboration with health partners, to ensure that those responsible for calling an ambulance have sufficient information to do so without delay and to give accurate information about the condition of the patient.

Inquest

61. At the inquest, held from 24 February to 4 March 2025, the jury concluded that Mr Vujkovic died from natural causes, due to sudden unexpected death in epilepsy.

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