Investigation into the circumstances surrounding the death of a man at HMP Parc in May 2005

Prisons and Probation Ombudsman for England and Wales

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This report concerns the circumstances surrounding the death of a man at HMP and YOI Parc on 30 May 2005. The man was a 32 year old single man, born and brought up in South Wales. He was serving a four year sentence for drug offences. At the age of 15, he moved to a new area with his mother where he was drawn into the culture of drugs and alcohol. The man had very little schooling and found reading and writing difficult. He suffered with epilepsy from a young age and rarely had paid employment. He received a disability living allowance prior to his imprisonment.

In custody, he was perceived as a quiet man, keeping his own company much of the time. Some fellow prisoners described him as vulnerable and it appears he was the butt of unkind behaviour, verging on bullying. I was concerned that officers may have failed to recognise such behaviour as bullying and consequently did not intervene. The Director has promised to take steps to ensure staff training addresses this deficiency.

The man's epilepsy was recognised and treated by prison medical and nursing staff throughout his time in custody, in Swansea, Erlestoke and Parc. His seizures were unpredictable and usually came without warning. At Parc he signed a medical disclaimer which stated that despite being made aware that he should be in a shared cell, he chose to have a single cell. The man was found dead in his cell on Bank Holiday Monday, 30 May. Resuscitation was attempted by the prison nurses but the paramedics declared life extinct when they attended.

The outcome of the initial post mortem examination on 2 June was inconclusive, pending further investigations. The pathologist at the Wales Institute of Forensic Medicine at Cardiff University finally received two toxicology reports, one on 26 January 2006 and one on 10 February. He completed his conclusive post mortem report on 14 February, concluding that the cause of death was epilepsy. Unfortunately due to a serious computer failure, the report was not retrieved and despatched to the Coroner until 5 May. The post mortem blood tests revealed relatively low concentrations of anti-epileptic medication raising questions over the man's compliance with his medication. However my investigation found only reports that the man was knowledgeable about his illness and assiduous in collecting his medication from the nurses.

I would like to extend my condolences to the man's family for the tragic loss of him at such a young age. I would like to thank the drug strategy manager and the residential manager who ably assisted my investigator in her investigation and the Director of Parc for his attention to issues raised during my investigation. I am also grateful to the Coroner's Officer, Bridgend and Glamorgan Valleys for his liaison over the post mortem report.

I make eleven recommendations arising from my investigation of the man's sad death. I am pleased to note that my first nine recommendations have all been accepted and my remaining two recommendations have been partly accepted. I attach to this report an action plan received by my office in October 2006.

STEPHEN SHAW CBE **November 2006**

Contents

Summary

The Investigation

Parc prison

Events prior to 30 May 2005

Events of 30 May

Events after the man's death

Clinical review

The family's concerns

Conclusions and recommendations

Action Plan received on 31 October 2006

Summary

1. The man was born on 21 August 1972 and grew up in Wales, dropping out of school at 14, with very poor literacy and numeracy skills. When he was 15 the man and his mother moved to live in different area. At the age of 15 he began to misuse alcohol and drugs, escalating to intravenous heroin use at 17. He became immersed in the drug culture and lost touch with his family. Some time later he returned to Wales. The man suffered from epilepsy from the age of 15 and rarely undertook paid work. Before going to prison he was receiving a Disability Living Allowance.

2. During 2003 the man made positive progress in complying with a Drug Treatment and Testing Order (DTTO) for about ten months but breached it by getting involved in drug dealing and recommencing heroin use. The man told a probation officer that he had been hoping to complete the DTTO and return to live with his mother in a different area.

3. The man was 31 when he went into HMP Swansea, on remand for possessing and supplying class A drugs, on 3 December 2003. It was his first experience of prison custody although he had incurred 11 previous convictions, mainly for shoplifting. At first he seemed to find imprisonment difficult. He faced a number of adjudications in early 2004 for breaking prison rules.

4. He was convicted on 29 March and sentenced to four years imprisonment on 29 April. In August he progressed to Erlestoke, a training prison in Wiltshire. He required a hospital admission after an epileptic seizure on 12 August. He slipped his handcuffs at Salisbury hospital and was charged with disobeying an order. From the records it seems he was disorientated after the fit and not aware of his actions. The man was returned to Swansea because he required 24 hour health care. From their reports, it appears that staff at Swansea found the man “lazy, childish and immature”. He was warned to “keep a low profile”.

5. On 2 February 2005 the man transferred to Parc where he was resident on A4 wing, the main location for prisoners who have achieved the enhanced level of the Prison Service Incentives and Earned Privileges scheme (IEP). The man engaged with the drug workers and was on the waiting list for a course for prisoners addressing drug related offending (PASRO). The man was described fairly consistently by staff and prisoners who were interviewed, as being quiet, a ‘loner’, vulnerable, slow to learn, lacking language and social skills.

6. Although his epilepsy was assessed he was not identified as having a disability. The man signed a medical disclaimer indicating he had been advised of the risks of not being in shared accommodation. Not all the staff on the wing were aware of his illness or the risk of fits. The Health Care Manager expressed her concern that staff were not alert to the man’s condition or its implications. She expressed her intention to put in place a system which would enable prisoners with epilepsy to give consent for staff to be aware that there was a risk they might have a fit. This would not be in breach of medical confidentiality requirements. My investigator discussed this issue with the Director who agreed to support such an arrangement.

7. At Parc, in contrast to his profile at Swansea he tried to be compliant with the rules and regulations of prison life. However, in the fortnight before his death he had been most unusually angry over what he saw as an unjust written warning for misuse of the cell bell. He was described by a fellow prisoner as 'panicky' about anything which might harm his chances of parole. The man was seen during the evening before his death and spoken to by a fellow prisoner, around 9pm, when the doors were locked for the night. The prisoner told my investigator that the man had said he was not feeling well but he was worried about using the cell call bell.

8. Just after 9am on 30 May a prison custody officer, went to unlock the man so he could collect his medication. He was unresponsive in his bed. She raised the alarm and the nursing staff commenced resuscitation very swiftly. It is likely he had been dead for some time and when the paramedics attended they recognised signs of rigor mortis and pronounced that life was extinct at 9.20am.

9. In his autopsy report on 2 June the pathologist at the Wales Institute of Forensic Medicine, University of Cardiff, reported that there were physical signs consistent with an epileptic fit having occurred. He said that signs such as bruising, abrasion and superficial lacerations in the mouth were consistent with injuries occurring during a fit, providing any recent altercation involving blows to the face was excluded. The police who investigated the man's death reported that they found no untoward circumstances. My investigator found no evidence among those staff and prisoners interviewed, of any altercation or accident involving the man having taken place in the days prior to his death. The pathologist concluded that without further tests the cause of death could not be ascertained.

10. The pathologist received a report from a Consultant Neuropathologist on the post mortem examination of the brain. The post mortem neuropathology examination found no convincing evidence of recent trauma in the brain.

11. Having received the neuropathology and toxicology reports the pathologist concluded in his final report on 14 February 2006 that the cause of death was epilepsy. He commented that it was not unusual for examination of the brain to be essentially negative in such cases and such findings did not exclude the possibility that death was the result of epilepsy. He continued:

> *"It is recognised that subjects with epilepsy die suddenly, not necessarily related to a fit or prolonged fitting."*

12. He further commented that:

> *"A comprehensive toxicology analysis confirmed the presence of anti-epileptic medication (carbamazepine and sodium valproate) in the blood at relatively low concentrations. Interpretation of such concentrations is problematic. It is clear there was no evidence of toxicity but it is less clear whether these concentrations mean that the blood concentrations during life were sub-therapeutic. However, that remains a distinct possibility and therefore the man may have been more susceptible to a fit and also at increased risk of sudden death."*

13. In summary the pathologist conclusion was that:

"the pathological investigations failed to reveal any evidence of significant recent trauma, drug/alcohol toxicity or natural disease. It is recognised that subjects with epilepsy have an increased risk of sudden death, the circumstances of this death – being face down in bed in the morning – and the finding of 'relatively low' concentrations of anti-epileptic medication would be in keeping with a "sudden death in epilepsy".

14. Without expert examination of the man's medication by a neurologist specialising in epilepsy, it is not possible to conclude whether or not the man's prescribed medication was appropriate. However, it was unfortunate that at no time during his period in custody, despite the instability of his epilepsy at Swansea in particular, was the man referred to the local NHS for an expert opinion on his epilepsy management.

15. Initially, prison staff and police had difficulty contacting his family because he had not given details of any next of kin when he was received into custody. Over the next two days, his mother was located in the North East of England and his father and other family members in Wales. His aunt took charge of the funeral arrangements and collected his property from Parc. The family requested that no representative from the prison should attend the funeral.

16. I make nine recommendations for changes of policy and practice at Parc and two for improvements in the management of prisoners with epilepsy generally.

The investigation

17. The investigation began on 1 June when the clinical reviewer contacted the Drug Strategy Manager allocated to be our liaison officer. She supplied notices to be issued to staff and prisoners announcing the investigation and inviting anyone with information relevant to the man's death to contact her.

18. My investigator visited Parc on 7 and 8 June, familiarising herself with the prison, particularly A wing where the man resided and meeting staff and prisoners. She talked informally with a member of the Independent Monitoring Board.

19. On 16 August, the South Wales Police forwarded to my investigator copies of all the statements they had taken during their enquiries. She returned to Parc on 24 and 25 August. A copy of the preliminary post mortem report had been received at the prison on 22 August. Seven staff and four prisoners were interviewed. Six prisoners had initially indicated their wish to talk to my investigator but two were transferred or discharged before she was able to return to Parc. Records of the interviews were forwarded to all the interviewees to check, amend as necessary and sign.

20. My Family Liaison Officer made contact with the man's aunt on 24 June, by telephone. From the aunt we learned that the family had heard a number of rumours about the man. These included him having a blood disorder, being beaten up in his cell and that he should not have been in a single cell due to his epilepsy. The family had also heard that he had been lying on the floor of his cell for some time before he was found. The aunt was particularly concerned that he had been moved to Parc because she believed the healthcare facilities were better for him at Swansea. She wanted to know whether his transfer was a correct decision.

21. The investigation was completed on 23 September 2005, but was still subject to a final autopsy report from the pathologist at the Wales Institute of Forensic Medicine. That report was received on 6 May 2006 and the investigation report was revised in accordance with the findings.

Parc

22. Parc is a modern prison building, built to an American design. It opened in November 1997. It is the only privately operated prison in Wales. The operating company is Securicor Custodial Services. Health Care Services are provided by Primecare Forensic Medical Services. The population is usually about 830 in total.

23. Parc holds unsentenced juveniles, remanded and sentenced young offenders and sentenced adult males. There are some structural adaptations for prisoners with disabilities of mobility and provision to help those with hearing problems use telephones. The main accommodation for adult males is A wing which comprises four 90 bed units. All cells have in-cell sanitation, ventilation, electricity and television.

24. The prison was last inspected by Her Majesty's Chief Inspector of Prisons (HMCIP) in September 2002. Records show that there were two deaths at Parc in 2004, both from natural causes.

Events prior to 30 May

Swansea 3 December 2003 – 28 July 2004

25. The man was 31 when he went into Swansea, on remand for possessing and supplying class A drugs, on 3 December 2003. It was his first experience of prison custody. He was assessed as low risk for sharing a cell using the cell sharing risk assessment (CSRA). His epilepsy was not identified on the CSRA but the doctor assessed him and continued the medication he had been taking in the community.

26. He made a number of court appearances by video link before being convicted at the Crown Court on 29 March 2004. Following pre-sentence reports, he was sentenced to four years imprisonment on 29 April. He began serving his sentence at Swansea and, at first, seemed to find imprisonment difficult. He faced a number of adjudications in early 2004 for breaking prison rules.

27. At Swansea he was given 'one-to-one' counselling for his drug addiction from 14 January 2004. He appeared to respond well to this and completed an action plan agreed with his counsellor. On 13 July he was given a full assessment by a member of the drugs team at Swansea.

Erlestoke 28 July – 15 August

28. In July the man progressed to Erlestoke, a training prison in Wiltshire. He participated in an induction assessment during which his epilepsy and past drug use were identified. The officer who interviewed him noted that his first language was Welsh and his literacy was poor. The man had a severe epileptic fit on the night of 11/12 August and the prison staff transferred him to Salisbury Hospital. At the hospital under escort, he became confused and tried to slip out of his handcuffs. When he was returned to Erlestoke on 14 August, he was placed in segregation because of the handcuff episode. A suicide and self harm monitoring form (F2052SH) was opened on 14 August because he was distressed and incoherent. He was examined by the visiting general practitioner (GP) on 14 August. She found minor bruising and swelling consistent with having been handcuffed and restrained at the hospital by police and prison officers. By then, arrangements were in hand for him to return to Swansea. The GP signed that he was fit to remain in the segregation unit and fit to travel. The F2052SH was closed at 7am on 15 August and the man was returned to Swansea that day.

Swansea 15 August – 2 February 2005

29. The man was initially received on to the health care unit at Swansea before transferring to a residential wing the next day. He scored low on the assessment of risk for sharing a cell.

30. He gained a drug awareness certificate and completed an anger management course. Although he was no longer doing formal work on his drug use the man spoke to a drugs worker on his wing on 5 October. He wanted to talk about a

recent bereavement, which was understood to be his brother, who had died of an overdose.

31. Despite his positive achievements, in remaining drug free on the voluntary testing unit, it appears from their reports, that staff at Swansea found the man "lazy, childish and immature". He was warned to "keep a low profile". Again, somewhat in contradiction of the entries in his wing record, he earned the privileges of enhanced status in the Incentives and Earned Privileges scheme (IEP).

Parc 2 February – 30 May

32. On 2 February the man transferred to Parc as part of an overcrowding draft. He was assessed as a medium risk for sharing a cell but there were no reasons given to support that assessment. The fact that he suffered from epilepsy was annotated to an entry indicating he had no concerns about sharing a cell. From talking to staff, it appears he initially shared a cell but moved to a single cell at his own request some time before he died.

33. The record of the man's induction was very sketchily completed. He was not identified as having a disability which might cause unintentional risk to his safety ie having a fit although the form allows for this to be recorded. Although noted to be poor at reading and writing, no question appears to have been asked about any preference for Welsh or English language communication.

34. In contrast to his profile at Swansea the man was observed by staff at Parc to be compliant with the rules and regulations of prison life. The man was described fairly consistently by staff and prisoners who were interviewed, as quiet, a 'loner', vulnerable, slow to learn, lacking language and social skills. However, he often played pool with another prisoner. The prisoner said the man needed help with food, menus and applications. The prisoner thought staff had not given him help. Another prisoner mentioned that prisoners serving the meals on the wing often gave the man the wrong food to 'wind him up'.

35. The man engaged with the drug workers and was on the waiting list for a course for prisoners addressing drug related offending (PASRO). On 10 March the man told a drugs worker that he was back in touch with his family. He was visited quite frequently by his brother. As a prisoner with enhanced status he was able to have more visits than those on the standard or basic regime.

36. The man guarded his enhanced status carefully. However, in the fortnight before his death, he had been most unusually angry over what he saw as an unjust written warning for misuse of the cell bell. A prisoner said the man "threw a wobbly" in the wing office about the warning and "that would have gone against him". A manager and the prisoner both recalled the event which led to the warning. They said the man had been locked in another prisoner's cell so he rang the bell to be let out. The prisoner described the incident as an example of the bullying or victimisation which the man suffered on the wing. As another example, he described a scene where other prisoners thought it was funny to pull down the man's trousers when he was carrying his food tray. The prisoner

described the man as ‘panicky’ about anything which might harm his chances of parole.

37. After initially sharing a cell the man requested a single cell when his cell mate was transferred. He was allocated a single cell on A4 wing, just opposite the stairway on the first landing. He had been advised by the health care assistant, that as a person with epilepsy, he would be safer in a shared cell. The man signed a medical disclaimer accepting that he was choosing to occupy a single cell against professional advice. Some officers and some prisoners knew he suffered from epilepsy, usually because he had told them himself.

38. On Sunday 29 May the man spent an uneventful day on A4 unit. Officers who were questioned recalled no particular interaction with him. The prisoners who volunteered information recalled that the man had complained of a headache and seen a nurse who took his blood pressure but it was unclear when that occurred. A prisoner said that on association on Sunday evening (ie the day before the man died) He said he wasn’t feeling well. The prisoner encouraged him to ring his bell but the man said he was worried about doing so because of the warnings. More than one prisoner referred to the man being both angry and concerned about the implications of the cell bell episode.

Events of the morning of 30 May

39. On Bank Holiday Monday 30 May, a nurse was administering medicines to prisoners on A wing. A prison custody officer went to unlock the man just after 9am, to collect his medication from the nurse. A prisoner who was undertaking cleaning duties on the landing heard the prison custody officer shouting the man's name and followed her into the cell. She and the prisoner found him face down under his duvet and they could not rouse him. In his statement to the police the prisoner said he saw the man's foot sticking out under the duvet and had no doubt from its discolouration, that he was dead. He said so to the prison custody officer and she ran for help. She called to the more senior officer in charge of the wing, asking whether she should call a 'Code Red' on her radio. He confirmed she should and she did so.

40. A nurse arrived very quickly because she was already on the wing. In her evidence to the police she described how, with the help of a prison custody officer, she turned the man onto his back and felt that he was warm to the touch. All those who attended reported that there was blood on the man's pillow and some mentioned a yellow discharge from his nose. The nurse noted that the man had been incontinent of urine. She commenced chest compressions and her colleague joined her and commenced mouth to mouth resuscitation. They continued their efforts until the paramedics arrived after about 20 minutes. The paramedic assessed immediately that signs of rigor mortis (the stiffening of joints which occurs after death) were present and stopped the resuscitation. The paramedic declared life extinct at 9.20am. A doctor certified death at 10.20am.

Events following the man's death

41. The Church in Wales's chaplain was in the chaplaincy office when the Code Red was broadcast. The chaplain anticipated that the emergency might relate to a prisoner with whom she was currently working so she went to the wing. However, when she got to the cell she found the prisoner concerned was not whom she had thought it might be, but the man, whom she had not met before. The chaplain met an officer on the landing who told her the man was dead. The chaplain had trained as a nurse so she joined the nurse tending to the man and gave the two initial mouth to mouth respirations before another nurse arrived and took over. The chaplain said it was obvious to her that the man was dead but the nurses carried out resuscitation until the paramedics arrived. The chaplain felt it was important to stay with the man after the paramedics declared life was extinct. She stayed by him and said prayers for him. She felt this was important for him and that it might be an important comfort to his family to know this had been done.

42. The Methodist chaplain was called by the duty director to lead on staff care while they waited for the arrival of the police. The Church in Wales's chaplain joined them. She said that the Care Team at Parc was currently being redeveloped but the Methodist chaplain had always been involved so he was delegated the responsibility on this occasion. The Church in Wales's chaplain said the wait for the police and Coroner's team extended to a couple of hours so she went about her normal duties.

43. She said at interview that the normal process for notifying next of kin would have been for two chaplains to visit and break the news. She said the chaplaincy do lots of news-breaking and dealing with next of kin issues. She was very aware of the sensitivity required. (The chaplains are not actually identified as family liaison officers.) The entry regarding next of kin on the electronic database at Parc was 'States None'. In his core record it was noted that the man had given his brother as next of kin but with an incomplete address and no contact number. In another record the man had given his mother as his next of kin, living in the North East of England. Her name was spelt in a number of different ways in his papers and only on his epilepsy assessment in his medical file was a phone number recorded for her. This information was not readily available to the chaplaincy.

44. On being asked to help with contacting next of kin, the local police found his father after some delay and informed him. The police reported to the prison that a brother of the man's had died from an overdose recently (later found to be October 2004).

45. On 31 May the Church in Wales's chaplain learned that a name and address for the man's mother had been obtained. The police were undertaking the notification because the address was in Middlesborough. On 1 June the duty director reported that the man's mother had been informed. Contact details were given to the chaplaincy. The senior chaplain phoned the mother, offered condolences and explained what support was available if she wanted it. The senior chaplain told my investigator that the conversation was very short and no help was requested. Eventually the man's aunt contacted the prison and

established herself as the responsible next of kin, together with a younger sister and the brother already mentioned. It was the aunt who, some days later, came to collect the man's property. At interview the orderly officer on, when the man's aunt came to collect his property said she had offered the aunt a visit to the wing and the cell but she declined. The orderly officer helped her take the property to the car. She said she hoped she had conveyed the staff's sympathy for the loss of her nephew.

46. At interview the Church in Wales's chaplain recalled that on 3 June the man's half sister, telephoned and was put through to the chaplaincy. The chaplain indicated that this was not because the operator knew she was the right person but because the chaplaincy is one of the few (perhaps only) departments which accepts outside calls at Parc. The half sister explained that she was estranged from the rest of the family. The chaplain gave the half sister appropriate information. The half sister phoned again on 9 June distressed because when she went to see the man's body at the undertakers she had been told she could not see him because he was in a sealed bag. She wanted to know from the prison whether the reason for this was an infection or something of that nature. The chaplain had no explanation to give so she referred the half sister to the duty director. The duty director gave the half sister the contact details for the Coroner's officer. It appears that there was no substance to what the half sister had been told by the funeral director.

47. The senior chaplain spoke to the man's aunt, on 10 June. She was organising the funeral and he offered for the prison to be represented but this was declined and the family's wishes were respected. The Church in Wales's chaplain recalled that staff had wondered if the man's ex-cellmate who had been transferred to Usk, would like to attend the funeral. Unfortunately the notice of the funeral date left too little time to organise this. No-one at the prison offered to assist with funeral costs. My FLO asked the prison management to make an offer of financial assistance.

Clinical Review

Reception screening

48. When the man entered Swansea on 3 December 2003 he was the subject of a first reception health screening assessment. The nurse identified that he suffered from epilepsy and used illicit drugs, including heroin. He was 5' 9" but weighed only 32kg[1]. He was seen by the prison doctor who prescribed epilim 1gram twice daily. The man missed the follow-up general health assessment which he should have attended, due to a video link appearance. The man was on remand and made a number of court appearances but most of them were by video link. On those occasions he went to court he was not given any further health check on return.

49. When he was transferred to Erlestoke he had a thorough health assessment. His weight had increased to 79kg. At Erlestoke the man told the nurse he had used heroin intravenously but never shared equipment. At Parc his initial health assessment identified that he had been a heroin user but not that he had injected intravenously. However he was noted to be at risk of blood disorders.

The man's general health

50. When first admitted to Swansea, the man complained of poor sleep and abdominal cramps. On 3 February, he was complaining of feeling dizzy. He was prescribed stemetil 5mg[2] three times a day. On 2 May, a nurse's entry described him as being "in a low mood post sentence". On 4 May the doctor wrote "4 year sentence last week therefore amitryptiline[3]". He prescribed 25mg twice daily but the man only ever had one dose. On 4 June he received a prescription of oxytetracycline 250mg twice daily[4] (an antibiotic) for his acne which he continued for some months.

51. On 5 August at Erlestoke the man scalded his wrist and received treatment there. On 10 August he was complaining of abdominal pain. A urine test was ordered and he was given paracetamol[5]. He complained of abdominal pain again on 12 October when he also mentioned feeling dizzy. He presented similar symptoms on 11 November and a doctor prescribed ranitidine 150mg[6] twice daily. A week later the man was no better. The doctor prescribed omeprazole 40mg daily[7]. The man returned to see him again on 23 November with an abrasion on his left forehead, which apparently happened when he fell off a stool the day before.

52. The man first presented at the nurse triage clinic in Parc on 17 February complaining of pain in his groin and leg. The doctor diagnosed a groin strain

[1] A healthy weight for a height of 5ft 9ins would be between 61 and 76kgs
[2] Stemetil is prochlorperazine a drug used to treat nausea and vertigo. This dose is for preventing symptoms occurring.
[3] an antidepressant
[4] The recommended dose is 500mg twice daily
[5] An 'over the counter' painkiller
[6] A treatment to reduce stomach acidity
[7] A treatment for benign stomach ulceration

probably caused while playing football. He suggested a rest from exercise and paracetamol for pain relief. On 23 February the man presented with a 'stabbing' and nauseous headache. The nurse prescribed pizotifen 0.5mg[8] at night. He was given one dose and advised to return to the doctor if it did not improve but he did not return.

53. On 17 March, in the triage clinic again, the man was dizzy and aching. He was treated for influenza. A week later he was suffering with diarrhoea and on 29 March and 5 April he reported abdominal pain again and was prescribed omeprazole again. The symptoms were reported again on 18 April when the nurse he saw decided he should have a blood test for helicobacter pylori (a bacterium which causes stomach ulceration). She advised that he was to continue the omeprazole and eat less fat. The blood test was done on 4 May.

54. On 29 April, 10 and 20 May the man reported suffering with back pain. He was prescribed etodolac 300mg twice daily[9].

<u>The man's epilepsy and medication</u>

55. On 3 December, when he arrived at Swansea, the man had been taking epilim 700mg three times a day. At Swansea the doctor prescribed epilim 1000mg twice a day. On 30 December an entry in the man's medical record states that he had a 'further fit yesterday'. There was no record of a previous fit. Blood tests were ordered. In January 2004 (date obscured) he had a further fit. The doctor thought the epilim was ineffective so he prescribed carbamazepine 200mg twice daily[10].

56. On 2 May a nurse recorded that the man had had a fit and been admitted to the health care centre. On 28 May there was a verbal order for an additional dose of carbamazepine 200mg and he went back to the wing on 29 May.

57. On 1 June a doctor prescribed carbamazepine 200mg twice daily but, although it was dispensed, none was administered. Instead, a new prescription for epilim 200mg twice daily was given, dispensed and administered. However, on 4 June the man requested to increase his epilim and the doctor prescribed 500mg twice daily.

58. On 26 June, according to the record, the man had another possible seizure. He was examined. No injury was detected. On 28 June he started receiving carbamazepine 200mg twice daily. On 6 July the doctor recorded that the man had had four fits and increased his carbamazepine with an additional 400mg dose at night.

59. On 9 July the man saw a locum doctor following another fit. The doctor ordered checks of his blood carbamazepine levels. On 16 July blood was taken but recorded as being taken for epilim levels. On 10 August, now at Erlestoke, the doctor noted that the blood test results needed to be chased

[8] A drug for the prevention of headache including migraine. The usual dose is1.5mg at night.
[9] A non steroid anti-inflammatory drug used to treat arthritic pain
[10] Listed in the BNF as the drug of choice for simple and complex seizures.

60. On 29 July he was reassessed at Erlestoke. The doctor noted that he was on carbamezepine. S/he described the man as having had fits of an unknown type since age 15 but noted that he had not had an electro-encephalogram (EEG) – a recording of electrical activity in the brain used to diagnose or assess epilepsy. The doctor increased the carbamazepine to 400mg twice daily.

61. On 12 August he had repeated fits and was admitted to Salisbury hospital where he had a CT (computed tomography) scan of his brain. There was no report from the scan in the man's record. The Erlestoke health care team decided he needed to be in a prison with full time (24 hour) health care. On 15 August he returned to Swansea and was prescribed carbamazepine 400mg twice daily.

62. The man had further fits on 16 and 23 August. On 7 September a visiting doctor prescribed epilim 200mg once daily in addition to the carbamazepine. On 12 October he was complaining of being dizzy and the doctor increased his epilim prescription to twice daily. On 18 October he had two further fits.

63. On 19 October the man was admitted to the health care centre in the night following a fit at 1.30 am. At 2.40am he fitted again and was treated with rectal valium. A further fit followed at 4.40am and a further dose of rectal valium was administered at 5.10am. He was seen later by the doctor but the entry is illegible. An entry on 20 October noted there had been no further fits and on 21 October he went back to the wing.

64. The man's health was uneventful until 25 January when a nurse was asked to see him regarding a possible fit. She thought he had not had a fit but needed to rest. She taught him some breathing techniques to use when he felt anxious.

65. On 2 February the man was transferred to Parc where the nurses noted his history of severe epileptic seizures. He was referred to the team's epilepsy specialist, a health care assistant. The health care assistant was experienced in the care of people with epilepsy having done specific training in her previous job. She holds National Vocational Qualifications (NVQ) in Care at level 2 and in Promoting Independence at level 3. One of her responsibilities was to organise and run clinics for patients with epilepsy. When a new prisoner is identified as having epilepsy she undertakes a full assessment and then sees them on a regular basis, varying between two and six monthly intervals, depending on the severity and instability of their condition. On average there are 12 patients with epilepsy in Parc at any time.

66. A copy of the health cares assistant assessment of the man, undertaken on 18 February was in the record. In addition to confirming her written record at interview, she recalled that the man suffered tonic/clonic epileptic fits (or seizures). He experienced no aura before a fit and there were no known triggers to an attack. He was quite knowledgeable about his condition and its medical treatment. The health care assistant affirmed that he was very compliant with his medication regime.

67. At interview the health care assistant and her manager were asked about the medical disclaimer signed by the man and the health care assistant on 18 February. This disclaimer states that in the interests of health and safety patients with epilepsy were always advised to be located on the ground floor in a shared cell. It also listed aspects of care which had been discussed and agreed with the patient. The man had signed, witnessed by the health care assistant, that he was exercising his right to decline this advice. The form included the words '*Primecare will not be held responsible if you fail to comply with the advice given'.* The manager immediately explained that she had been initially unaware of the wording of this standard form but once she had sight of one, she had replaced it with one from which those words had been removed. She did this because she recognised that responsibility could not be denied in this way. The current form with which she provided me a copy also had an extra clause added so that regular clinic reviews were listed as part of the care discussed and agreed together with location, shared cell, compliance with medication and seizure recording.

68. The health care assistant drew up a plan of care for the man and arranged to review him in three months. In addition to planned reviews, she tries to review any patient with epilepsy after a seizure has occurred or if medication is changed. An entry in his medical record on 8 March by a doctor mentions that the man last had an epileptic fit "15 days ago". This is the only record of the man having a fit at Parc and no other entries refer to it.

69. The multi-disciplinary record showed that the health care assistant saw him on 26 March when he was asking to have his medication split into two divided doses each day. She consulted the doctor who agreed. This was a confusing record since the prescription charts showed that the man had been on twice daily medication since arriving at Parc, continuing the medication regime he was on in Swansea.

70. The health care assistant said she last saw the man on 21 May in the epilepsy clinic. He reported he was feeling fine having had his medication increased. Again this is a confusing record since the prescription charts show no evidence that the epilepsy medication had been increased. It is possible he was referring to some analgesia he was taking for back and abdominal pain. The health care assistant planned to see him in three months time or before if he had a seizure.

71. On the morning of 30 May the man was found unresponsive in his cell at 9.05am by a prison custody officer. A prisoner, who entered the cell with the custody officer, reported that he saw the man's foot, which was sticking out under the duvet, was blue in colour. All those who attended reported that there was blood on the man's pillow and some mentioned a yellow discharge from his nose. A nurse noted that the man had been incontinent of urine. She commenced chest compressions and her colleague joined her and commenced mouth to mouth resuscitation. They continued their efforts until the paramedics arrived after about 20 minutes. A paramedic assessed immediately that signs of rigor mortis (the stiffening of joints which occurs after death) were present and stopped the resuscitation. The paramedic declared life extinct at 9.20am. A doctor certified death at 10.20am.

72. The outcome of the initial post mortem examination on 2 June was inconclusive, pending further investigations. The pathologist suggested that the injuries in the man's mouth were consistent with having had a fit providing injuries incurred during an altercation leading to blows to the face could be excluded. We uncovered no evidence of the man being involved in any sort of altercation. The police enquiry uncovered no untoward findings.

73. In his final post mortem examination report on February 14 2006 the doctor noted that the Consultant Neuropathologist had made a post mortem examination of the brain and found that there was 'no convincing recent traumatic, infective or hypoxic/ischaemic damage'. In his opinion it was 'not currently possible to tell from the brain appearances at autopsy whether a subject had a seizure shortly before death'. However, there were some microscopic changes, which although not specific, had previously been reported in 'epilepsy brains'.

74. The doctor had received the first toxicology test results on 26 January 2006. He reported that the results, presented by the toxicologist indicated that the concentration of epilim[11] was 11mg/litre. This was described by a doctor as 'consistent with therapeutic dosage and does not indicate an overdose of sodium valproate prior to death'. However, he wrote that, conversely, 'the relatively low concentration could indicate non-compliance with the deceased's anti-epileptic medication'.

75. The second toxicology test results were received on 10 February. The doctor had analysed both blood and urine samples retained at the post mortem examination. The only positive findings were the presence of carbamazepine and sodium valproate in the blood. The concentrations were:

    Carbamazepine – 11.3mg/L

    Sodium valproate – 11.0mg/L

    The doctor commented that 'the concentrations of anti-epileptic medication is not consistent with an overdose of the medications'.

76. The doctor, who carried out the post mortem, reiterated that comprehensive toxicology analysis had confirmed the presence of anti-epileptic medication (carbamazepine and sodium valproate) in the blood at relatively low concentrations. He emphasised that interpretation of such concentrations was problematic. It was not clear whether these concentrations meant that the blood concentrations during life were sub-therapeutic. However, he thought that remained a distinct possibility and therefore the man may have been more susceptible to a fit and also at increased risk of sudden death. He added that there was no evidence of toxicity due to other drugs or alcohol.

77. In summary the doctor conclusion was that:

    "the pathological investigations failed to reveal any evidence of significant recent trauma, drug/alcohol toxicity or natural disease. It is recognised that

[11] Also known as sodium valproate, commonly used to control seizures in epilepsy

subjects with epilepsy have an increased risk of sudden death, the circumstances of this death – being face down in bed in the morning – and the finding of 'relatively low' concentrations of anti-epileptic medication would be in keeping with a "sudden death in epilepsy".

78. From the records it can be seen that the man's epilepsy was infrequently reviewed by the prison medical and nursing staff. At Erlestoke the general practitioner who assessed him in July 2004 noted that apparently he had never had an EEG to confirm his epilepsy diagnosis but there was no evidence of any action taken. When he was transferred to an NHS hospital following a fit at Erlestoke (the only time he went to an NHS facility from prison) the doctor ordered a CT scan but no report was lodged in his clinical record. At Swansea the man's medication was altered on a number of occasions in response to reported symptoms or fits but on only one occasion was a blood test ordered. There was no evidence of the outcome in the records.

79. I would draw attention to two important documents: *'The National Sentinel Audit on Sudden Death in Epilepsy'*, published by the Department of Health in May 2002, and *'The National Institute of Clinical Excellence Guideline on the Diagnosis and Management of Epilepsies*', published by NICE, in October 2004. The Sudden Death Audit indicated that in up to 40% of cases of sudden death in patients with epilepsy, sub-optimal care was considered a factor in that death. The NICE guidelines give very helpful recommendations regarding the most appropriate management of epilepsy, and can be recommended as an appropriate standard.

80. Ideally the management of epilepsy should be under the supervision of a suitably experienced and trained health professional, normally this would be a Consultant Neurologist, although this may not be possible given current workforce limitations in neurology. It would however be appropriate for doctors responsible for the management of prisoners with epilepsy to have had suitable additional training. The NICE guidelines also recommend that patients with epilepsy should have access to an epilepsy specialist nurse. At Parc a health care assistant with experience and training in epilepsy in a previous job took responsibility for assessing and managing the man's condition, in conjunction with medical supervision from the prison doctors. Despite her prior experience, a health care assistant could not be construed to have the same authority as a clinical nurse specialist in epilepsy.

The family's concerns

81. From the man's aunt, we learned that the family had heard a number of rumours about him. She hoped that the investigation would provide answers to some of them. They are set out below.

82. There was a suggestion that the man had a blood disorder. He had some history which could have led to a blood infection. However he told staff who interviewed him about his drug misuse that he had never shared injecting equipment. There was no evidence that he had a blood disorder. He had suffered a number of different episodes of abdominal and back pain and these were treated.

83. The man's aunt asked if he had been beaten up in his cell. There were no reports of any assault on him. The only injuries which were reported and about which he was seen by a doctor were incurred at Swansea in a fall on the stairs and a fall from a stool.

84. The man's family were concerned about him being alone at night in a single cell. That issue is addressed more fully in my conclusions and recommendations.

85. The family had also heard that he had been lying on the floor of his cell for some time before he was found. As can be seen in the foregoing evidence this was not the case. He was in his bed. However it has proved impossible to estimate how long it was between him being taken ill and being found.

86. The man's aunt was particularly concerned that the man had been moved to Parc because she believed the healthcare facilities were better for him at Swansea. She wanted to know whether his transfer was a correct decision. We established that he was moved to Parc, together with other prisoners, because Swansea was becoming overcrowded and needed to make space for new prisoners coming from the courts. Both Swansea and Parc have a full 24 hour medical and nursing service so there was no detriment to his medical oversight in the move. At Parc he had a specific assessment of his epilepsy and was subject to routine monitoring of his condition.

Conclusions and Recommendations

87. The man's aunt expressed to my family liaison officer her concern that he should not have been in a single cell due to his epilepsy. This concern was also voiced by some of the prisoners interviewed or listened to on the wing. I am satisfied that the nursing staff at Parc undertook a risk assessment of the man's epilepsy and warned him that having a single cell was not advisable for someone at risk of fits. He chose to go against that advice and signed a disclaimer to that effect. The man was therefore in a single cell by his own choice. To have insisted he shared a cell would have been contrary to his personal dignity. He was exercising choice just as a patient in the community might do so.

88. The man had the facility of a call bell in his cell with which he could summon help if he had enough time and control when a fit began. It was extremely unfortunate if the man's understanding of the wing rule, about misuse of the bell and the penalty for so doing, made him reluctant to use his bell. There was substantial evidence from fellow prisoners that this was the case. It was also evident that the wing regulation about cell bell misuse was not understood by other prisoners. They believed that the penalty for three warnings would be loss of enhanced status, without due consideration of the circumstances. The manager of the wing assured my investigator this was not the case but nevertheless it was the prisoners' perception. They also felt that their case for parole was often under threat for misdemeanours although there was no objective evidence to support this.

89. Another indicator that the relationship between some prisoners and some staff was not good was the evidence that some prisoners recognised behaviour as bullying when staff apparently did not. For example they appear to have witnessed the man being subjected to the indignity of having his trousers pulled down while carrying his meal tray or being aggravated by the prisoners serving the meals. The staff do not appear to have intervened and those officers interviewed said they had seen no bullying of the man.

Recommendation

The Director should ensure that staff training includes effective instruction about the recognition of bullying behaviour and how to deal with it.
(The Director was advised of this on 25 August and agreed to take action.)

90. The man's personal officer knew the man had epilepsy because he told him. The prison custody officer who found him unresponsive on 30 May did not know about his condition although she had observed that he was on regular medication. The wing manager said that the staff did not know who had epilepsy unless the prisoner told them himself. The health care manager was surprised to hear this. She could see that, providing the prisoner consented, the result of the nurse's risk assessment of each epileptic should be shared with the wing staff (and education or gym staff as appropriate).

Recommendation

The Director and health care manager should draw up a protocol for the sharing of medical information with staff on residential units and in other activity units where there is an element of risk to the prisoner's safety.
(The Director was advised of this on 25 August and agreed to take action.)

91. Considerable distress was caused to members of the man's family by the inability of the prison to identify and inform his next of kin of his death in a timely manner. Prison Service Order 2700: Suicide and self harm prevention contains the following guidance under the heading 'Identifying next of kin'.

92. "Efforts should be made, particularly during the reception and first night screening processes, to identify whom the prisoner considers next of kin. The establishment should have clear details as to who, in the event of the prisoner suffering a serious illness, having a serious accident, or committing a serious incident of self-harm, the prisoner would wish them to contact."

93. Too often prisoners give no information when asked about their next of kin and "none" is what is entered in the file. The man had given variously his brother, his mother and none as his answer to the question. The contact details for his mother and brother were incomplete. The situation was made worse by Parc having no clear policy for notifying the next of kin or sending condolences, dealing with property or funeral arrangements. The manager in the resettlement group, responsible for induction and sentence planning told my investigator that since the confusion over the man's next of kin, she had instructed her staff to be much more rigorous in obtaining details fully. She had helped her team to give prisoners positive undramatic reasons why the prison might need to know their next of kin, for example if they broke a leg playing football.

94. The Church in Wales's Chaplain told us that normally two chaplains went to break news but this did not seem to be enshrined in policy. The chaplain also told us that the chaplaincy deals with a lot of news breaking but they are not designated family liaison officers.

Recommendations

The Director should ensure that the staff briefing on gaining next of kin details should be put in writing and included in the induction policy, standard and procedure document.

The Director should ensure that a procedure should be drawn up and published, clearly stating the role of family liaison officer and who will undertake it in the event of a prisoner's death.

The Director should ensure, and incorporate in appropriate instructions, that next of kin are informed as soon as possible by the timeliest means but preferably by staff from the prison. A direct telephone number for the designated family liaison officer should be provided to the next of kin.

The Director or deputy should personally write a letter of condolence to the bereaved next of kin.

Consideration should be given to incorporating criteria for the prison assisting the family with funeral expenses.

95. The chaplain's colleague, the Methodist chaplain took action to care for the staff who dealt with the man's death because he had often acted in that capacity. However the drug strategy manager told my investigator that there was no care and support team in Parc because it had been disbanded. We were assured on 30 August that a new team was being formed but there should not have been a vacuum between the old and new arrangements.

Recommendation

The Director should ensure that a care and support team for staff is reconstituted and membership widely publicised in the prison as soon as possible.

96. The man appears to have had some difficulty in coping with imprisonment particularly because of his own lack of communication skills. The evidence showed that he told the staff who conducted his induction at Erlestoke that his first language was Welsh. There was no mention of this in documents at Swansea or Parc. It is possible that some of his difficulties with social interaction, understanding instructions and forms were a result of English not being his first language.

Recommendation

Consideration should be given to identifying on induction whether Welsh prisoners use English or Welsh as their main language. If their preferred language is Welsh, efforts should be made to accommodate this.

97. Two prisoners remembered speaking to the man about 9pm on 29 May and that he was complaining of a headache. Both advised him to ring his bell if he felt unwell but he was reluctant to do so. The electronic record of cell bell use shows that there was no call from his cell that night. The man appears to have had only one fit at Parc, around 22 March whereas he had much more frequent fits in Swansea and a severe one at Erlestoke. At Parc his medication was consistent whereas at Swansea the doctor had seen a need to alter doses and drugs from time to time because the man's epilepsy was quite unstable. The man had never reported having any warning signs to alert him to a fit being about to occur. People with epilepsy sometimes experience what is called an aura before a fit starts or learn that certain things, such as strobe lighting, can trigger an attack.

98. When the man saw a visiting general practitioner at Erlestoke (distinct from a prison doctor in Swansea and Parc), s/he noted with perceptible concern that the man had apparently never had an electro-encephalogram investigation for his epilepsy. On 12 August when the man had repeated fits and was admitted to Salisbury hospital he had a CT (computed tomography) scan of his brain,

according to the notes made at the time. However, there was no report from the scan in his record. Blood tests to monitor the levels of the drugs he was taking were ordered at Swansea on one occasion but no results were recorded.

99. It is not possible to find conclusively that the man's health care was better, worse or equivalent to that he would have received in primary care in the community. The Sudden Death Audit indicated that in up to 40% of cases of sudden death in patients with epilepsy examined by the Department of Health researchers, sub-optimal care was considered a factor in that death. This indicates that epilepsy care in the community is inconsistent and less than perfect. However, there were shortcomings in the man's medicines management in Swansea and he received no specialist epilepsy management from a Consultant Neurologist while in custody.

Recommendation

Consideration should be given by the Welsh Office/Director of Prison Health to the issuing of guidelines for doctors and nurses on the management of prisoners with epilepsy. The guidelines should take cognisance of the National Institute of Clinical Excellence Guideline on the Diagnosis and Management of Epilepsies, published by NICE, in October 2004'.

Recommendation

Consideration should be given by the Welsh Office/Director of Prison Health to the possibility of appointing either as a full time post, or as part of a post with epilepsy responsibilities outside the prison service, an epilepsy specialist nurse for the prisons in Wales who could provide support and advice on the management of epilepsy, and act as a liaison between the prison community and mainstream NHS specialist provision. Such a specialist nurse could also advise prison officers on the appropriate supervision of individuals with epilepsy.

No	Recommendation	Accepted/ Partially accepted /Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1.	The Director should ensure that staff training includes effective instruction about the bullying behaviour and how to deal with it.	Accepted	1. All prison staff are initially trained and given regular refreshers in procedures for identifying and dealing with incidents of bullying 2. Review training plan to ensure all staff refreshed every Three years 3. Monthly Violence Reduction Meetings, which monitor issues surrounding bullying have been introduced to monitor performance	1. No Action. 2. October 2006 3. Complete	
2.	The Director and Healthcare Manager should draw up a protocol for the sharing of medical information with staff on residential units and in other activity units where there is an element of risk to the prisoner's safety.	Accepted	1. Review current arrangements and introduce protocol for Sharing Medical information with staff on residential units	1. October 2006	
3.	The Director should ensure that the staff briefing on gaining next of kin details should be put in writing and included in the induction policy, standard and procedure document.	Accepted	1. Review current policies on admission and induction and include section on importance of gaining next of kin details 2. Brief all admission, induction and residential staff on importance of having up-to-date next of kin details for those in our care 3. Leaflet for prisoners during induction which outlines the importance of up-to-date next of kin details	1. October 2006 2. October 2006 3. October 2006	
4	The Director should ensure that a procedure should be drawn up and published, clearly stating the role of the family liaison officer and who will undertake it in the event of a prisoner's death.	Accepted	1. Review Death in custody policy and include section on Family Liaison Officer 2. Select and arrange training for two Family Liaison Officers	1. October 2006. 2. Completed – SMT members trained	

5	The Director should ensure, and incorporate in appropriate instructions, that next of kin are informed as soon as possible by the timeliest means but preferably by staff from the prison. A direct telephone number for the designated family liaison officer should be provided to the next of kin.	Accepted	1. Review Death in custody policy and include section on informing Family members of a death in custody. 2. Produce guidance booklet for bereaved families following a death in custody, including contact details for FLO's.	1. October 2006 2. October 2006	
6.	The Director or deputy should personally write a letter of condolence to the bereaved next of kin.	Accepted	1. Review Death in custody policy and include action letter of condolence, to the bereaved next of kin.	1. October 2006	
7	Consideration should be given to incorporating criteria for the prison assisting the family with funeral expenses.	Accepted	1. Review Death in custody policy and include section on assisting the family with funeral expenses.	1. October 2006	
8.	The Director should ensure that a care and support team for staff is reconstituted and membership widely published in the prison as soon as possible.	Accepted	1. Review current arrangements and implement a policy covering, recruitment, training and guidance. 2. Publicise Care team members and contact details to all staff.	1. October 2006 2. October 2006	
9.	Consideration should be given to identifying on induction whether Welsh prisoners use English or Welsh as their main language. If their preferred language is Welsh, efforts should be made to accommodate this.	Accepted	1. Review current Admission/Induction arrangements and implement a policy revision, which clearly identifies the need to establish main language spoken. 2. Review current arrangements for welsh language speakers and ensure appropriate provision made to accommodate in custody	1. October 2006 2. October 2006	
10	Consideration should be given by the Welsh Office/Director of Prison Health to the issuing of guidelines for doctors and nurses on the management of prisoners with epilepsy. The guidelines should take cognisance of the **National Institute of Clinical Excellence Guideline on the Diagnosis and Management of Epilepsies, published by NICE, in October 2004.**	Partly accepted by Director of Offender Management for Wales (NOMS)_	1. The concerns in the PPO Report relate to perceived inadequacies in a public-sector prison in Wales, where since 1 April 2006, Health Services have been commissioned through the Local Health Board. (At the time of Mr Allsopp's death these arrangements were as yet not in force). The DOMW will formally request of the Welsh	1. The Director of Offender Management for Wales will write to the chair of the Prison Health Project Board (PHPB)by 15 September 2006,	

			Assembly Steering Group for Prison Health, known as the Project Board, that they consider the general implications of the investigator's recommendations and that she be copied into any remedial action plans that emerge.	copied to the Chief Exec of the LHB and to Prison Health.	
11	Consideration should be given by the Welsh Office/Director of Prison Health to the possibility of appointing either as a full time post, or as part of a post with epilepsy responsibilities outside the Prison Service, an epilepsy specialist nurse for the prisons in Wales who could provide support and advice on the management of epilepsy, and act as a liaison between the prison community and mainstream NHS specialist provision. Such a specialist nurse could also advise prison officers on the appropriate supervision of individuals with epilepsy.	Partly accepted by DOMW	1. The Report observes that the deceased prisoner received no specialist epilepsy management whilst in custody. Mr Allsopp spent time in both a contracted prison and a public-sector prison in Wales, which are now subject to differing health services arrangements. This omission in his care is so serious that it is felt appropriate once again to point this out to the Project Board for their attention.	1. DOMW, to write to PHPB chair by 15 September 2006 (copied to relevant LHBs, and to Prison Health for implications for England) requesting consideration of the need to improve access to specialist epilepsy care.	