PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent investigations

Investigation into the circumstances surrounding the death of a man at outside hospital in November 2011, while in the care of HMP Pentonville

Report by the Prisons and Probation Ombudsman for England and Wales

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This is a report into the death of a man in November 2011, at outside hospital, while in the custody of HMP Pentonville. He was 41 years old. A post mortem concluded that he died from spontaneous peritonitis (an infection of the abdomen), decompensated liver disease (where liver capacity is insufficient for it to carry out its normal functions) and chronic hepatitis (liver inflammation lasting for more than six months) and alcohol excess. I offer my sincere condolences to his family and friends for their loss.

The investigation was carried out by one of my colleagues. I would like to thank the Governor of HMP Pentonville and his staff, for their co-operation during the course of our enquiries. I would also thank Islington Primary Care Trust (PCT) for appointing a clinical reviewer to review the man's clinical care. As the man died from natural causes, the findings of the clinical review were essential to my own conclusions.

The man had a number of health problems when he entered prison. These were largely managed well while he was at Brixton. However, the quality of his care declined when he moved to Pentonville. Despite the work previously undertaken by hospital and Brixton staff, care plans were not properly implemented to manage his complex needs. This resulted in it taking longer than necessary to realise he was seriously unwell before he was admitted to hospital for the final time. A combination of oversights and opportunities to continue the man's care plan, critical to maintaining his liver function, were missed. The clinical review finds that the lack of appropriate management at Pentonville may have resulted in his deterioration and was not comparable to that he could have expected to receive in the community.

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Prisons and Probation Ombudsman **August 2012**

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SUMMARY

1. The man was convicted of attempted burglary and remanded into custody on 10 August 2011, awaiting sentencing at a crown court. He was initially taken to HMP Brixton and underwent an initial healthscreen (a process to identify immediate health needs and to obtain a medical history). He disclosed a history of drug and alcohol misuse and said that he was taking methadone (methadone is widely prescribed as a substitute to those wanting to combat heroin addiction). He also disclosed that he was receiving treatment at a hospital for chronic liver disease (cirrhosis) with hepatitis C virus infection, and said that he suffered from epilepsy.

2. The clinical records at Brixton demonstrate that they communicated with the outside hospital to ensure that they were fully aware of the man's history, and that he received appropriate care. He became constipated, resulting in him developing hepatic encephalopathy (a syndrome affecting the brain resulting in a reduced level of consciousness, caused by an accumulation in the bloodstream of toxic substances that are normally removed by the liver). This was a serious medical emergency. Following a short admission to outside hospital, doctors at the prison followed the clinical care plan outlined on the discharge letter. They ensured that he was regularly monitored and received the correct treatment to minimise the likelihood of a recurrence of an encephalopathic state. In addition to this clinical care plan, and in response to the man's refusal to be located on the in-patient wing at Brixton, special monitoring measures were put in place to ensure that he was regularly checked.

3. Following an appearance at court on 15 September, the man was sent to Pentonville prison. He underwent an initial healthscreen with a nurse, and was referred to the prison reception doctor for further assessment and examination. During the investigation it became apparent that, throughout this first night healthscreen process, there were a number of oversights related to the assessment of risk and need for medical treatment. There was no evidence of an assessment of the hepatic risk (liver failure) or that the care plan documented at Brixton had been continued, and there were inadequate prescribing directions. In addition, the special monitoring procedures were not followed and this resulted in an absence of additional monitoring. The man was located overnight on A wing, the induction wing, and did not attend an appointment with the prison doctor the following day. The reason for his non-attendance was not recorded or followed up.

4. The man was assessed by a substance misuse doctor the following day and was located in Pentonville's Integrated Drug Treatment System (IDTS, explained later in the report) wing for observation. He remained on a methadone maintenance prescription. Over the next few days he was monitored by healthcare staff. He complained of stomach pains, was unsuccessfully treated with laxatives and, after seven days of constipation, was admitted as an emergency to outside hospital on 24 September. The man's condition deteriorated and on 1 October he was moved to the intensive

care unit where he remained. He died on a day in November with his family present.

5. The conclusion of the investigation, and that of the clinical reviewer, is that the standard of care which the man received at Pentonville was below that which he could have expected in the community. There was evidence that his condition had improved following treatment in hospital in August, and his last review in the liver clinic in September confirmed this. Greater scrutiny of the medical records upon reception at Pentonville should have resulted in a more robust clinical management plan. Adequate prescribing directions and increased observations as part of the special monitoring measures may have ensured that he did not deteriorate when he did. Given the man's long history of substance misuse and chronic liver condition, there was a high possibility of a fatal outcome in the future. However, it is possible that had there been a clear management plan, his death may not have occurred at this point.

6. We make five recommendations a result of this investigation which relate to the clinical performance of a reception prison doctor, IDTS, ACCT (special monitoring measures), staff support and safety of documents.

THE INVESTIGATION PROCESS

7. The investigation was opened on 15 November 2011, when a senior investigator visited HMP Pentonville on behalf of his colleague. Prior to the visit, she issued notices announcing the investigation to staff and prisoners. All the documents relating to the man were made available to the senior investigator. During the opening visit he met a Governor, the prison family liaison officer (FLO) and the Safer Custody Manager. No prisoners or staff came forward in response to the notices of the investigation.

8. Islington PCT asked a clinical reviewer to review the man's clinical care on their behalf and he was provided with the available and relevant documentation to assist this review. We would like to thank the clinical reviewer for undertaking this review and for his timely and comprehensive report.

9. The investigator, along with the clinical reviewer, returned to Pentonville on 4 January 2012. The delay returning to interview staff was due to difficulties in the prison staff being available for interview. In addition, a document required by the investigator could not be located; further reference is made to this in the key events section of this report. During this visit they formally interviewed four members of staff. Two staff identified for interview were absent on sick leave and extended annual leave respectively and were not interviewed, although this did not adversely affect the investigation. Initial feedback from the investigation was provided, in writing, to the Governor on 11 January 2012. The clinical reviewer also provided immediate feedback to the Head of Healthcare at Pentonville and Islington Primary Care Trust (PCT).

10. The investigator contacted Her Majesty's Coroner who is responsible for the Inner North London District area to inform him of the nature and scope of the investigation. A post mortem was not undertaken as the man had died in outside hospital where he had been for a number of weeks. Upon completion, the investigation report will be sent to the Coroner to assist his enquiries into the man's death.

11. One of the office's family liaison officers contacted the man's mother on 6 December to inform her about the investigation and to invite the family to ask questions or raise concerns about his care. She raised the following issue:

    - Would the investigation look at the care the man received at Brixton?

12. The investigator and clinical reviewer did not feel it necessary to interview staff at Brixton, although the care the man received while there was considered and is reflected throughout the report.

13. According to the terms of reference of this office, when an investigation report criticises an identified member of staff, we will disclose an advance draft of the report. In this case, the report was shared with the PCT and the prison, because it was a prison doctor who was criticised. Following the advance disclosure, an internal review at Pentonville was completed, a review by an

independent clinician was undertaken regarding the competency of the reception GP, as recommended following interview by the clinical reviewer, and NHS North Central London undertook their own review of the issues raised.

14. On 2 May, the investigator, an assistant ombudsman and the clinical reviewer, met the healthcare manager, business/practice manager from Pentonville and the assistant director of quality and safety for NHS North Central London. The response to the advance disclosed report was discussed, and has been incorporated into the investigation report.

15. The man's family received a copy of the draft version of the report as part of the consultation period. Having considered the investigation findings they requested to meet with the investigator and FLO, which was facilitated on 5 July. The man's family reiterated their concerns about the lack of care their relative received at Pentonville and which the investigator had sought to address in the investigation. We are grateful to the man's family for the time they have taken to consider the report and for the feedback they have provided. Any concerns not covered in the finalised report are addressed in separate correspondence to the man's family.

HMP BRIXTON

16. HMP Brixton is a large Victorian prison. It is a male local prison serving a number of courts in South London. (A local prison sends and receives prisoners directly to and from the courts. These prisons experience large numbers of movements through the reception each day and are extremely busy). The prison has an operational capacity of 798, with a very high turnover, of about 700 prisoners a month.

17. Healthcare services are delivered by a group led by Care UK, including the South London and Maudsley NHS Foundation Trust (SLaM), with pharmacy and other services provided by Lambeth Community Health, and dental services by Weymouth Group. NHS Lambeth (the Primary Care Trust) is the commissioner and holds the contract with Care UK, which was recently extended to 2013.

Independent Monitoring Board (IMB)

18. Each prison has an IMB, whose members are appointed by the Secretary of State for Justice from members of the community. Their role is to satisfy themselves that the prisoners are treated humanely and justly and that there are adequate programmes for preparing prisoners for release. The IMB report directly to the Secretary of State if they have any concerns and to highlight good practice. They also submit annual reports on how the prison has met the standards and requirements placed on it. Members of the IMB have access to every prisoner, every part of the prison and every prison record.

19. The most recent annual report published by the IMB at Brixton covers the period from 1 July 2009 to 31 August 2010. In the overall judgement of the establishment, the Chair reports:

> "The Board's overall judgement is that Brixton is continuing to improve at a steady pace. This was recognised when its performance status was raised from 2 to 3. This is judged by national targets, so it is a real achievement within Brixton's constraints."

HM Inspectorate of Prisons' report

20. An unannounced full follow up inspection of HMP Brixton by the HM Chief Inspector of Prisons was completed in December 2010. In his introduction to the report of the inspection, the Chief Inspector said:

> "Brixton had improved since our last inspection. Some of these improvements were significant. However, the problems that did remain were substantial and it was clear that managers and staff would struggle to maintain what, in many respects, were the minimum of basic standards"

21. In respect to healthcare services, the Chief Inspector said:

> "Health services were well managed by the various providers, and the environment in the health care centre for the care and treatment of patients was adequate ... Prisoners received a good level of GP care and waiting lists were short. Facilities for the administration of medicines were satisfactory."

HMP PENTONVILLE

22. HMP Pentonville was built 170 years ago. It is a male local prison and serves the north London courts. It has an operational capacity of 1,310 prisoners.

23. A manager heads Pentonville's healthcare department, with Whittington Health, Camden & Islington NHS Foundation Trust, and Barnet, Enfield and Haringey NHS Mental Health Trust providing health services. Services provided include substance misuse, mental health services, psychiatric care and primary care services.

24. The healthcare centre is a new purpose-built building offering both inpatient beds and a day care facility for prisoners with mental health problems. There are primary care facilities on the wings, including a consulting and dispensary area. Healthcare staff are available 24 hours a day. Doctors, mental health and nurse-led clinics are available, as well as a range of more specialised services.

Cell Sharing Risk Assessment (CSRA)

25. All prisoners are subject to a Cell Sharing Risk Assessment (CSRA) during the reception process. The CSRA process is designed to assess the risks posed by an individual to other prisoners which includes taking into account any previous violence or mental health issues. An assessment takes place before a prisoner spends their first night in custody and triggers a plan to minimise risk for those identified as high or medium risk which is reviewed at regular intervals. The man was assessed as low risk.

Restraint Risk Assessments

26. On each occasion a prisoner is escorted outside the prison to hospital, a risk assessment is undertaken to consider the risk to the public, potential for escape and likelihood of outside assistance. The assessment informs the decision about the number of escorting officers and the type of restraint to be used (single cuffs or two metre long escort chain with a cuff at either end). It also determines the circumstances and the authority required for the restraints to be removed. The risk assessment is reviewed each day that a prisoner is in hospital and amended where necessary.

Person Escort Record

27. This is a form that accompanies prisoners on all journeys, such as those from and between prisons, police and hospital. It serves as a communication tool about risks a prisoner poses on escort or transfer. It also provides a chronological record of the escort, such as meals served, journey times and any other significant event.

Integrated Drug Treatment System (IDTS)

28. The introduction of IDTS is a joint initiative between the Department of Health and Ministry of Justice. It is being rolled out in stages to prisons throughout the UK. The project aims to improve the quality and access to drug treatment within prison. IDTS requires the prison, Primary Care Trust (PCT) and the Drug Action Team (DAT) to work together to ensure funding is spent appropriately.

29. IDTS provides structured interventions and programmes for those prisoners who are drug dependant. It aims to provide a range of treatment options available to those in prison, notably substitute prescribing, together with clinical and emotional support. A single care plan promotes a consistency of care and treatment, from reception into custody and upon release back to the community. Many prisoners have complex needs (a combination of drugs, alcohol and depression) and who may over or under report their drug use to healthcare staff, which causes difficulty in prescribing the correct therapeutic dosage. Identification of an individual's needs is often difficult, particularly if they are to receive support for a number of different issues.

Independent Monitoring Board (IMB)

30. The latest IMB report covered the period from 1 April 2010 to 31 March 2011. It noted that:

> "The assessment of newly-arrived prisoners at Reception – in terms of their physical and mental heath, their drug problems, and their risk in terms of cell-sharing – is potentially compromised by the numbers that have to be dealt with each week-day evening. It is to the credit of the staff that, despite these strains, prisoners are in general treated with respect and the relationship between officers and prisoners remains good."

HM Inspectorate of Prisons' report

31. The most recent inspection of Pentonville by Chief Inspector of Prisons was an unannounced visit from 24 February 2011 to 4 March 2011. The inspection report, published in June 2011, said in summary:

> "Pentonville is an iconic prison, but not always for the right reasons: its four central wings are over a hundred and fifty years old, it has a large and transient population drawn from some of London's poorest boroughs, and its prisoners have amongst the highest incidence of mental ill health and substance abuse of any local prison in the country. Despite these almost insuperable challenges, this unannounced follow-up inspection found that Pentonville was making some progress but inevitably there was much more to do.
>
> "Reception remained immensely busy and staff had little time to address all the immediate issues presented by prisoners. Similar pressures on first

night and induction arrangements meant that much work remained to be done to ensure the safety of prisoners in their most vulnerable early days in custody.

"Many men arriving at Pentonville were dependent on drugs and\or alcohol and treatment arrangements had improved with the introduction of the integrated drug treatment system. There had also been some success, working with the police, to reduce the flow of illicit drugs into the prison.

"There was an impressive health care centre and most services were good."

Previous deaths at HMP Pentonville

32. There have been four previous deaths at Pentonville in the past year. The investigator reviewed the Ombudsman's reports into these deaths and she found no issues in common between the earlier deaths and that of this man. There have been 24 previous deaths in total since the Ombudsman was given responsibility for investigating deaths in custody in England and Wales in April 2004, eight due to natural causes, 15 self-inflicted and one unclassified. There are no direct similarities between these previous deaths and that of this man.

KEY EVENTS

33. The man was born in July 1970. Prior to entering custody, he resided in the Poplar area of London with his parents. He was arrested on 9 August 2011, for an offence of attempted burglary. He appeared at a magistrates' court on 10 August. He was convicted and the case was remitted to a crown court for sentencing. He was remanded in custody and taken to HMP Brixton. A Person Escort Record (PER) had been completed, which indicated that the man may be a medical risk as he was suffering from cirrhosis of the liver due to his history of alcohol and drug misuse.

34. A nurse completed an initial healthscreen with the man as part of the reception process. His weight was 84kg, his blood pressure was 150/89 (the normal range for blood pressure is 100/70 to 140/90, although the pressure varies throughout the day depending on the individual's activities. A blood pressure reading of greater than 140/90 is classed as high and a reading of 90/60 or below is classed as low). His pulse was 88 beats per minute (bpm - normal range is between 60 – 80 bpm). He disclosed that he was a chronic alcohol misuser and polydrug user (the use of more than one drug) and that he was on a methadone prescription of 35mg. (Methadone is widely prescribed as a substitute to those wanting to combat heroin addiction). Brixton contacted the man's GP surgery, who confirmed he was prescribed a maintenance dose of 35mg of methadone when in the community.

35. He also advised the nurse that he was taking medication for epileptic seizures, was positive for hepatitis C (an infectious disease resulting in cirrhosis) and under the care of a liver specialist at outside hospital. He did not disclose any history of mental illness, was not considered to be a risk to himself and was located on G wing the induction wing. The nurse referred him to the prison doctor and the prison substance misuse team following an assessment for chlordiazepoxide. (This is otherwise known as librium which is a benzodiazepine used in the treatment of alcoholism for its sedating and anxiety-relieving effects which help relieve the symptoms of acute alcohol withdrawal).

36. During the reception process, as well as gathering a prisoner's medical history, other assessments are completed, including a Cell Sharing Risk Assessment (CSRA). This document is used to determine the appropriateness of placing prisoners in shared cells, and if there are any known risks or concerns. Another reception nurse stated on the healthcare section of the CSRA completed for the man that there was no increased risk with him sharing a cell.

37. A prison doctor who undertook the secondary healthscreen began ACCT (Assessment, Care in Custody and Teamwork) procedures. ACCT procedures are pivotal in the management of at-risk prisoners and are the principal tools for assessing, monitoring and managing any prisoner thought to present a risk of self-harm or suicide. There is no indication that the man was thought to be specifically at risk to himself, but by opening ACCT procedures, the doctor alerted staff on G wing of the need to undertake regular

observations. Utilising the ACCT in this way is extremely unusual. However, this action ensured that the man was closely monitored.

38. The same day, a nurse wrote in the man's medical that he was at high risk due to his detoxification, and that he needed to be well monitored and encouraged to move to D wing. A care plan was set up and he was made aware of the risk to his health. Later the same day, he was also examined by another prison doctor, who reiterated the risks of failing to be admitted to the prison healthcare centre. The doctor requested blood tests and noted:

> "I have explained our [the prison's] concern regarding his diagnosis of epilepsy, not taking anticonvulsants at the moment, his alcohol withdrawal and his jaundice that I would very strongly advise he should be admitted to hospital. I have explained the severity of our concern and that if he does have a seizure it could result in his death. He is aware of this fact and has capacity to make this decision".

39. The results of the blood test were received the same day by a doctor and showed that the man's liver function was impaired. The next day, the doctor contacted outside hospital to compare blood results with the most recent ones taken to determine if there had been any deterioration. He spoke with the on-call gastroenterologist (a medical professional who specialises in the treatment of patient conditions affecting the liver, intestine and pancreas) who did not feel that there was a significant deterioration. It was decided that contact would be made with the hospital consultant to arrange an appointment for review within the next few weeks.

40. Over the next few days, the man continued to live in a single cell on G wing and was seen regularly by healthcare staff. On 15 August, a doctor examined him and recorded that: "[The man] looks much improved, markedly less jaundiced". He was also examined by a further prison doctor who noted: "less yellow no tremor, not sweaty… alcohol withdrawal over almost complete meds for detox re methadone feels under dosed wants increase to usual dose of 35mg/day… increase to 35mg now off librium". The man completed his alcohol detoxification on 17 August.

41. On 16 August, a prison doctor reviewed the man who complained of cramps in his legs and arms and said that both his legs were swollen. In consultation with a further prison doctor, they decided to send the man to outside hospital as they wanted to rule out that he was suffering from a deep vein thrombosis (a blood clot typically found in the leg veins). A risk assessment detailing the level of restraints to be used should have been completed; however, this document, along with the Person Escort Record (PER) was not available to the investigator.

42. The man was taken to the Accident & Emergency unit of the hospital but he discharged himself back to Brixton. The hospital requested that he return the next day but the man refused and signed a disclaimer to this effect.

43. The man was regularly checked over the next few days and his observations were within normal range. Following a visit on 20 August, the man's mother contacted Brixton as she was worried about his health. She was given reassurance that the prison was aware of his health problems.

44. On 21 August, a nurse examined the man following concerns expressed by staff on G wing that he was drowsy, had slurred speech and swollen legs. The nurse recorded that the man's health had deteriorated and his liver was failing, but he still refused to go to D wing or outside hospital for closer observation. The man signed another disclaimer to this effect. His blood pressure was recorded as 127/75 and his pulse 74 bpm. As he had refused to be located on D wing, ACCT procedures restarted (as the document was not available to the investigator it is not known when the original ACCT was closed or if this was a continuation) and staff were advised to maintain hourly observations.

45. The next day at 9.00am, the man's pulse was recorded as 106 and his blood pressure 149/81. A prison doctor examined him at 9.53am and recorded that the man was confused and disorientated, appeared more jaundiced and looked anxious. He diagnosed probable Wernicke's syndrome, also known as hepatic encephalopathy. (This can occur where liver function is poor, a patient becomes constipated and toxins in the bowel accumulate. These cause temporary inflammation of the brain and result in a serious medical emergency).

46. The prison doctor explained to the man that he needed to go to hospital but noted that he was 'not keen' on being taken. There was no thiamine (important vitamins when detoxifying from alcohol and administered to help prevent hepatic encephalopathy) available at Brixton and the doctor consulted with his colleague who agreed that the man may need to be sectioned under the Mental Health Act as he was not capable of making a decision regarding going to hospital. This was not deemed necessary and the man was taken to the primary care unit at Brixton where he was re-examined by a doctor who noted that he was still unwilling to go to outside hospital. The doctor requested an emergency ambulance and completed a referral letter for the hospital outlining the man's history and he was taken to outside hospital.

47. The man remained in hospital for three nights. The restraints risk assessment, PER and bed watch log (a history recorded by escort officers, of time and events which take place while a prisoner is out of the prison as an inpatient at hospital) for this period were also not made available to the investigator. Brixton were unable to locate these documents and could not provide an explanation for the absence of this information. During his stay at outside hospital, the man was treated with intravenous parbinex (a preparation containing vitamins, including thiamine) and hospital staff were in contact with outside hospital where he was being treated for his liver condition. The Nurse Manager at Brixton visited the man on 24 August. She noted in the medical record that he remained jaundiced and was not particularly alert.

48. The next day, the man was discharged back to G wing at Brixton at 7.16pm, having been diagnosed with hepatic enchalopathy secondary to constipation. He was prescribed folic acid, vitamin B, thiamine, omeprazole (an antibiotic used for treating the stomach) and he was prescribed lactulose and phosphate enemas (used to prevent chronic constipation). He was observed hourly by healthcare staff who noted that he appeared to have slept well overnight.

49. On 26 August, a prison doctor created a clear management plan at 9.13am as outlined in the discharge letter from outside hospital. He wrote:

> "History: pt [patient] was discharged last night from hospital following his admission after he became drowsy while in prison. was diagnose with hepatic encephalopathy secondary to constipation is on laxatives now, he has to be on regular laxatives to make sure that he is passing stools 4 times a day to prevent further encephalopathy. Plan: explained to patient to use phosphate enema if lactulose alone does not ensure passing of stools at least 3 times a day"

The man's methadone dose was reviewed and reduced to 30mg.

50. Over the next few days the man was regularly monitored and continued to improve. On 31 August, he appeared at court and returned to Brixton. The next day a prison doctor examined him. He recorded that he was fully compliant with his medications and stabilised on 30mg of methadone. The doctor advised staff to continue to observe the man and any change in his presentation should prompt an urgent medical response. The doctor has noted that as the man had been admitted twice to outside hospital, he should remain on an ACCT and be examined by a prison doctor twice per week.

51. The man was taken to outside hospital on 6 September, where he was examined by the liver specialist In the medical records made available to the clinical reviewer, the liver specialist noted that the man was: "completely abstinent from alcohol for weeks. Advised to reduce methadone whilst in prison. Hepatitis C virus undetectable". However, there was no entry made in his prison medical records about the outcome of the appointment.

52. The man's condition stabilised. He remained on 30mg of methadone and was prescribed phosphate enemas on alternate days, although on 14 September he twice refused to have an enema administered. The next day, he appeared at a crown court and then went to Pentonville. This was a particularly busy and pressured time for London prisons, as a result of riots in the local area and the increased number of prisoners being detained. The reason the man went to Pentonville and did not return to Brixton is that the crown court is within the jurisdiction of Pentonville and, as long as there are adequate spaces, all those appearing at this court are directed to Pentonville.

53. On arrival at Pentonville, a nurse completed an initial healthscreen. She referred the man to the reception prison doctor for further examination and

noted, in respect to whether he was fit to be located within the main prison: "possibly needs healthcare [admittance to the healthcare unit] depending on medical examination". An entry was made on the electronic medical record by a doctor at 7.32pm that noted his assessment. During interview, the doctor confirmed that he met and assessed the man, but did not physically examine him. The doctor said:

> "I gathered from the history that he'd [the man] had, he'd been quite unwell with liver failure, secondary Hepatitis C and also alcohol use as well and had been under a professor at [outside hospital]. And had also had a recent flare up of acute and chronic liver failure whereby he became encephalopthic [pertaining to an encephalopathy state] and constipated.
>
> I think based on his, my communications and examination just in terms of inspection, he [the man] was coherent, he was not clammy, he wasn't showing any signs of tremor. He was alert, orientated in time, place and person. And also he was also not complaining specifically of any abdominal pain or any actual problems. For me doing an examination to confirm chronic liver disease I don't feel would have made or changed my acute medical management of him, certainly in terms of overnight."

54. The electronic initial healthscreen that was completed during the reception process was provided to the investigator and clinical reviewer. There were a number of omissions made where sections were not completed or not completed adequately. The detail of these omissions and the relevance to the clinical care are outlined in the clinical reviewer's report.

55. The man was initially located on A wing, the first night centre (where prisoners are located as part of the induction process and for assessment for the most suitable location within the prison), and moved to F wing the following day, where all those on a methadone prescription are placed for observation. He continued on a 30mg maintenance dose of methadone.

56. The man arrived at Pentonville subject to the ACCT procedures begun at Brixton. The doctor recorded that the ACCT was open, although there is no further comment noted on his medical record related to the reasons why, or how this should be managed. The doctor stated in interview that: "If he was on an ACCT it would have been shown to me", although he could not recall having viewed the document.

57. Following his reception healthcare screening, the doctor confirmed that a referral was made for the man to see another prison doctor the next day. This referral was made, although Systm One (the electronic medical recording system containing the initial healthscreen document) was not completed properly and the decision to refer with the reasons why was not recorded by the doctor. The man failed to attend for this appointment with the prison doctor at 10.30am on 16 September. No reason for this failure was recorded in the medical record and there was no follow-up to ascertain the reason for

the referral or failure to attend. The investigator, along with the clinical reviewer, was provided with a copy of the first night screening documents completed by the doctor. There was no record made of past and current physical history, no history of substance misuse recorded and the need for close observation or that the man was subject to special monitoring via the ACCT procedures.

58. Later the same day, a substance misuse doctor examined the man. He noted that he was stable and referred him for assessment with the substance misuse team upon arrival on F wing.

59. During interview, the substance misuse doctor explained that:

> "All of those patients who are needed to have treatment like methadone or subutex [a prescribed substitute for opiate drug use] they will be in F wing but if they have a serious medical problem they will be housed in the healthcare co-managed by my team … All of my patients that are first to be assessed or seen I review briefly what has been assessed by the GP or past medical history taken by the first night reception GP or in case of they were transferred from another prison their medical history at least I know what would be the problem and during their assessment I also ask what are the past medical history that's included to my assessment."

60. The substance misuse doctor confirmed that he was not a qualified GP and his role exclusively related to the management of substance misuse and detox medications. He explained that he did not have any direct medical input with the management of complex physical needs, as this would be the responsibility of initially the reception GP, then the prison doctors. He did not recognise that the decisions about substance misuse and management of the man's liver disease were interrelated. The man continued on a maintenance dose of methadone and detoxification, as suggested by the liver specialist, was not discussed by the substance misuse doctor with the man or other healthcare colleagues.

61. The ACCT document remains missing and the investigator was unable to ascertain if regular observations were undertaken by Pentonville. However, there is evidence that this form had arrived at Pentonville. An entry made in the bed watch risk assessment completed on 24 September, states the ACCT was closed on 18 September. As the form is missing, there is no information available to verify who closed the document, or the reason for closure.

62. Over the next few days, the man's observations were regularly taken while he was on F wing. On 21 September, he told a nurse that he had abdominal pains, was not eating well and had been constipated for a few days. The nurse recorded his blood pressure as 138/88 and pulse 98 bpm at 4.30pm. She referred him to the reception GP for an urgent medical assessment. Twenty minutes later, the nurse completed a further set of observations and the man's blood pressure was recorded as 149/91 and pulse 109 bpm.

63. At 7.15pm, a doctor visited F wing as an emergency. She examined the man and suspected he had an obstruction of the bowel. He was subsequently sent to outside hospital. A risk assessment was completed that authorised a two officer escort and the use of restraints to be removed for emergency treatment purposes only, with the duty manager's approval. The prison records note that the man left the establishment at 12.25am on 22 September. There is no explanation recorded why there was a delay in the doctor initially examining the man, or the delay in transferring him to hospital. The prison records note the man returned to Pentonville at 4.01am. He had been given two enemas and diagnosed with constipation. The investigator contacted Pentonville to try and establish if these timings were accurate, and was advised that the entries were not necessarily made at the actual time, and was told that he was taken to hospital at 9.00pm, as a non emergency.

64. The man was given another enema on 22 September by a nurse and he recorded that the man was sick after he ate. The next day, he complained of a bloated stomach and a nurse recorded at 8.42pm that she administered another enema. He was observed overnight and, at 5.10am on 24 September, he told a nurse that he was in pain. The man said that the enema given the previous night had not worked so he was given another one, again without effect. The nurse noted that the man appeared to be in a lot of pain, looked pale and his abdomen was tender. There was no evidence that a further medical opinion was requested. His blood pressure was recorded as 150/89 (classed as high) and pulse 113 bpm (classed as high).

65. An ambulance was requested by the nurse and paramedics arrived at F wing at 6.10am. A risk assessment was completed and the man was subject to an escort chain restraint with a two officer escort. The assessment stated that the restraints were to be removed for emergency treatment purposes only with the duty manager's approval. The ambulance departed Pentonville at 6.30am and arrived at outside hospital at 6.45am.

66. Initially, the man was admitted to a ward and his family were made aware of the situation. Following a decline in his health, he was moved to the intensive care unit (ICU) on 25 September. Over the next few days his condition improved and on 29 September he was moved to a further ward.

67. The man was moved back to ICU on 1 October as his condition deteriorated, but he was described as stable. The next day at 3.25pm authorisation was given for the escort chain to be removed. Over the next few days the man remained in the ICU and he continued to receive regular visits from his family.

68. On 5 October, the man's health continued to deteriorate and he was placed on a ventilator (a machine that supports breathing). His condition did not improve and, on 9 October, the prison nominated a family liaison officer (FLO) to be a point of contact, although the family were aware of the man's condition as they regularly visited him.

69. The man received a blood transfusion on 14 October. He remained on a ventilator and was sedated (while patients have a breathing tube, they are

given medications to keep them at a reduced level of consciousness and comfortable so breathing through the tube does not bother them). For the next few days nursing staff attempted to wean the man off of the ventilator to see if he could breath independently. However, they were not successful.

70. The outside hospital advised the man's parents on 1 November that his health was deteriorating and his life expectancy was a few days. Bed watch staff informed the duty governor. The next day, the nurse manager visited the man at outside hospital and discussed his condition with medical staff. She was told that his condition was deteriorating and it had been decided that he would not be resuscitated, if his health failed (an emergency procedure which is performed in an effort to manually preserve brain function until further measures are taken to restore blood circulation and breathing in a person). A tracheotomy was performed (an operative procedure to create an airway in the windpipe to help a patient wean off a ventilator). However, he was not able to sustain breathing on his own and he was diagnosed with end stage liver failure with a short life expectancy. Over the next few days his condition remained the same. His family were present during these days.

71. On a day in early November, the prison FLO visited outside hospital at 12.50pm to meet the man's family, but they were not present at the time of this visit. The next day, he was treated for encephalopathy. The prognosis was very poor and the man's family were present and aware of the situation. Later the same day at 4.00pm, a Governor authorised staff to sit outside the man's room to allow his family time alone with him. At 9.00pm the ventilator was switched off and the man died. Death was certified at 9.40pm.

72. Following the man's death, a governor took over the role of prison FLO as the current FLO was on leave. However, another member of staff contacted the man's family the next day as she was the operational manager over that weekend. On 7 November, a governor contacted the man's parents and arranged to visit them on 9 November. During this visit, in accordance with PSO 2710 (Guidance and instructions for actions to be taken following a death in custody), a contribution to the funeral expenses was offered.

73. The man's family expressed their thanks to Pentonville staff for their care whilst their relative was in hospital. On 16 November, a governor visited the man's parents again and gave them a letter of condolence from Pentonville. He also explained the inquest procedure and the Ombudsman's investigation. Further contact was made by telephone after the funeral and the governor returned the man's property and money to his parents on 21 December.

Support for prisoners

74. A notice to prisoners was issued by the Governor the same day announcing the death of the man and expressing condolences. This notice reminded them of the available support, via wing staff and the prison chaplaincy. A memorial service was not held.

Support for staff

75. A notice to staff was issued by the Governor the same day announcing the death of the man which reminded them of the available support, through the Care Team. A debrief was not held as he had been in hospital for a number of weeks before he died.

ISSUES

Clinical care

76. The clinical reviewer was commissioned by Islington Primary Care Trust (PCT) to review the medical care that the man received while in prison custody. His clinical review looks at the care and treatment he received at Brixton and Pentonville, and assesses whether it was appropriate and comparable to that which might have been available in the community. The clinical reviewer has concluded that the care the man received at Brixton was comparable, but the care at Pentonville was not. The clinical reviewer makes five recommendations concerning clinical performance, polices and procedures, record keeping, the loss of the ACCT document and emergency treatment, which are reflected in this report's consideration of the issues.

77. The clinical reviewer concluded:

> "This investigation has highlighted excellent care provided by [the man's] GP, the community substance misuse team, and [the Professor] at the liver clinic. There was good communication between all concerned with his management and this continued when he was in prison. Evidence showed that he received excellent care during the five weeks he was in HMP Brixton. He had hepatic cirrhosis and there was a high possibility of a fatal outcome at some time in the future. However recent evidence showed that his condition had improved following treatment in hospital in August, and this was confirmed in his last review in the liver clinic in September.
>
> "His [the man's] management in HMP Pentonville was not considered comparable to the care he might have received in the community. Although there was a high risk of recurrence of encephalopathy, there was no action plan to reduce this risk. His condition was not monitored or followed up, and some nursing clinical assessments of acute illness were inadequate.
>
> "The issue that remains unresolved is whether the lack of appropriate management in HMP Pentonville was a contributory factor in the death of [the man] at that time. The opinion of the liver specialist who had been looking after [the man] could be sought to try and answer this difficult question."

Transfer following court appearance on 15 September

78. The man's complex medical needs were well known to healthcare at HMP Brixton.. While it may not have been possible to place him on clinical hold to remain at Brixton, a referral letter for staff in another prison to outline his acute medical problems could have been completed.

Reception procedures at Pentonville

79. During the interview with the reception prison doctor who saw the man on his arrival to Pentonville, it was apparent that there had been a number of omissions during the reception healthscreen process at Pentonville on 15 September. In addition, following interview with the substance misuse doctor, there is evidence of a lack of communication regarding the management of a prisoner with complex needs. These issues are outlined in detail within the clinical review report. The clinical reviewer has summarised the main factors that contributed to the failure to follow-up the man's care as:

- Failure to provide a referral letter when he left HMP Brixton.
- Failure to assess his [the man's] risk and health needs at first night reception.
- Failure to implement the HMP Pentonville ACCT procedure that would have ensured observations continued to be made.
- Failure of healthcare staff to ensure existing care plan recorded in the Brixton medical records was continued in HMP Pentonville.
- Lack of any written procedure for GP when patient did not attend urgent post-reception next day appointment.
- Failure to review the man's care at the daily meeting to review management of high risk complex patients.
- Failure to recognise the need for shared care decisions when managing substance misuse in someone with severe liver disease.
- Failure to assess new symptoms adequately or ask for medical advice.

80. Following the interviews, the clinical reviewer contacted the Head of Healthcare at HMP Pentonville and Islington PCT outlining his immediate concerns about the clinical care provided to the man following his reception. As a result of this contact, a letter was received from the Chief Executive of Islington PCT dated 19 January, confirming that the doctor "has been suspended from first night assessments whilst the issues are being addressed".

81. Following the Chief Executive's letter, the independent clinical advisor to Pentonville prison reviewed a substantial sample of the doctor's reception consultations and considered the issues raised by the clinical reviewer. She concluded that:

> "I did not find [the doctor] unsafe, but there is a need to improve consultation details within the free text [on the electronic medical system]."

82. In addition, the medical director, Primary care, North Central London wrote to the investigator on 13 April and stated:

> "I can confirm that I have met with [the doctor] and discussed the content of the report and the annexes with him … As part of our considering whether to take any action under the National Health Service (Performers list) Regulations 2004 as amended I checked with our Clinical Governance systems in relation to his [the doctor's] work

as a GP and found that there were no concerns relating to his clinical performance as a GP."

83. The man was well looked after at Brixton and they provided Pentonville with the relevant information and care plans which should have been continued. Due to individual failings and a lack of communication between healthcare and IDTS, the care provided to the man declined.

The clinical reviewer has concluded:

> "Continuation of the HMP Brixton action plan would have ensured appropriate daily monitoring of his condition. This could have prevented 7 days of constipation which resulted in his deterioration and hospital admission on 24.9.11. Implementation of the recommendations to address the system and performance deficiencies identified in this report should lead to improved management of other patients with complex physical and substance misuse needs at HMP Pentonville."

The Governor and Head of Healthcare should work with Islington PCT to ensure that an investigation into the clinical performance of Pentonville, in particular this doctor's, is undertaken immediately.

Integrated Drug Treatment Services

84. The co-ordination of the man's physical health needs, and those relating to the management of his substance detoxification were quite distinct. There was a lack of communication between prison doctors and no evidence that the advice from the liver specialist had been considered. During interview the Head of Healthcare said:

> "There is also a morning meeting every morning at 8.30 where all the sections of healthcare meet to do a handover from the previous night. So we would look then for substance misuse, primary care, mental health, inpatients to all have a representative there who had been briefed on any activity the night before and they'll be able to bring that to us and share information between each other about what cause of action and care management or risk management they are going to enter into."

There was no evidence that the man's health had been discussed at such a meeting, despite him having such complex needs.

The Governor and Head of Healthcare should ensure there is a joined up approach by healthcare specialists and the quality of information is sufficient to avoid any future significant oversights.

ACCT procedures

85. The rules that govern all aspects of running a prison are set out in a series of Prison Service Orders (PSOs). PSO 2700 (Suicide prevention and self-harm management) details prison procedures for looking after prisoners at risk of suicide or self harm. Any member of staff can start the ACCT process, by completing a Concern and Keep Safe form which explains the reasons for their concern. An Immediate Action Plan is then written by the manager of the wing where the prisoner is located and an ACCT assessment must be carried out within 24 hours.

86. After the ACCT assessment has taken place, a multi-disciplinary (representation by all relevant departments from within the prison) ACCT case review is held to determine what measures can be taken to monitor and support the prisoner effectively. The prisoner attends the case review and is encouraged to contribute to the decisions being made. An ACCT CAREMAP (care and management action plan) is drawn up with details of each of the actions required to keep the prisoner safe and identifies who is responsible for carrying out each action. Case reviews are held at regular intervals to review the actions and the prisoner's level of risk.

87. The man was made subject to these procedures after his reception at Brixton. There was clear evidence contained in the electronic medical file that he was not considered to be at risk of harm to self, but due to his medical condition, required regular observation. The ACCT procedures were begun to ensure that these observations, in conjunction with the clinical care plan, would be carried out by wing staff. While this is a highly unusual reason for implementing such procedures, it was an imaginative and appropriate way in this instance to ensure that the risk posed to the man due to his physical health issues was managed.

88. There was no follow up by Pentonville to establish why the ACCT procedures had been implemented at Brixton. It was evident from staff interviews that there was a lack of regard for the process, once it had been established that the man did not pose a risk to himself. The investigator was unable to establish how, if at all, Pentonville monitored the man's physical health.

The Governor and Head of Healthcare should ensure that all staff follow ACCT procedures until they are formally closed.

Liaison with the man's family

89. The man's family were at his bedside when he died and were able to freely visit for the duration of his time at outside hospital. Financial assistance towards the cost of the funeral was accepted. A governor visited the man's family at their home on a number of occasions, and ensured that his property was returned to them. Despite three separate individuals acting in this role in some capacity, Pentonville managed this contact well and the family were well supported.

Support for staff

90. As the man had been in hospital for a number of weeks by the time he died, the prison did not hold a debrief for staff. Although there is no requirement to do so, giving staff the opportunity to collectively discuss an incident and reflect on all aspects of how it was managed provides those directly involved with an opportunity to process events. It can also be fundamental to providing the prison with feedback on any issues that need to be addressed as a matter of urgency (or indeed recognise good practice). Although informally supported by their peer group, the prison had a duty of care to ensure the wellbeing of all staff involved.

91. With reference to the response to a death in custody, Prison Service Instruction (PSI) 08/2010 Post Incident Care says:

> "The manager responsible must ensure a suitable environment for the meeting, ensure that all staff involved in the incident are invited and given information about the meeting and ensure that staff who wish to attend are released from duty for sufficient time to attend the whole of the meeting."

The Governor of Pentonville should ensure that all staff are provided with formal support from the establishment following a death in custody in line with the requirements of PSI 08/2010.

Record keeping

92. The man was placed on an ACCT on 11 August, whilst he was at Brixton. This form travelled with him to Pentonville where there is evidence that the ACCT procedures were subsequently closed on 18 September. Despite the attempts of the liaison officer at Pentonville to locate this document it could not be found.

93. In PSO 2710 Follow up to Deaths in Custody, paragraph 6.5 gives clear instruction that the prison is required to 'Hand over copies of all documents requested by the investigating teams'. It is clearly not acceptable that prisons lose such vital documents. While damaging to the investigation, in other contexts it could have direct influence on the care of a prisoner.

94. The absence of this ACCT document resulted in the investigation not being able to establish if the man received the level of support or observation intended when this process was opened. It is important that all significant documents relating to a prisoner are available and accessible to provide an accurate chronology of events, and to show the prison service is transparent about interactions regarding prisoners in their care.

95. In addition, the restraint risk assessments and PER forms relating to hopsital escorts from Brixton were not made available. Pentonville advised the investigator that they were not in possession of these documents. Brixton

were unable to locate them and provided no expination for the absence of this information.

The Governors of Brixton and Pentonville should ensure that all documentation relating to a prisoner is stored securely and able to be retrieved as necessary.

CONCLUSION

96. The man entered custody with complex physical health needs and a long history of drug and alcohol misuse. Given his diagnosis of hepatic cirrhosis there was a high possibility of a fatal outcome in the future. However, the clinical reviewer judges that the man received clinical care at Pentonville which fell below that which he could have expected in the community. The investigation has also highlighted a significant concern in respect to the clinical performance of the reception doctor at Pentonville at the time the man entered the establishment and poor management of those prisoners with complex needs.

RECOMMENDATIONS

1. The Governor and Head of Healthcare should work with Islington PCT to ensure that an investigation into the clinical performance of Pentonville, in particular the reception prison doctor who saw the man on his arrival to Pentonville, is undertaken immediately.

Accepted:

A review of [the doctor] was undertaken immediately on receipt of a letter from the clinical reviewer outlining concerns. A joint decision between Whittington Health, NHS North Central London and [the doctor] agreed that he should not undertake further practice at Pentonville until the results of the review was known. The review highlighted a number of minor concerns regarding appropriate record keeping and recording of prescription information. In addition the performance of [the doctor] has been reviewed by the GP Medical Director of Whittington Health and by the Medical Director of NHS North Central London who additionally interviewed [the doctor]. No clinical concerns were raised and all reviews have cleared the doctor involved as being fit to practice. As a consequence he is now cleared to resume work at Pentonville having accepted the recommendations of the reviews.

The NHS North Central London (NCL) Reference Committee (a sub-committee of the NCL Board which discusses and reviews individual performers whose performance gives cause for concern) has undertaken and completed the review of the individual practitioner in question in line with the Ombudsmen's recommendation. The PCT Partnership Board has now approached the NCL Associate Director of Primary Care to support them in taking forward the review of the clinical performance at Pentonville, in particular the primary healthcare pathway, including reception and release/transfer processes and the interaction with other services and providers, for example mental health.

This review will be collaboration between HMP Pentonville, NHS North central London, and Whittington Health NHS Trust. The review sets out to achieve both an overview of primary healthcare provision in Pentonville at a time of significant change, financial pressures and following a recent death in custody, and to gain an understanding of the issues faced by those delivering prison primary healthcare services.

The key aim of this review is to understand and assess the primary healthcare delivery experienced by prisoners in Pentonville and provide recommendations for service improvement.

The timeline for this work will be based on a decision to be made by the Governor.

Target: *Immediate (review of [the doctor]). Awaiting comment on terms of reference for wider review before date is set.*

Progress: *A review Terms of Reference has been drafted and awaiting final comment and the steering group are to arranging to meet shortly.*

2. The Governor and Head of Healthcare should ensure there is a joined up approach by the various healthcare specialists and the quality of information shared sufficient, to avoid any further significant oversights.

Accepted:

A number of actions have been implemented as a result of this death in custody.

1. Guidance has been issued regarding patients who do not attend for appointments. The guidance highlights the need to review the medical records and rebook the patient if deemed necessary by the clinician.

2. A review of reception procedures and staffing has been undertaken to include the introduction of case management and the formal risk stratification of patients.

3. A review of the management structure is underway to produce a more streamlined and ultimately more effective cross team management group to better support clinical delivery.

4. A review of cross team clinical working practices is underway to ensure joined up working practices and clinical co-ordination.

Target: *November 2012 (this is due to consultation requirements around any staffing changes.*

Progress: *Guidance issued immediately. Reception review underway. Some working practices including the introduction of case management and the stratification of patients into risk bands has already been implemented. Staffing changes are currently out for consultation.*

Management restructure is due for discussion at July 2012 Partnership Board.

Clinical leads across all three areas of Healthcare are due to meet in July / August 2012 to formalise cross working protocols.

3. The Governor and Head of Healthcare should ensure that all staff follow ACCT procedures until they are formally closed.

Accepted:

Guidance has been re-issued with regards to ACCT compliance. All Healthcare staff have undergone or are undergoing ACCT refresher training. Healthcare and Safer Custody now have a much closer working relationship and regular checks are made of compliance to ACCT procedures.

Target: *Complete and ongoing*

4. The Governor of Pentonville should ensure that all staff are provided with formal support from the establishment following a death in custody in line with the requirements of PSI 08/2010.

Accepted:

[The operations manager] is in charge of the Care Team, support is always offered to those involved in incidents as per the PSI.

5. The Governors of Brixton and Pentonville should ensure that all documentation relating to a prisoner is stored securely and able to be retrieved as necessary.

Accepted:

Records are kept in the Custody department. The Safer Custody Coordinator is ensuring that all ACCTs are returned to the Safer Custody Office when closed so they can be located if needed.