Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Solomon Bamidele, a prisoner at HMP Pentonville, on 16 November 2023

A report by the Prisons and Probation Ombudsman

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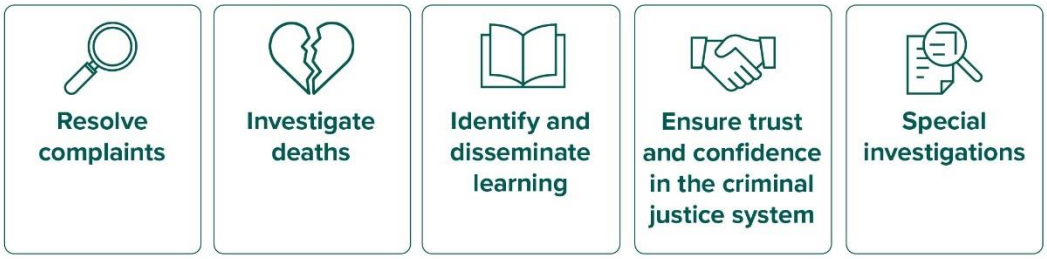
OUR VISION

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

1. 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.

2. 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.

3. On 4 October 2022, Mr Solomon Bamidele (incorrectly spelt Soloman in some records) was remanded to HMP Pentonville. On 18 August 2023, he was sentenced to life imprisonment for murder, with a minimum period to serve of 23 years. Mr Bamidele died of epilepsy on 16 November. He was 26 years old. We offer our condolences to Mr Bamidele's family and friends.

4. The Ombudsman's office wrote to the solicitors acting on behalf of Mr Bamidele's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They asked questions about the investigation procedures and the evidence gathered, particularly CCTV and body worn camera footage, and these were addressed in correspondence.

5. NHS England commissioned a clinical reviewer to review Mr Bamidele's clinical care at HMP Pentonville.

6. The PPO investigator investigated the non-clinical issues relating to Mr Bamidele's care. We did not find any non-clinical issues of concern.

7. The clinical reviewer concluded that the clinical care Mr Bamidele received at Pentonville was not equivalent to that which he could have expected to receive in the community. She found that the management of his epilepsy did not adhere to national guidelines, as it was not structured, there was no care plan and no provision to review his condition. We make the recommendations below, but the Head of Healthcare will want to consider the clinical review in its entirety.

8. We sent a copy of our report to Mr Bamidele's next of kin. He did not notify any factual inaccuracies.

9. The initial report was shared with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies and accepted the recommendations.

   - The Head of Healthcare should ensure that prisoners diagnosed with epilepsy are managed in line with national guidance.

   - The Head of Healthcare should review the management of prisoners with diagnoses linked to recurrent seizures to ensure that:

     healthcare staff create detailed individual care plans, including reporting seizures, medication issues and emergency responses and decisions not to provide follow up care are taken with appropriate consultation; and

prisoners who experience recurrent unprovoked seizures are regularly discussed at the Multi-Professional Complex Case Clinic (MPCCC).

Inquest

10. At an inquest held on 23 June 2025, the Coroner concluded that Mr Bamidele died of natural causes.

Adrian Usher
Prisons and Probation Ombudsman **December 2024**

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